



Government of **Western Australia**
Department of **Health**

Womens and Newborns Health Network

**Policy for Publicly Funded Homebirths including
Guidance for Consumers, Health Professionals
and Health Services**

Revised October 2013

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Glossary

ACM – Australian College of Midwives

AIMS – the Advanced Incident Management System, a standardised reporting system to enable the recording of clinical incidents consistently across the State

Amniotomy – rupture of the amniotic sac to induce or augment labour

Amniotic sac – the membranes which hold the developing fetus

Antenatal – existing or occurring before birth (also known as prenatal)

Antenatal care – care of women during pregnancy by doctors and midwives in order to predict and detect problems with the mother or the unborn child. Advice is also offered on other matters relevant to pregnancy and birth

Antepartum haemorrhage – bleeding from the birth canal in the second half of pregnancy

Apgar score – system for assessing the physical condition of infants immediately after birth (a maximum of two points awarded for each of five categories: heart-rate, breathing effort, muscle tone, reflexes and colour)

Augmentation of labour – a medical (e.g. Intravenous oxytocin) or surgical (amniotomy) intervention in an attempt to increase the effectiveness of uterine contractions to expedite the birth

BMI – Body Mass Index

Caesarean section – delivery of an infant through a surgical incision in a woman's abdomen

Child health nurse – registered nurses with post graduate qualifications in child and family health. They work in partnership with parents and carers of babies and children 0-4 years

Clinical governance – a systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes

Clinical incident – an event or circumstance resulting from health care which could have, or did lead to unintended harm to a person, loss or damage, and/or a complaint

Complication – a disease or injury that develops during pregnancy, birth or the postnatal phase that may alter the course and/or the management of the pregnancy, birth or postnatal phase

Consumers – users of maternity services, for example the pregnant woman and her family

Continuity of care – care that helps women develop a relationship with the same carer, or group of carers, throughout pregnancy, birth and after the birth. All carers share common ways of working and a common philosophy

Continuity of carers – care provided over time by the same trusted carers (usually including back-up arrangements)

Doula – is an experienced birthing companion who understands the emotional and physical needs of women and her family throughout her pregnancy, labour and birth, and provides continuous support (non-clinical) and care for women throughout her whole birth experience

Episiotomy – a surgical cut in the area between the vagina and the anus during childbirth

Evidence based – the process of systematically finding, appraising and using research findings as the basis for clinical decisions

Fetal – relating to the fetus (the unborn baby), or the period after the seventh or eighth week of pregnancy

General practitioner (GP) – a doctor who is qualified and competent in general practice and has the skills to provide whole person, comprehensive, coordinated and continuing medical care

Gestation (also gestational age) – length of pregnancy, expressed in weeks (calculated from the first day of the mother's last normal menstrual period ideally confirmed with ultrasound assessment). It is recommended that the due date is adjusted to coincide with the ultrasound assessment, if there is more than five days variance in the first trimester or seven days variance in the second trimester

Gestational diabetes – diabetes found in pregnancy; temporary high blood glucose levels in pregnancy

GP obstetrician – a GP obstetrician is a general practitioner who has a diploma in obstetrics from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) or a comparable qualification recognised by RANZCOG

Group B Streptococcus (GBS) – Group B Streptococcus is a common bacterium that is found in the body and is usually harmless. Sometimes the GBS bacteria can cross to the baby during labour and birth. It is the most common cause of severe infection in the newborn and most often occurs in the first seven days of life

Guidelines – systematically developed statements that assist in decision-making about appropriate health care for specific clinical conditions

High risk – a term used by clinicians to describe women who have a history of problems in a previous pregnancy, have an existing medical condition or have some potential risk of complications that might require specialist treatment

Home birth – a planned event where the woman decides to give birth at home, with care provided by a midwife

Hypertension – high blood pressure

Induction of labour – a surgical (amniotomy) and/or medical (e.g. intravenous oxytocin) intervention in an attempt to start the woman's labour

Informed choice – when women has the autonomy and control to make decisions about her care after a process of information exchange that involves providing her with sufficient, evidence based information about all options for her care, in the absence of coercion by any party and without withholding information about any options

Informed consent – when a woman consents to a recommendation about her care after a process of information exchange that involves providing her with sufficient, evidence based information about all the options for her care so that she can make a decision, in the absence of coercion by any party that reflects self-determination, autonomy and control

Instrumental birth – birth assisted by the use of forceps or vacuum

Intrapartum – during labour

Intrauterine – of or in the uterus, or during the part of development that takes place in the uterus

KEMH – King Edward Memorial Hospital (Subiaco, Western Australia)

Low risk – a term used by clinicians to describe women whose history and condition suggests there is little likelihood of complications in pregnancy, labour and birth

