Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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

Document reference number	**HB003**	**Document developed by**	**Sub-group of Clinical Governance Group, chaired by Ms Eithne Coen**
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Contents

1. Policy Statement

This policy is provided to support the Self-Employed Community Midwife (SECM) in undertaking a risk assessment of women regarding their eligibility and suitability to avail of a Home Birth Service with the HSE

2. Purpose

2.1. The purpose of this policy is to support the Self-Employed Community Midwife in risk-assessing the eligibility and suitability of women for inclusion in the HSE Home Birth Service by utilising the tables provided in this document.
2.2. This policy shall support the SECM to assess the risks for the mother and baby at booking, throughout the pregnancy, during the labour and following the birth.
2.3. The policy shall provide guidance for healthcare professionals, women and their partners on the eligibility criteria and suitability for women planning a home birth.
2.4. The policy has been prepared to support the SECM to exercise her/his professional judgement in assessing the eligibility and suitability of a woman to proceed with a home birth.

3. Scope

The HSE has adopted the National Institute for Health and Care Excellence (NICE) Clinical Guideline 190 Intrapartum Care: Care of Healthy Women and their Babies during Childbirth (NICE 2014) as the evidence base to assess the eligibility and suitability of women requesting a home birth. This scope includes the risk assessment at time of booking and should be utilised throughout pregnancy, labour and post-partum. The Scope of Practice for Nurses and Midwives (NMBI 2015) assists the SECM, woman and DMO in their decision making to achieve the best possible outcomes.

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 Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (NMBI 2014)
4.4. Practice Standards for Midwives (NMBI 2015)
4.5. The Scope of Nursing and Midwifery Practice Framework (NMBI 2015)
4.6. Delivery on Choice: Home Birth Options for Women in Ireland Report (HSE 2008)
4.7. NICE Clinical Guideline 190 - Intrapartum Care: Care of Healthy Women and their Babies during Childbirth (NICE 2014)
4.8. The Irish Maternity Early Warning System (IMEWS) NCEC (DOH 2014)
4.9. Communication (Clinical Handover) in Maternity Services NCEC (DOH 2014)
4.10. Sepsis Management NCEC (DOH 2014)
4.11. HSE Risk Assessment Tool and Guidance (HSE 2011)

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

5. Definitions

5.1. Latent first stage of labour is a period of time not necessarily continuous when there are painful contractions and there is some cervical change, including cervical effacement and dilation up to 4 cm (NICE 2014).

5.2. Established first stage of labour is when there are regular painful contractions and there is progressive cervical dilation from 4 cm. (NICE 2014).

5.3. Eligible means satisfying the appropriate conditions (Oxford Dictionary).

5.4. Suitable means right or appropriate for a particular person, purpose, or situation (Oxford Dictionary).

5.5. Referral means making arrangements for the woman to see another professional for consultation, review, or further action if the care she needs falls outside the scope of safe midwifery practice (NMBI 2015).

5.6. Transfer means move from one place to another (Oxford Dictionary) and in this policy it means to move the woman or baby's care from home to a maternity unit/hospital for medical care under a consultant obstetrician.

Reference should also be made to 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. Director of Primary Care

The Director of Primary Care shall ensure the provision of:

6.1.1 An adequate budget for the Home Birth Service.

6.1.2 Appropriate governance systems and structures for the Home Birth Service.

6.1.3 An annual report to the HSE executive.

6.2. HSE Chief Officer

The HSE Chief Officer or their delegate shall:

6.2.1 Ensure that the appropriate systems and structures are in place for the DMO and SECM to adhere to this policy and procedure.

6.2.2 Sign and quality-assure the evidence to support the signing of the contract between the SECM and the HSE.

6.2.3 Communicate with and support the DMO and SECM if a case conference or alternate plan of care is required for the expectant woman.

6.2.4 Request that the SECM and DMO report any adverse incidents to NIMS as per HSE guidelines, informing the CO or their delegate.

