Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

TARA SUITE

Information for expectant mothers choosing a Home Birth

Home birth can be a safe option for low risk healthy women. Low risk means no history of medical or surgical problems that might affect your pregnancy and no present or previous pregnancy complications. Research shows that a planned home birth is an acceptable and safe alternative to a planned hospital birth for some pregnant women when it is supported and structured in a maternity care system with well-trained midwives and a good referral and transportation system (1, 4).

However the rate of home birth in Ireland (0.2%) & U.K. (2%) is low in comparison to countries like the Netherlands where access to specialist services and short transfer times are the norm. Specialist services and short transfer times may not always be available across Ireland and the UK therefore the safety of home birth needs to be considered in the context of the availability of local services (2).

If this is your first baby, you can apply for a home birth; however there is recent evidence from a large study in the U.K. that for first time mothers choosing a home birth, the risk of an adverse outcome for their baby is approximately twice the risk for first time mothers giving birth in hospital (3). Over all the risk of an adverse outcome remains very low. The key points from this study are available at
The Birthplace cohort study: key findings | SHEER | NPEU > Birthplace (ox.ac.uk)
Women may wish to have a home birth because they

- feel safer at home
- dislike being in hospital
- want to feel more in control
- want to avoid intervention
- don't want to be separated from older children.

You in consultation with your midwife and other medical advisors of your choice will decide whether home birth is a safe option for you and your baby. Home birth may not be a safe option if you have medical problems, previous obstetric and gynaecological problems, or

unsuitable home conditions. Pregnancy and childbirth is a process and risks/safety may change at any stage. Midwives are trained to recognise signs of complications during pregnancy and labour. If complications arise during pregnancy/labour/following birth your midwife may advise you to transfer to a hospital service.

First time mothers are more likely to transfer to hospital during pregnancy and birth than women who have given birth before. It is safer for you and your baby to transfer well before the situation becomes an emergency. To view the most recent statistics on planned home birth in Ireland visit

NPECHomeBirthsannualreport2021.pdf

'Birth is mostly a natural physiologic process……There are a number of biological reasons why the process might be enhanced if the mother is supported in a quiet, secure and known environment. On the other hand the growth of the foetus and the concluding childbirth are complicated biological processes which occasionally go astray, and where a need for interventions may be felt' (5).

Please see the attached list of Tables for more information on the risk factors that identify women who may be at risk for a home delive

References

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

2. RCOG 2013 Statement on BMJ home birth study: www.rcog.org.uk

3. Birthplace in England Collaborative Group (2011) Perinatal and maternal outcomes by planned place of birth for healthy low risk pregnancies: Birthplace in England national prospective cohort study. BMJ, 343:d7400.

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

5. Olsen O. and Jewell MD. (2003). Home versus hospital birth (Cochrane Review). In: The Cochrane Library, Issue 4. Chichester, UK: John Wiley & Sons, Ltd.

Risk factors that identify those women who may be at risk for a home delivery

(This is not an exhaustive list)

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.

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 (AC less than the 10th Centile and/or EFW less than 10th Centile)		
	Abnormal fetal heart rate (FHR)/doppler studies		
	Ultrasound diagnosis of oligo/polyhydramnios		
Previous gynaecological history	Myomectomy		
	Hysterotomy		

Table 3 Medical conditions requiring individual 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 National 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		

Table 4 Additional factors / medical conditions requiring consideration regarding eligibility for HSE's National Homebirth Service

Factor	**Additional information**	**Yes**	**No**
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		
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 key factors that staff and stakeholder respondents felt were key in the management of transfer. In the cohort study, the main three reasons for transfer were delay in the 1st stage of labour, signs of fetal distress and delay in 2nd stage. Repair of perineal trauma was the main reason after birth**.** In 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 also 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 8 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 the SECM responsibility is to transfer the woman as soon as possible once the decision to transfer is made, communicating 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 ambulance response times in that area and other influencing factors such as time of day, weather etc. Harris et al (2011) indicates 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 all future transfers are prospectively reviewed and analysed so that more accurate guidance can be made in future policy documents.

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 fetal monitoring (EFM) including abnormalities of the fetal heart rate (FHR) on intermittent auscultation		
Confirmed *delay in the first or second stage of labour, as per HB004: Midwifery Practice Guidelines HSE Home Birth Service.		
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		

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.		

Contact details for the Self Employed Community Midwives providing a service for Our Lady of Lourdes Drogheda

SECM	Email	Telephone
Nanni Schluenz	Nannisch@me.com	0863311531
Sarah McCann	sara@birthlogic.ie	0879625544
Niamh Bates	nobates@gmail.com	0861556115

BIRTH AT HOME

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Birth at home is a safe option for women who have no previous medical problems which may affect this pregnancy or birth. It is offered to women who are normal risk and assessed as being suitable to birth at home. This service is free of charge.

A midwife who is contracted by the hospital, will provide individualised care throughout the pregnancy and birth, and will provide care at home, for a period of up to 14 days following the birth of your baby.
You will see the same midwife throughout your pregnancy and birth. Continuity of care has been associated with better birth outcomes and good experiences for women. The option to birth in water is also available for births at home.
Should any concerns regarding you or your baby arise, you may require transfer to the hospital for further management.

If you are interested in discussing or considering homebirth you can contact the Designated Midwifery Officer (DMO) in Our Lady of Lourdes Hospital on 0871009125 for more information.

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CONTACT DETAILS

ANTENATAL CLINIC: 041 9837601 Ext 2275

SCAN DEPARTMENT: 041 9837601 Ext 4769

LABOUR WARD: 041 9837601 Ext 2112

MATERNITY DAY UNIT: 0419837601 Ext 5229

ANTENATAL WARD: 0419837601 Ext 2282

POSTNATAL WARD: 0419837601 Ext 2284

PARENTCRAFT: 0419837601 Ext 2601

BIRTH REGISTRATION: 0419837601 Ext 2107

Emergency Services: 999 / 112 (if no mobile phone coverage)