Maternal – relates to the mother

Midwife – a midwife is a person who has acquired the requisite qualifications to be registered and legally licensed to practise midwifery. Midwives provide care and advice to women during pregnancy, labour, birth, the early postpartum period, and care for the newborn baby in a variety of settings

Model of care – a multifaceted concept, based on best practice principles which broadly define the way health services are delivered

Mortality rate – number or frequency of deaths

Multigravida – a woman who has been pregnant before

Multiparous – having given birth before

Multiple pregnancy – having twins or higher order plurality

Neonatal – relating to the baby from birth until 28 days of life

Neonatologist – a neonatologist is a paediatrician who has specialised in newborn medicine

Obstetrician – an obstetrician is a doctor who specialises in the management and care of pregnant women, labour and birth and gynaecology

Oligohydramnios – a reduction of amniotic fluid in the amniotic sac

Oxytocic – a hormone naturally produced by the mother's body in labour. Giving synthetic oxytocin (syntocinon) through an intravenous (IV) drip can be used to induce or augment labour. It is also given to assist the birth of the placenta and reduce the amount of bleeding after the birth

Paediatrics – a branch of medicine dealing with the development, care and diseases of children

Partogram – is a composite graphical record of key data (maternal and fetal) during labour entered against time on a single sheet of paper. Relevant measurements might include information such as maternal and fetal observations, pattern of contractions and cervical dilation and descent of the presenting part. It is intended to provide an accurate record of the progress in labour, so that any delay or deviation from normal may be detected quickly and treated accordingly

Perinatal – refers to the period from 20 weeks of pregnancy to 28 days after birth

Perineal suturing – the sewing together of torn or cut tissues in the perineum (area between the vagina and anus) to allow proper healing

Perineum – area between the vagina and the anus

Physiological - description of the processes and function of the organs and tissues of the human body

Placenta praevia – when the placenta is located at the bottom of the uterus, close to or covering the cervix

Polyhydramnios – an excess of amniotic fluid in the amniotic sac

Postpartum haemorrhage – excessive bleeding (more than 500 mL) from the birth canal after the birth of the baby

Postnatal (also postpartum) – pertaining to the six weeks after birth

Pre-eclampsia (also pregnancy induced hypertension) – a multi organ disorder specific to pregnancy which is often detected by high blood pressure

Pre-labour rupture of membranes – the amniotic sac breaks or leaks before the commencement of labour

Presentation – identifies the part of baby that lies closest to the cervix

Preterm (labour or birth) – occurring before 37 completed weeks of pregnancy

Preterm pre –labour rupture of membranes (PPROM) before 37 weeks – amniotic sac breaks or leaks well in advance of the due date and before the commencement of labour

Primigravida – a woman who is pregnant for the first time

RANZCOG – Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Retained placenta – when all or part of the placenta is left behind in the uterus during the third stage of labour

Shoulder dystocia – when the baby's shoulder is caught behind the mother's symphysis pubis (pubic bone) and manoeuvres are required to birth the baby

Third stage of labour – the time period from the birth of the baby to the placenta being expelled of the uterus

Uterine rupture – a tear in the wall of the uterus (myometrium) which can be life threatening for the mother or baby; usually occurring in labour though may occur during late pregnancy and often associated with previous uterine surgery (including caesarean section scar)

Uterine inversion – when the uterus is turned 'inside out' either partially or completely through the cervix; occurs when the placenta fails to detach from the uterus during the third stage of labour and as it delivers pulls on the inside surface of the uterus

Vasa praevia – when fetal vessels, unsupported by the umbilical cord or placental tissue, cross or run close to the internal opening of the cervix

1. Introduction

WA Health aims to develop, deliver and provide maternal and newborn services that are safe, integrated, effective, and responsive to the individual needs of women and their babies in their community setting.¹

The objective of the [Improving Maternity Services: Working together across Western Australia. A Policy Framework](#)¹ is to improve care provision of pregnancy and in childbirth. The policy promotes models of care across the spectrum of care from home birth to tertiary hospital based consultant led care with a focus on the highest standards of quality and safety to meet the individual situations and clinical needs of the woman and the baby.¹

The [Review of homebirths in Western Australia](#)² released in August 2008 highlighted that women have a right to choose a maternity care option that suits them and therefore, 'developing systems to support safe and satisfying systems of care that provide childbearing women with a diversity of options is essential'.

This Home Birth policy defines home birth as a planned event where the woman chooses to give birth at home, with care provided by a midwife.³ In Western Australia each year approximately 200 women have a planned home birth which represents 0.6-0.8% of all births.² In recent years this proportion has remained relatively stable.