6.3. Designated Midwifery Officer (DMO)

The DMO shall:

6.3.1 Provide information about the HSE Home Birth Service to women.

6.3.2 Facilitate contact between the woman and the SECMs in the area.

6.3.3 Facilitate the signing of the contract between the HSE CO and the SECM.

6.3.4 Process the expectant woman's application form (Appendix I), copy and return it to her, discuss the application with her and notify her in writing that her application has been approved (Appendix II), is pending approval following individual assessment (Appendix III), or not approved (Appendix IV) to avail of the Home Birth Service provided by the HSE.

6.3.5 Notify all other key stakeholders electronically, where possible, including the SECM, GP, DPHN and midwifery manager in the booking hospital that approval has been granted to the expectant woman for the HSE Home Birth Service (This list is not exhaustive – see letter templates (Appendix II).

6.3.6 Support and communicate with the CO or delegate, SECM and expectant woman if a case conference or alternate plan of care is required.

6.3.7 Visit the expectant woman at her home before the birth to discuss any concerns or issues with the HSE Home Birth Service, complete the risk assessment process and provide a home birth pack to the woman.

6.3.8 If the DMO identifies any change in relation to the risk status of the woman then the eligibility may be reconsidered in consultation with the SECM – 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 consultant assessment is received, or 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.

6.3.9 Provide reports as requested by the CO or Director of Primary Care.

6.3.10 Liaise with Ambulance Control as per National Policy for Communication with National Ambulance Service (HSE 2015)

6.4. Self-Employed Community Midwife (SECM)

The SECM shall:

6.4.1. Ensure that the expectant woman and her partner have read the home birth information letter provided by the HSE Home Birth Service.

6.4.2. Ensure that the woman understands the conditions referred to in tables 1 to 6 in Section 8 of this policy document.

6.4.3. Undertake a comprehensive assessment of the woman to risk-assess her:

a) Home environment as suitable for a home birth.

b) Consult with the DMO regarding risks that could materialise and impact adversely on the suitability of the home environment for a home birth.

c) Eligibility and suitability for a home birth with the HSE, and if the expectant woman requires individual assessment refer her to a consultant obstetrician.

6.4.4. Complete the HSE Home Birth Service application form and forward it to the appropriate DMO within two weeks of the woman and the SECM signing it.

6.4.5. Document in the notes evidence of continuous risk assessment carried out relating to the expectant woman at all antenatal visits.

6.4.6. Inform the expectant woman that risk is continuously assessed throughout pregnancy and labour and if her status changes from low risk the eligibility for the HSE Home Birth Service can be withdrawn and the woman will be referred immediately to an obstetric unit.

6.4.7. Communicate with the DMO on all aspects of the woman's care as required.

6.5. Consultant Obstetrician

The consultant obstetrician shall:

6.5.1. Assess the suitability of the woman for a home birth, taking account of tables in this policy, and document this in the woman's maternity record.

6.5.2. Provide a copy of the assessment to the SECM and DMO in circumstances where the woman does not carry her own maternity record.

6.6 National Ambulance Service (NAS)

The Ambulance Service shall, if requested, contribute to the risk assessment for the suitability of the home environment in liaison with the DMO.

6.7 Home Birth Applicant/Woman

The woman shall:

6.7.1. Provide the SECM with accurate information at the booking visit.

6.7.2. Discuss any concerns she or her partner may have regarding the birth process and place of birth.

6.7.3. Verify the information provided on her application form when contacted by the DMO.

6.7.4. Have the opportunity to discuss any issues that may have arisen during pregnancy when visited by the DMO prior to the planned home birth.

7. Procedure for the application of this guideline

7.1. The SECM shall assess the eligibility and suitability of each woman applying for a home birth.

7.2. The tables in Section 8.0 shall be referred to in carrying out the initial risk assessment when booking the expectant woman and signing the application form.

