RQIA Guideline for Planning to Birth at Home (Maternity Health Care Provider Version)

This guideline* relates to all healthy women with a straightforward singleton pregnancy (1), see page 9 who plan to birth at home (see (2), page 10-13) below for NICE recommendations.

Women who meet the following can also plan to birth at home without any additional discussions:

- Are aged ≥ 16 Years & ≤ 40 years at booking appointment
- Had assisted conception with Clomifene
- Have a BMI at booking of ≥ 18kg/m² & ≤ 35kg/m²
- Had a previous third degree perineal tear with no significant symptoms
- Had a previous baby with a condition requiring medical assistance, with no evidence of the possibility of reoccurrence
- Had up to 4 previous vaginal births in the absence of a previous C/S uterine scar
- Have experienced mental ill-health and fulfil the criteria for Step 1 & 2 of the Regional Mental Health Care Pathway (3), see page 14
- Had a threatened miscarriage, now resolved
- Have a last recorded Hb ≥100g/l prior to labour
- Had a suspected low lying placenta, now resolved
- Have a medical condition that is not impacting on pregnancy
- Have required Social Services support and there is no related impact on the pregnancy
- Have had a threatened preterm labour, now resolved
- Have Serum Antibodies of no clinical significance
- Have had previous cervical treatment, now term
- Have an expected birth weight of a baby with appropriate growth on a customised growth chart
- Have had SROMs 24 hours and no signs of infection
- Have meconium stained liquor of no significance (4), see page 14 in the absence of any other risk

In addition, women who do not meet these criteria but who still wish to plan a home birth after discussion and the development of an individualised care plan should be supported to do so (See Page 15).

Midwives and Maternity Care Providers always aim to build trusting woman-centred relationships. Any queries or difficulties, contact the Head of Midwifery/Consultant Midwife in your Trust. Further multidisciplinary discussion may be necessary, with documentation as appropriate.

These notes (1-4) are additional information linked to the text in the grey box above (and the purple box in the women’s booklet that may assist maternity care professionals and women with discussion of the evidence).

(1) A straightforward singleton pregnancy, is one in which the women does not have any pre-existing condition impacting on her pregnancy, a recurrent complication of pregnancy or a complication in the pregnancy which would require on-going consultant input, has reached 37 weeks gestation and ≤ 2) Term +14 (GAIN, 2016).
Northern Ireland Care Pathway for Women Planning Birth at Home (Maternity Care Provider version)

To promote partnership and positive relationships between women, their partner’s and maternity health care providers (HCP), discussions should:

- Be individualised & relevant
- Be evidence based and balanced, particularly when discussing uncommon events and complications
- Use absolute numbers rather than percentages and present the information ‘both ways’ (e.g. 3 babies per 1000 (0.3%) will have a serious medical problem compared to 2 babies per 1000 (0.2%) born in an alongside midwifery unit (AMU) and 3 babies per 1000 (0.3%) born in a freestanding midwifery led unit (FMU) or an obstetric unit. What this means is 2 or 3 babies per 1000 will have a serious medical problem regardless of place of birth).
- Avoid unnecessary repetition and document discussions clearly.

Use the resources in Appendices 5, 6 & 7 to assist you in your discussions of the evidence.

As early as possible in pregnancy (preferably by 28 weeks) speak to the woman re options for place of birth including planning to birth at home

Use the list on page 8 (contained in grey box) (purple box in woman’s leaflet) a guide for discussion with the woman

The woman’s plan to birth at home is supported by the evidence

Follow NI HSC Maternity Care Core Pathway for Antenatal care

Agree an individualised care plan with the woman and document it

Any queries or difficulties, contact the Head of Midwifery/Consultant Midwife in your Trust. Further multidisciplinary discussion may be necessary, with documentation as appropriate.