Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Home Birth Office
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Important information about Home Birth Service:

Please keep this letter

Dear

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

Your choice

When deciding where to give birth, remember that:

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

How to find out more about having your baby at home

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

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

Visit with your midwife

Your chosen midwife will arrange to meet you. At this meeting, she or he will take a detailed history from you and decide if a home birth is a safe option for you and your baby. Depending on your history, your midwife will organise a further assessment at the hospital if needed. If you and your midwife decide to go ahead with your plans for a home birth, your midwife will send **your application form** to the HSE Designated Midwifery Officer (DMO) in your area. This application form includes a consent form signed by you.

Giving your consent

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

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

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

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

Who approves your application for the HSE Home Birth Service?

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

What to do if you are eligible

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

Birth plan

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

HSE Designated Midwifery Officer Visit

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

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

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

Yours sincerely

Siobhan & Jo

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Designated Midwifery Officer for Home Births

Information for expectant mothers choosing a Home Birth

About this document

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

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

Home birth can be a safe option for a healthy woman

You are considered healthy if you have no history of medical or surgical problems that might affect your pregnancy and no present or previous pregnancy complications. Research shows that a planned home birth is a safe alternative to a planned hospital birth for **some** pregnant women. However, this is when the home birth service is structured in a maternity care system with well-trained midwives and a good referral and transportation system[1].

How many women have a home birth in Ireland?

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

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

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

Who will support me during labour and birth?

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

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

Professional support will be provided by your midwife. You may also choose to have your partner or whoever you decide to have with you in labour.
A second midwife, also funded by the HSE, will be present at the birth to support the midwife during your labour and birth of your baby. Your midwife may arrange to introduce you to the second midwife during your pregnancy.

When might home birth not be a safe option?

Pregnancy and childbirth is a process where risks and safety may change at any stage. Midwives are trained to recognise signs of complications during pregnancy and labour. If complications arise during your pregnancy, labour or following the birth of your child, your midwife may advise you to transfer to hospital care. To view the most recent statistics on planned home birth in Ireland, visit:
https://www.ucc.ie/en/npec/publications/

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

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

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

You should be aware that the risk to your baby's wellbeing doubles if you are a first-time mother.
The key points from this study are available at:
https://www.npeu.ox.ac.uk/downloads/files/birthplace/Birthplace-key-findings.pdf

Risk factors to be considered when approving a home birth

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

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

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

Useful web sites

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

Community Midwives Association www.communitymidwives.ie

Home Birth Association of Ireland www.homebirth.ie

Health Service Executive www.hse.ie

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

Nursing and Midwifery Board of Ireland www.nursingboard.ie

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

Royal College of Physicians of Ireland www.rcpi.ie

The Child and Family Agency www.tusla.ie

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

Plain English Approved by NALA

Tús Áite do Shábháilteacht Othar
Patient Safety First

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 (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		

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		

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)		
	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.

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.

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.		

Guidance to the Schedule for Antenatal Care for the HSE Home Birth Service

How the Scheme operates:

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

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

SCHEDULE OF VISITS

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