7.3. A risk assessment, underpinned by the tables in Section 8.0, shall be documented in the midwifery notes at each antenatal visit with the woman or at any time where the woman's condition deviates from normal.

7.4. Where a deviation from the normal has been identified, the SECM shall inform the:

7.4.1. Woman who has applied for the Home Birth Service.

7.4.2. Relevant clinical practitioner, consultant obstetrician, midwifery manager in booking maternity hospital and the DMO.

7.5. All assessments shall be documented in the midwifery notes and in the national maternity hand-held notes where possible.

7.6. The SECM and DMO shall support and participate in any case conference/multidisciplinary meeting if required to discuss the outcome and action plan for the woman.

7.7. The SECM shall support the DMO in monitoring and audit for compliance with this guideline.

7.8. Where a change in plan occurs – for example, transfer of the woman for hospital confinement or referral for further assessment by a consultant obstetrician – the SECM shall document and communicate to the DMO as soon as possible:

7.8.1 Date and time of assessment of the woman.

7.8.2 Date, time and detail of any telephone call or email sent to third party, for example consultant obstetrician.

7.8.3 Reason for referral and/or transfer.

7.8.4 Clinical assessment and environmental findings giving rise for concern.

7.8.5 Any actions undertaken.

7.8.6 Baseline data recorded.

7.8.7 That a clear explanation was given to the woman and her partner.

7.8.8 How the DMO was contacted: by email or telephone.

7.8.9 Any other information considered relevant to the referral, for example the SECM's contact details and mobile number

7.8.10 Recommendations made to the clinician to whom the woman is being transferred in the hospital.

7.9. The SECM shall refer and be guided by the ISBAR Communication Handover Tool (Appendix V) when transferring a woman or infant to hospital maternity services and The Policy to Support the SECM with the Transfer of Women and/or their Babies from Home to Hospital Maternity Services (HSE 2016).

8. Eligibility criteria for inclusion/exclusion of women for planned home birth with HSE Home Birth Services

8.1. The SECM shall refer to the tables in this section when assessing the suitability of the expectant woman for home confinement and assessing the risk status of the woman.

8.2. In determining whether a woman is suitable for a home birth it is the responsibility of the SECM to comply with requirements as set out in the HSE agreement (Responsibilities of the Self-Employed Midwife).

8.3. The tables form part of the contract between the HSE and the Self-Employed Community Midwife.

- **a.** Tables 1 and 2 relate to areas of high risk whereby if a woman presents with any of these conditions (medical or other factors) she is deemed ineligible for home birth. In this instance the SECM and/or DMO should direct the woman to the options available to her in a maternity unit/hospital.
- **b.** 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, which is subsequently noted on the woman's file.
- **c.** Women who do not relate to any of the conditions on any of the tables, i.e. 1 to 4, are therefore deemed eligible based on an assessment of low risk.
- **d.** However, if a woman presents with a medical or surgical procedure that is not referred to in Tables 1 to 4, and the woman, SECM or DMO require advice on this, the woman can be referred to a consultant obstetrician or relevant physician/surgeon for individual assessment and advice.

8.4. During the course of the pregnancy the risk factors may change and therefore a woman deemed originally as low risk may, during the course of their pregnancy, develop a condition on one of the four tables that may either deem them high risk and therefore ineligible (tables 1 and 2), or medium risk requiring review by an obstetrician (tables 3 and 4).

8.5. The decision to refer the expectant woman with regard to the conditions on the tables is a requirement for the midwife in order to enable the midwife to make a risk assessment when planning the place of birth. In making the final assessment the midwife is expected to liaise with the woman's consultant obstetrician regarding the assessment and to record this on the woman's notes. The consultant obstetrician's assessment is included in the midwife's final assessment for the planning of a home birth. If the consultant obstetrician advises the woman to have a hospital birth, then the woman becomes ineligible for a home birth under the HSE Home Birth Service. The outcome of the final assessment by the midwife is made available on request to the DMO.