Planned home births in WA are currently provided by the publicly funded and operated programs as follows:

- Community Midwifery Program (CMP), North Metropolitan Area Health Service (NMAHS)
- Midwifery Group Practice, Bunbury Hospital, Western Australian Country Health Service (WACHS) – South West.

Private fee paying home birth services are also provided in WA by independent Privately Practicing Midwives (PPM) or eligible privately practicing midwives.

This policy should be read in conjunction with the ACM National Guidelines for Consultation and Referral, 3rd Edition, 2013.⁴ Note – there are some differences in the exclusion criteria for home birth in this policy and the ACM guidelines.

This policy has also been informed by and builds on the existing policies and procedures of the Community Midwifery Program, NMAHS.

2. The WA Health Home Birth Policy

The WA Health Home Birth Policy applies to qualified health professionals (i.e. registered midwives and/or medical practitioners) funded either wholly or in part by the Western Australian public health system ('WA Health') who are providing continuity of care for women who are eligible and enrol to have a planned home birth. Health professionals working in WA Health cannot provide maternity care in a private capacity without expressed approval as stipulated under the Public Sector Management Act⁵

The policy sets out the home birth:

- Eligibility criteria for women considering home birth
- Role of and services provided by the midwife and WA Health maternity services
- Care pathways and protocols to ensure high quality and safe continuity of care through the ante-natal, intra-partum and post-natal period
- Workforce competencies, professional development and ongoing education
- Clinical safety and quality guidelines and reporting mechanisms
- The key themes outlined in the Improving Maternity Services: Working together across Western Australia. A Policy Framework¹ are the guiding principles for this policy. They are listed as follows:
 - Pregnancy and birth are normal physiological life events.
 - Equitable, safe, high quality, evidence based care is fundamental for all women and will remain as the foundation of effective maternity services in WA.
 - Service delivery will be sustainable, adequately resourced and aimed to provide continuity of care.
 - Maternity care will be women and family focused, offer appropriate choice and support, and will be accessed as close to home as possible.
 - Health disparities and inequalities must be minimised for WA women and babies.
 - Maternity services should be essentially community based wherever possible, with an emphasis on continuity of care.¹

2.1 Key policy directions

This policy is informed by and aligns with the following key strategic policy frameworks and reports into maternal health in Western Australia:

[Improving Maternity Services: Working together across Western Australia. A Policy Framework¹](#), 2007.

[Models of Maternity Care – A review of the evidence³](#), 2008.

[Review of homebirths in Western Australia²](#), Undertaken for the Department of Health WA, Professor Caroline Homer & Dr Michael Nicholl, August 2008.

[Models of Maternity Care: Updated Evidence on Outcomes and Safety of Planned Home Birth⁶](#) 2011.

[The 13th Report of the Perinatal and Infant Mortality Committee of Western Australia for Deaths in the Triennium 2005-07⁷](#), 2010

2.2 The evidence

The evidence base for home birth is set out in [Models of Maternity Care: Updated Evidence on Outcomes and Safety of Planned Home Birth 2011](#).⁶ All studies of planned home birth report increased maternal satisfaction and reduced obstetric interventions including requirement for epidural analgesia, assisted birth and caesarean section.

However, the debate on safety of planned home birth continues in literature, policy and practice across the developed world.

[The 13th Report of the Perinatal and Infant Mortality Committee of Western Australia for Deaths in the Triennium 2005-07](#)⁷ found that home births are associated with preventable stillbirths and infant deaths. The increased risk of perinatal mortality risk in planned homebirths was similar to that seen in 2002-2004. The Report recommends that midwives offering home birth services obtain informed consent from women to acknowledge that they have been informed of the increased risks of perinatal death associated with homebirth.⁷

The difficulty in the evaluation of safety of home birth relates to the limitations of published studies including the differences between maternity care provision and the inclusion of women at all levels of obstetric risk.

The review of the evidence found that:

- Planned home birth with a qualified home birth practitioner is a safe alternative for women determined to be at low risk of pregnancy complications by established screening criteria.
- Women should be counselled about the potential for transfer to hospital if complications arise and systems should be put in place for a smooth transition to hospital care in case of complications
- For women who are not determined to be at low risk, particularly at the onset of labour, there appears to be an excess neonatal morbidity and mortality associated with homebirth.
- A large prospective UK national cohort study of place of birth⁸ has recently been published and consequently not included in 'Models of Maternity Care: Updated Evidence on Outcomes and Safety of Planned Homebirth 2011'.⁶ This study found that
- For multiparous women, home births appear to be safe for babies and offer benefits to both the mother (fewer interventions) and baby (more frequent initiation of breastfeeding).
- For women having their first baby, there is some evidence that planning to give birth at home does carry an increased risk of an adverse perinatal outcome, although the increased risk is modest.