8.6 Table 1: Medical conditions indicating increased risk requiring planned birth at an obstetric unit

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
	Atypical antibodies that carry a risk of haemolytic disease of the newborn
Infective	*Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended
	Infective hepatitis B/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
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
Endocrine	Diabetes
	Maternal thyrotoxicosis
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.

8.6 Table 2: Other factors indicating increased risk requiring planned birth at an obstetric unit

Factor	Additional information
Previous pregnancy complications	Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty to be discussed with neonatologist and obstetrician
	Previous baby with neonatal encephalopathy
	Pre-eclampsia requiring pre-term 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
	Preterm labour <37 +0 weeks' gestation
	Post-term pregnancy [For medical review by 40 weeks +10 days' gestation] Home birth feasible to day 14 post-term.
	Term pregnancy (37+0 to 42+0 weeks' gestation) rupture of membranes for more than 18 hours
	Pre-term labour or pre-term pre-labour rupture of membranes
	Placental abruption
	Body mass index at booking greater than 35kg/m² or less than 18 kg/m²
	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

8.6 Table 3: Medical conditions requiring individual assessment by a consultant obstetrician when planning place of birth

When individual assessment is required regarding the choice of planned place of birth, this should be undertaken by a consultant obstetrician in consultation with the woman and her partner and the Self Employed Community Midwife and, if required, the DMO. A plan of care is agreed for the woman's pregnancy, labour and birth and post-natal period. This plan is reviewed continuously through consultation and mutual agreement.

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
	Anaemia – haemoglobin less than 8.5g/dl -10.5g/dl at onset of labour
Infective	Hepatitis B/C with normal liver function tests
Immune	Nonspecific connective tissue disorders
Endocrine	Unstable hypothyroidism such that a change in treatment is required
	Hyperthyroidism
Skeletal/ neurological	Spinal abnormalities
	Previous fractured pelvis
	Neurological deficits
Gastrointestinal	Liver disease without current abnormal liver function
	Crohn's disease
	Ulcerative colitis

8.6 Table 4: Other factors requiring individual assessment by a consultant obstetrician when planning place of birth

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
	Previous term baby with jaundice requiring exchange transfusion
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation)
	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
Previous gynecological history	Major gynecological surgery
	Cone biopsy or large loop excision of the transformation zone
	Fibroids
	Female circumcision

Other non-clinical factors to be considered in liaison with the DMO and SECM	Lack of family support/peer support network
	Safeguarding of children and vulnerability issues
	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.

8.6 Table 5: Indications requiring intrapartum transfer

Rupture of membranes greater than 18 hours
Maternal request for medical (epidural or alternative) pain relief
Indications for electronic fetal monitoring (EFM) including abnormalities of the fetal heart rate (FHR) on intermittent auscultation
Confirmed *****delay in the first or second stage of labour.
The presence of meconium
Temperature of 38°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 blood pressure (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
Obstetric emergency – including haemorrhage, cord presentation, cord prolapsed, maternal seizure or maternal collapse, shoulder dystocia
Retained placenta or incomplete placenta more than one hour following the birth
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.

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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.

8.6 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.)

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 and tenderness
	Symptoms of a urinary tract infection
	Offensive lochia
	Perineal infection and/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 ≥10 mmHg in the systolic or diastolic blood pressure reading where a baseline has been established two hours post 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/artesia
	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 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, pallor, high pitched cry, 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 ≥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.

9. Monitoring and Audit:

9.1. Monitoring of compliance with this policy shall be undertaken by the DMO.
9.2. Audit of compliance with this policy shall be undertaken by HSE professionals.

10. Training:

The SECM shall ensure that she/he has sourced appropriate education and training to support the implementation of this policy.

11. References/Bibliography:

References and bibliography for this document can be sourced within Guidance on Reference Sources to Support the Development of Clinical Governance Systems and Structures for the Health Service Executive Home Birth Service (Clinical Governance Group for the HSE Home Birth Service 2016).

12. 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.

Appendix I

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		
	Atypical antibodies that carry a risk of haemolytic disease of the newborn		
Infective	*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/m² or less than 18 kg/m²		
	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		
	Previous term baby with jaundice requiring exchange transfusion		
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation)		
	Body mass index at booking of greater than 35kg/m² or less than 18 kg/m²		
	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 to be considered in liaison with the DMO and SECM may include	Lack of family support/peer support network		
	Safeguarding of children and vulnerable persons		
	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 ≥ 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 ≥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 II

Template for letters following approval of application for the HSE Home Birth Service

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Home Birth Office (include email and contact no.)

Dr.

Date:

Re:

Home Birth **E.D.D.:** **Date of Booking:**

Dear Dr.

The above-named woman who has applied for midwifery services for a home birth is eligible for same and has been informed accordingly.

This woman has booked with **Self-Employed Community Midwife……** and is planning to have a home birth. …… will visit her regularly in her home and at her clinic to carry out her antenatal care, deliver her baby and look after her in the postnatal period up to day 14.

This woman has been advised to register with you as her GP and also to have a booking visit at the maternity hospital of her choice. The SECM would like to do combined care with you if you are agreeable. This will involve antenatal care and a physical examination of the newborn – **you are not expected to be involved in the actual delivery.** Should this client wish or require attendance for hospital services, it would be a matter for you to make the appropriate arrangements.

If you need any further information regarding this woman's progress, please contact the SECM listed above. The midwife may be in contact with you with regard to prescription for Anti-D and Vitamin K if required and we hope you will assist her/him in these cases.

Please see attached letter sent to **……** (the woman).

Yours sincerely

_____

Designated Midwifery Officer for the HSE Home Birth Service

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Home Birth Office
(include email and contact no.)

Woman's contact details
Date:

Dear

I am in receipt of your application for domiciliary midwifery services and I note that you intend to be confined at your **home address……** I am also in receipt of your consent form, which states that if any complications arise during your pregnancy/labour/postnatal period you agree to have the management of your care transferred to a hospital-based team if the midwife deems it necessary.

Your application details have been assessed and you are deemed eligible at present for midwifery services under the Home Birth Service. You will appreciate that risk assessment is an ongoing process throughout pregnancy, and should you require an individual assessment by a consultant obstetrician or circumstances arise contraindicating a home confinement, you may be told that your eligibility for this service has ceased and that in your own and your unborn infant's best interests you are advised to transfer to hospital-based care.

I have notified your GP that you have booked with (**midwife name)** and that you are planning to have a home birth. **Midwife name** would like to do combined care with your GP if he/she is agreeable. This will involve shared antenatal care and a physical examination of the newborn baby – **your GP is not expected to be involved in the actual delivery.**

As per the National Guidelines for Home Births you are advised to register with a GP for the Maternity and Infant Care Scheme and to book at a maternity hospital of your choice. It would be a matter for your midwife to make the appropriate arrangements. I have also notified your local **public health nurse ……** of your intentions and she can be contacted at **…… health centre phone number.**

It is a matter for yourself and your midwife to discuss and agree the details of the service to be provided. Your midwife is not an employee of the HSE but has indemnity insurance cover provided by the Clinical Indemnity Scheme for Midwifery Services, provided in accordance with an agreement between the midwife and the HSE from the date of your first consultation with your midwife up to and including day 14 following the delivery of your baby.

All newborn babies are now being offered a free hearing screening test prior to being discharged from the hospital. As your baby will be born at home, after the birth your midwife will refer your baby for hearing screening. You will be contacted by the staff of the Newborn Hearing Screening Programme and invited to bring your baby to the hospital for this screening. Please see the attached brochure for more information regarding your baby's hearing test.