3. Who should have a Home Birth?

It is recognised that women have the right to choose who cares for them during pregnancy and continuity of care is desirable⁹, however the care needs to be based on clinical guidelines and risk assessment to ensure the highest level of safety and quality.

The evidence states that planned home birth with a qualified home birth practitioner is a safe alternative for women determined to be at **low risk** of pregnancy complications by established screening criteria.

Access to evidence based information on maternity care options will empower and support informed decision making by women and their partners. Health professionals will undertake a health assessment of all women and inform women of the advantages and risks of the birth options, to allow for informed choices regarding how and where they give birth.⁹

Based on evidence based best practice the criteria for inclusion and exclusion for home birth are described below.

3.1 Inclusion criteria

Women accessing publically funded planned home birth programs must be considered to be at low risk of pregnancy and birth complications and meet the following criteria.

- is over the age of 18
- has the capacity to give informed consent.^{10, 11}
- live within a geographical boundary no further than 30 minutes from a maternity service
- has received regular antenatal care, with a health professional beginning in the first trimester, in line with recognised guidelines
- has booked into the home birth program by 35 weeks of pregnancy
- have a singleton pregnancy
- at the time of labour has a cephalic presentation of gestational age between 37 and 42 weeks
- is free from pre-existing medical or pregnancy complications (as stated in the exclusion criteria in Section 3.2)
- has current Ambulance Cover
- has a suitable home environment including but not limited to:
 - clean running water and electricity
 - has easy vehicular access (that includes access by vehicles in the event transfer during labour is warranted)
 - general home cleanliness with ability to provide hygienic sanitation
 - a working phone (landline or mobile with adequate reception)

Note: The WA GIS data for the metropolitan area boundaries shows that between 2009-2012, 99.2% of total births were within the 30 minute travel time to a hospital maternity unit. For homebirths, 98.5% were within the 30 minute travel time.

3.2 Exclusion criteria for planning a home birth

Women will be ineligible for a planned home birth if on initial assessment any of the following exclusion criteria apply. These criteria are based on evidence based best practice guidelines – note they include additional criteria to the ACM guidelines.⁴

3.2.1 Previous obstetric history

- Caesarean section
- Postpartum haemorrhage in excess of 1000 ml
- Shoulder dystocia
- Retained placenta requiring manual removal
- Perinatal death at term of a normally formed infant.

3.2.2 Medical history

- Pre-pregnancy BMI <18 and > 35
- Any significant medical condition
- Uncorrected female genital mutilation

3.2.3 Social determinants of health

- Domestic violence
- Alcohol and/or drug dependency of woman and/or family member

3.2.4 Other factors for consideration

Where the following conditions apply to either the woman or the baby they should be referred for consultation with an obstetrician/neonatologist/allied health professional to determine the appropriate clinical pathway:

- Will not accept blood and blood products if required
- Previous baby with Group B Streptococcus (GBS) neonatal sepsis
- Newborn or child at risk of harm

4. Care pathways for pregnancy and home birth

This section sets out the antenatal, intrapartum and postnatal care pathways for women enrolled in the home birth program.

4.1 Antenatal care

Antenatal care is provided to assess the woman's physical, psychological and social wellbeing and the wellbeing of her baby.

The allocated midwife will undertake a full assessment of the woman at the time of the enrolment process. The woman will meet with the qualified health professionals who will be providing care for her planned home birth, including the support midwife or team of midwives. All women will be advised to have a general medical examination from a General Practitioner of her choice early in her pregnancy to screen for previously undiagnosed health problems.

The initial documentation will be completed that includes but is not limited to the Home Birth Terms of Care (see [Appendix 1](#)) and providing the woman with the WA Health Pregnancy Health Record that will be completed at each and all visits to a health professional.

To ensure that referral pathways are in place should complications arise during the woman's care, all women enrolled on the Home Birth Program must be booked with the maternity unit closest to her home. This unit must be within 30 minutes (in a private vehicle) of the woman's planned place of home birth.

All women will be provided with unbiased, evidence based information about the potential advantages and disadvantages of home birth including transfer rates and recommended management practice in pregnancy, labour and birth.

During the antenatal period the woman should receive a minimum of six antenatal consultations/visits for primigravida women and four antenatal visits for multigravida women by health professionals including the home birth midwife. The midwife and other health professionals monitoring the pregnancy and the woman's decisions should be clearly documented in the personal medical health record and the Pregnancy Health Record retained by the woman.

The woman is to read and sign the Terms of Care (refer to [Appendix 1](#)) document three times during the pregnancy, at enrolment, 28 weeks gestation and 36 weeks gestation.