Please take time to read the information contained in this letter, and may we take this opportunity to wish you a safe and happy birthing experience. We look forward to meeting you before the birth, when we will visit you to complete the risk assessment process for the HSE Home Birth Service and supply you with your home birth pack. Your local public health nurse may accompany us on this visit.

Yours sincerely,

_____

Designated Midwifery Officer for the HSE Home Birth Service

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Home Birth Office
(include email and contact no.)

MEMO

To: **Director of Public Health Nursing,**

From:

Date:

Re: **Application for Home Birth Services**

Enclosed find application for Home Birth Services from:

PATIENT'S NAME:

Home Birth **E.D.D.:** **MOBILE:**

The midwife for this woman will be:

I will deliver the maternity pack at least one month prior to the delivery date. I will send the PHN a copy of the application and enquire if she would like to accompany me on this visit.

Yours sincerely,

_____
Designated Midwifery Officers for the HSE Home Birth Service

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Home Birth Office
(include email and contact no.)

PHN Contact Details

Date:

Re:

Home Birth **E.D.D.:** **MOBILE:**

Dear

The above-named woman is having a home birth. She has booked with Self-Employed Community Midwife ……., mobile number **……**

I will deliver her maternity pack about one month prior to her due date. We can visit together at this time if you and the woman would like to meet before the birth.

Please contact me at the above number if you would like to do a joint visit.

Yours sincerely,

_____

Designated Midwifery Officer for the HSE Home Birth Service

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Home Birth Office
(include email and contact no.)

Midwife

Midwife Contact Details

Date:

Re:

Home Birth **E.D.D.:** **MOBILE:**

Dear

I refer to the application for domiciliary midwifery services by the above-named woman and confirm that she is at present eligible for the service and has been informed accordingly. She has been informed that risk assessment is an ongoing process throughout pregnancy and that if an individual assessment by a consultant obstetrician is required or should circumstances arise contraindicating a home confinement, her eligibility for the service will cease and she will be advised to transfer to hospital care.

The contact details for the public health nurse for this woman are:

Public Health Nurse:

Health Centre/Phone No.:
Mobile No.:

If there are any changes to this woman's details or the EDD, please inform this department. Please confirm to this department that you have arranged for a second midwife to attend this woman's birth with you. Arrangements will be made to deliver a home birth pack to this woman's home one month prior to EDD. Please forward this department the directions to this woman's residence as per National Ambulance Service policy if you have not already done so and notify Ambulance Control when this woman is in established labour. Please make contact with the PHN prior to discharging this woman on day 14 following delivery.

Yours sincerely,

_____

Designated Midwifery Officer for the HSE Home Birth Service

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Home Birth Office

MEMO

To: **Administration Officer for the Chief Officer, Community Healthcare Organisation**

From:

Date:

Re: **Application for the HSE Home Birth Service**

Ms _____has been approved for the HSE Home Birth Service. I will forward the invoice for payment to her Self-Employed Community Midwife …….once this service has been completed.

Woman's Name and Address:

Home Birth **E.D.D.:**

Yours sincerely,

_____

Designated Midwifery Officers for the HSE Home Birth Service

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Home Birth Office
(include email and contact no.)

Director of Midwifery
Address

Re: Ms
Home Birth E.D.D.: Date of booking:

Dear

The above-named lady who has applied for midwifery services for a home birth is eligible for same and has been informed accordingly.

This lady has booked with Self-Employed Community Midwife Phone:
She is planning to have a home birth. **Midwife name** will visit her regularly in her home to carry out her antenatal care, deliver her baby and look after her in the postnatal period up to day 14.

This lady has been advised to register with her GP and has booked with Dr. …….
in maternity unit/hospital ……. for antenatal care.

There were **(no/provide name of risk factor/s)** risk factor/s identified and **name of woman** had an assessment with her consultant obstetrician.