Throughout all stages of the pregnancy, the midwife and health professionals will provide quality consistent information and education to enable informed decision making. This will be available in a form that is suitable and accessible to the individual woman and her family including antenatal one on one and group education sessions, written material, DVDs, CDs and links to websites. Refer to the information leaflets in [Appendix 2](#) Information for Women.

With respect to antenatal screening and newborn care, specifically Group B Streptococcus, third stage of labour, gestational diabetes mellitus, Vitamin K, neonatal immunisation and newborn screening tests women will be provided with written evidence based information (refer to [Appendix 2](#)). If after consideration and discussion with her health care providers, the woman chooses to decline any or all of the above, her decision will be documented in the maternal medical record and the Child Health Record (Purple Book). This decision will be respected, however if the clinical situation changes, the health care provider will initiate further discussion.

The support midwife will meet the woman at least once and no later than between 35 and 37 weeks gestation and will provide antenatal care in the absence of the primary midwife.

4.2 Intrapartum care

The care will be provided by two appropriately qualified health professionals (one of whom must be a midwife experienced in home birth). **Two health professionals must be present for the birth.** The benefit of two health professionals present at every home birth is to enhance the safety of all births by:

- Working in partnership with the primary midwife
- Providing immediate support and clinical assistance in emergency situations
- Fostering a collegial team spirit among midwives sharing births
- Promoting opportunities for midwives shared learning within diverse clinical approaches to midwifery practice
- Providing capacity for improved documentation at births
- Enabling safe working hours (must comply with OHS Act and Flexible Agreement)
- Providing an environment for consultation when/if care requirements deviate from the norm; and
- Following the birth, both mother and baby will require attention and surveillance.

The environment will be safe for the woman and baby and comply with the [Western Australian Occupational Safety and Health Act and Regulations](#)¹², safe working environment.

The role of the support midwife is to provide clinical support, objective clinical second opinion and assistance in emergencies to the primary midwife. They will act as the primary midwife if the primary midwife has worked longer than 12 hours and birth is not imminent. For the full role and responsibilities of the support midwife refer to [Appendix 3: The role of the Support Midwife](#).

The health professional/s attending a home birth are required to have a kit packed with all the essential equipment. Progress notes for contemporaneous documentation are to be included with this kit. See [Appendix 4](#) for the full list of essential equipment for a home birth. The essential equipment includes oxygen. ([Appendix 5](#) sets out the responsible storage and transporting of oxygen cylinders.)

The midwife will follow this Home Birth Policy for Intrapartum care and the guidelines listed below:

[National Midwifery Guidelines for Consultation and Referral](#)⁴ 3rd Edition, 2013 (ACM Guidelines)

[RANZCOG Intrapartum Fetal Surveillance Clinical Guidelines](#)¹³

[The World Health Organization: The Partograph: A Managerial Tool for the Prevention of Prolonged Labour: Section III Facilitators Guide](#)¹⁴

[National Health and Medical Research Council: National Guidance on Collaborative Maternity Care](#)¹⁵

[The Australian Nursing and Midwifery Council: National Competency Standards for the Midwife](#)¹⁶

[Australian Health Practitioner Regulation Agency \(AHPRA\): Nursing and Midwifery Board of Australia: Codes and Guidelines](#)¹⁷

[KEMH Clinical Guidelines: Use of Partogram](#)¹⁸

4.3 Post natal care pathways

4.3.1 Care of the mother after the birth

The care of the mother after the birth will be provided by the midwife in attendance at the home birth. The care will include the assessment of maternal well-being, support of maternal/baby attachment and provision of support to other family members as necessary. The midwife will also facilitate the establishment of breastfeeding and health care needs as required for at least two hours after delivery of the placenta, or as circumstances require. Information and access to support services will be provided including Child Health Nurses and the woman will be advised to have the baby examined by a General Practitioner within 10 days of the birth.

The postnatal care will continue to be provided with a visit to the woman and baby within 24 hours of the birth and then at regular intervals as appropriate for 14 days to meet the physical, psychological and social needs of the woman and the baby.

4.3.2 Care of the baby after the birth

The care of the baby after the birth will be provided by the qualified health professional (typically the midwife) in attendance at the home birth. The care will follow the [King Edward Memorial Hospital Clinical Guidelines: Care of Neonate](#)¹⁹.

The midwife will also ensure the woman is given the child's Personal Health Record (purple book) and provide information on administration of Vitamin K, Hepatitis B vaccination and how to access Newborn Hearing Screening.

4.4 Midwifery care when woman makes a decision that is inconsistent with the Home Birth midwifery standard of practice

As a primary caregiver, the midwife must provide midwifery care that is consistent with the national professional standards for midwives and is within the scope and boundaries of her practice and those endorsed by the WA Health Area Health Services. When a woman's decision is at a variance from professional advice or guidelines, the midwife must consult and document accordingly. For details of the procedure for Midwifery Care when women make a decision that is incompatible with the Home Birth Midwifery standard of practice see [Appendix 6](#).

The woman has the right to give and to rescind consent at any time and the decision made needs to be acknowledged and supported.

Midwives are to provide information and inform the woman of the scope of their practice and its limitations and ensure that all conversations are documented accordingly.

In the course of labour or urgent situations when the steps for discontinuing care have not been undertaken or completed, as stated in this policy and the letter of withdrawal (refer to [Appendix 6](#)), the midwife may not refuse to attend the woman. Equally where women refuse emergency transfer of care in the course of active labour, the midwife must remain in attendance.

Documentation of the ongoing consultation with the obstetrician/specialist throughout the labour and birth is essential.

5. Criteria for consultation, referral and/or transfer to hospital/supporting maternity unit

This policy is to be used in conjunction with the [ACM Guidelines](#)⁴, 3rd edition 2013 and includes additional clinical risk indicators identified by WA Department of Health that require women to have consultation, referral and/or transfer to the supporting maternity unit.

For low risk women planning a home birth published studies show that:

- 7.4%-30% of women will be transferred during the antenatal period
- 1.5%-13% will require transfer after the onset of labour
- 0.7%-6.7% require transfer in the postpartum period for maternal reasons
- 0.06%-1.4% of neonates will require transfer to hospital after birth⁶

Risk factors that require the woman to be referred/transferred to hospital for clinical assessment and /or ongoing care:

5.1 Antenatal factors

- Antepartum haemorrhage
- Multiple pregnancy (twins or higher order plurality)
- Known or suspected fetal abnormalities where neonatal management is required
- Breech presentation after 37 weeks
- Abnormal placentation including low lying placenta confirmed on scan at 32-34 weeks
- Hypertension and/or preeclampsia
- Gestational diabetes requiring medication for glycaemic control
- Suspected intrauterine growth restriction or small for gestational age
- Polyhydramnios or oligohydramnios
- Preterm pre labour rupture of membranes (PPROM) before 37 weeks
- Pre-labour rupture of membranes > 24 hours if GBS negative and if not in active labour²⁰
- Pre-labour rupture of membranes > 18 hours if GBS positive or status unknown and if not in active labour. Note: Appropriate IV antibiotics for GBS prophylaxis should be commenced if GBS positive
- Post-term pregnancy (\geq 42 completed weeks)
- Women weighing >110kg prior to the onset of labour will be required to birth in a hospital unit for Occupational Safety and Health reasons

5.2 Intrapartum factors

- Abnormal presentation
- Breech presentation
- Active genital herpes in late pregnancy or at onset of labour
- Gestational hypertension (GH)
- Pre-eclampsia
- Preterm labour before 37 weeks
- Prolonged rupture of membranes (PROM) > 24 hours - appropriate IV antibiotics for GBS prophylaxis should be commenced if GBS positive.
- Intrapartum haemorrhage

- Vasa praevia
- Suspected placenta abruption and/or praevia
- Uterine rupture
- Prolapsed cord or cord presentation
- Fetal death during labour
- Pyrexia or evidence of infection or maternal temperature > 37.6° C on more than one occasion
- Meconium stained amniotic fluid
- Non-reassuring fetal heart patterns
- Requires continuous fetal monitoring
- Lack of engagement of the fetal head once in established labour
- Absence of progress in established labour as determined by lack of cervical dilation and descent of the fetal head.
- First stage of labour in excess of 18 hours
- Active second stage of labour in excess of one hour with minimal/slow progress and/or without head on view
- Progress of labour is outside the partogram action lines (King Edward Memorial Hospital Clinical Guidelines: Intrapartum Care)¹⁸
- Shoulder dystocia
- Uterine inversion
- Third or fourth degree perineal tear
- Retained or incomplete placenta
- Shock/Maternal collapse

5.3 Postpartum factors

5.3.1 Mother

- Postpartum haemorrhage > 600 mL and/or symptomatic blood loss
- Evidence of infection or maternal temperature > 37.6° C on more than one occasion

5.3.2 Neonate

- Apgar score < 7 at five minutes
- Neonatal respiratory problems
- Neonatal convulsions
- Unsuspected congenital abnormalities
- Low birth weight (< 2500 g)
- Neonatal temperature below 36.5 or above 37.4° C on more than one occasion

6. Transfer from home to hospital

In some clinical circumstances it may be necessary for the safety of the woman and her baby during the labour to transfer from a 'planned home birth' to hospital birth. This should be an anticipated or expected event and not be seen as a 'failure' by the woman or her care providers nor an adverse event by health professionals.