If you need any further information regarding this lady's progress, please contact the SECM listed above. The midwife may be in contact with …….. hospital with regard to access to laboratory and ultrasound scan results as required and I hope you will assist her with this.

The midwife will forward you a postnatal discharge summary or attach it to the woman's maternity records before returning them to the hospital.

Yours sincerely,

_____

Designated Midwifery Officer for the HSE Home Birth Service

cc. Consultant Obstetrician

Appendix III

Template for letter indicating 'pending approval status' for a home birth following application for the HSE Home Birth Service

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

(include email and contact no.)

Date:

Dear

I am in receipt of your application for domiciliary midwifery services and I note that you wish to be confined at your **home address……** Your application demonstrates that during your risk assessment with your midwife, **a risk of……**was identified on Tables 3 and 4 of the HSE Home Birth Service eligibility criteria. We must therefore advise you that you will need to have an individual assessment with a consultant obstetrician before we can approve you for a home birth with the HSE service.

If the consultant obstetrician confirms, following assessment, that you are suitable to give birth at home then you will be deemed eligible for midwifery services under the HSE Home Birth Service. We will approve you for the service and write to you accordingly.

However, if the consultant obstetrician finds that there are issues contraindicating a home birth, you will not be considered eligible for the HSE Home Birth Service and in your own and your unborn infant's best interests, you will be advised to transfer to a maternity unit/hospital for your ongoing care during your pregnancy. The SECM, doctor or DMO can assist you with the referral and transfer of your care to a hospital of your choice.

You are advised to register with a GP, if you have not already done so, for the Maternity and Infant Care Scheme and to book with a maternity hospital of your choice. It would be a matter for your midwife to make the appropriate arrangements.

Your midwife is not an employee of the HSE but has indemnity insurance cover provided by the Clinical Indemnity Scheme for Midwifery Services provided in accordance with an agreement between the midwife and the HSE from the date of your first consultation with your midwife and, if you are eligible for the HSE Home Birth Service, up to and including day 14 following the delivery of your baby.

Please take time to read the information contained in this letter and we will write to you again once we have received confirmation of the outcome of your individual assessment with the consultant obstetrician.

Yours sincerely,

_____

Designated Midwifery Officer for the HSE Home Birth Service

Appendix IV

Template for letters indicating ineligibility for a home birth following application for the HSE Home Birth Service

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Home Birth Office

Mother's Contact Details

Date:

Dear

I am in receipt of your application for the HSE Home Birth Service. As I discussed with you on the phone, the Health Service Executive (HSE) has a Home Birth Service provided by Self-Employed Community Midwives (SECMs), the purpose of which is to provide midwifery services to women who are 'low risk' in terms of maternity care who choose to have their babies at home.

Your application details have been assessed and unfortunately you are deemed ineligible for midwifery services under the HSE Home Birth Service due to your obstetric/medical history. In the circumstances where there are medical reasons contraindicating a home confinement, you will appreciate that the HSE should, in the best interests of a mother and her unborn child, advise that the delivery take place at the safest possible location and could not support a home birth in this situation.

I advise you to book in at a maternity unit of your choice for a hospital birth and discuss your birth plan with the hospital midwifery and medical staff. In the meantime, we are available to talk and meet with you if you have further questions.

Yours sincerely,

_____

Designated Midwifery Officers for the HSE Home Birth Service

Appendix V
Template for Handover communication using ISBAR tool (DOH 2014)

ISBAR Communication Tool	
I **Identify**	**Identify:** You Recipient of handover information Patient
S **Situation**	**Situation:** Why are you calling? (Identify your concerns)
B **Background**	**Background:** What is the relevant background?
A **Assessment**	**Assessment:** What do you think is the problem?
R **Recommendation**	**Recommendation:** What do you want them to do?

13. Signature Page

I have read, understand and agree to adhere to the attached:

_____

Print Name	Signature	Area of Work	Date