Ongoing evaluation of women planning a home birth with timely consultation and referral to hospital care enables appropriate transfer of women whose 'risk' status changes.

The criteria for transfer listed above in section 5.1 – 5.3 will be adhered to. Collaboration and communication with the 'back-up' hospital is essential and there should be mechanisms in place to allow the midwife to continue on-going care, where appropriate, once the woman is transferred to hospital.

Women need to be provided with realistic reliable information about the requirement for transfer including possible reasons and rates of transfer should complications arise.

The following section outlines the:

- Consent and process for transfer from home to hospital
- How to transfer to hospital (see [Appendix 7](#))
 - by ambulance urgent and non-urgent
 - by private vehicle
- Refusal to transfer to hospital on clinical advice from the midwife/health professional
- The role of the primary midwife, support midwife and doula
- Role and responsibility of the receiving hospital maternity unit

6.1 Consent and process for transfer from home to hospital

- Discuss with the woman and her support person(s) the reasons for the decision being made about transfer to hospital.
- Consult with the receiving hospital Consultant, Senior Registrar/Registrar, GP obstetrician or neonatologist and the Midwifery Coordinator of the receiving Labour and Birth Suite, the clinical need for/or intent on transferring client from home to hospital as soon as practicable.
- Prior to the transfer of CMP patients to units with no 24/7 on site specialist medical staff (obstetricians, paediatricians, anaesthetists) or pathology laboratory/theatre staff, the proposed receiving hospital Consultant Obstetrician should be contacted by the CMP midwife to ensure that transfer to that hospital is appropriate based on the local resources of the obstetric unit.
- Ensure all relevant documentation accompanies the woman and concise, detailed handover is given.

6.2 How to transfer to hospital

Transport arrangements should be appropriate to the level of assessed risk and clinical factors either by ambulance assistance or the woman's private vehicle. The midwife is **not** to transport the woman to hospital in his/her vehicle.

6.2.1 Urgent Ambulance Assistance

DIAL '000'

- If you do not have coverage on your mobile phone, try '112' or use woman's home phone or mobile if available
- Have woman's health care record with you whilst talking on the phone
- When you call '000' you will be asked:
 - Do you require Police, Fire or Ambulance?
 - What is the exact location of the emergency (including which state)?
 - You may be asked for the nearest cross street or land mark
 - What is your call back number?
 - What is the nature of the emergency?
 - Identify yourself as a WA Health midwife providing care to the woman and/or baby

6.2.2 Non- Urgent Ambulance Assistance

Dial '131233'

- Identify yourself as a WA Health midwife providing care to the woman and requesting a non-urgent ambulance transfer
- Advise operator of clients name, address and reason for transfer and the receiving hospital
- Provide your contact phone number
- Prepare client for departure from home

For detailed information refer to "How to transfer by Ambulance" Appendix 7

6.2.3 Private Vehicle Transfer

There may be situations either in the antenatal, intrapartum or postnatal periods where the clinical situation does not warrant the use of Ambulance services. Examples may include but are not limited to the following:

- Antenatal: e.g. reduced fetal movements, antenatal assessment/investigations
- Intrapartum: e.g. for pain relief, at less than 7cm dilated with good FHR pattern
- Postpartum: e.g. wound breakdown, mastitis
- Neonate: ongoing jaundice, raised temperature, decrease in weight >10% birth weight, signs of infection

In these situations contact and advise the receiving hospital of the woman's and/or baby's details and time of arrival. Ensure clients' pregnancy/neonate records accompany them to hospital and the 'transfer summary document' is complete

6.3 Refusal to transfer to hospital on clinical advice from the midwife/health professional

In the case of a woman who intends a planned home birth and is advised by the midwife/health professional during labour and birth that her clinical situation has varied from normal (as per

[ACM Guidelines](#)⁴ 3rd Edition, 2013), and the woman has declined transfer at the recommendation of the attending midwife, the following actions must be taken by the Midwife;

- a. The client must be referred to the Terms of Care document (refer [Appendix 1](#))
- b. Consult with another midwife and share the advice of that midwife with the client and her support people
- c. Document in the woman's records the consultation process, recommendations arising from the consultation and the woman's response to the advice
- d. Should the client continue to decline the professional advice of the midwives, the midwife must take the following action:
- e. Request the attendance of a midwifery colleague
- f. Notify the on-call Midwifery Manager
- g. Notify the woman's back up hospital Obstetric team of preceding events and seek advice
- h. Share the advice with the client and her support people and document in the woman's records the consultation process – with whom the consultation occurred, the recommendations arising from the consultation, the time when the client was advised of the recommendations and the woman's response
- i. Advise the on-call Midwifery Manager and the back up hospital Obstetric team of the client's response and keep them informed of progress
- j. If an emergency situation is anticipated, an ambulance should be called to be in attendance. The cost of call out fees and transfer for St John Ambulance services will be at the expense of the Home Birth Program

6.4 The role of the primary midwife, support midwife and doulas at the receiving hospital maternity unit

- On arrival at hospital it is the responsibility of the primary midwife to provide a thorough verbal and written clinical handover. The Home Birth Program documentation is to be photocopied and retained by the receiving hospital and the original is to be retained by the home birth program.
- The midwife will provide on-going care, where appropriate, once the woman is transferred to hospital.
- Mutual respect between support people, including doulas, and staff in the receiving hospital is to be maintained at all times.
- On discharge from the hospital the known midwife will resume care of the mother and baby.

6.5 Role and responsibility of the receiving hospital maternity unit

- Mutual respect between support people, including doulas, and staff in the receiving hospital is to be maintained at all times
- Hospital staff will facilitate the home birth midwife to provide ongoing care and appropriate support to the woman. They will also ensure the home birth midwife and other support people are involved in birth options and discussions as appropriate

7. Planned Hospital Birth

If the birth is planned to take place in hospital due to prior recognised risk factors, the woman and support person make their own way to hospital where the midwife will meet them.

It is understood that the Home Birth Program midwife will not attend the woman at home if the woman believes that she is in labour but will direct her, or her support person that the midwife will meet her at the hospital.

8. Professional and legal requirements for Midwifery Care

The following section sets out the legislative and regulatory requirements and competencies and professional development and ongoing education for midwives to practice within the WA publicly funded Home Birth program. For a detailed list of Competencies see [Appendix 8](#).

8.1 Experience

The midwife providing care for a planned home birth must be experienced in home births, demonstrated by the following:

- minimum of three years full time post registration experience
- participated in at least five home births under supervision
- competency in obstetric emergency procedures

By 2015 midwives providing planned home birth in the WA Health publically funded home birth program will meet the criteria for eligibility notation with the [Australian Health Practitioner Regulation Agency \(AHPRA\): Nursing and Midwifery Board of Australia: Registration Standards](#).²¹

8.2 Competencies

There are a number of mandatory competency requirements for midwives employed by WA Health.

They must abide by the [AHPRA: Nursing and Midwifery Board of Australia: Codes and Guidelines](#)¹⁷ and guidelines including:

- The National Competency Standards for the Midwife,
- The Code of Ethics and Professional Conduct for Midwives, and
- A midwife's guide to professional boundaries (companion document)

The [ACM Guidelines](#)⁴ 3rd Edition, 2013 and the NHMRC Guidelines on Collaborative Maternity Care are recommended for midwives as frameworks and guidance for facilitating collaborative maternity care.

Midwives wishing to provide midwifery care to women planning a home birth should have current competence to provide the full scope of antenatal, intrapartum and postnatal midwifery care.

Ideally, midwives should meet the criteria for gaining notation as an Eligible Midwife with the Nursing and Midwifery Board of Australia ("the NMBA").

The mandatory and competency requirements for WA Health are set out in [Appendix 8](#).

Following completion of the initial competency ongoing clinical competency will be reviewed at the annual performance appraisal.

8.3 Continuing professional development

This will be in line with the registration requirements of the [AHPRA Nursing and Midwifery Board: Registration Standards](#)²¹.

8.4 Indemnity insurance

The National Registration and Accreditation Scheme for Health Professionals have a requirement that all practitioners must be covered by professional indemnity insurance.

Health professionals contracted to work in the public health system have indemnity insurance cover as part of their employment contract.

8.5 Documentation and Record Keeping

A midwife providing midwifery care for a planned home birth must maintain documentation in accordance with best practice, as required by WA Health. This must include comprehensive clinical notes to facilitate consultation, referral and transfer, should this be required, and for evaluation and review of care. Documentation must include all of the woman's care from the first antenatal visit until her postnatal discharge, and the decision making processes undertaken, to inform the management of the woman's care.

The Midwife will use the [ACM Guidelines](#)⁴ 3rd edition 2013 which provides an evidence-informed national framework for consultation and referral of care between midwives, doctors and other health care providers in consultation with the woman receiving care.

The midwife:

- Makes the Hand Held Pregnancy Health Record available throughout labour which is taken after the birth and filed with other records. The woman should be offered a copy of the Hand Held Pregnancy Health Record
- In attendance at the birth is responsible for completing the Notification of Case Attendance Form (where available use Stork to complete this process) and providing this to the woman
- Completes relevant birth information under the Births, Deaths and Marriages Registration Act 1998 and provides the woman/partner with the form to enable them to register the child's birth within 60 days of the birth
- Ensures all documentation to be stored in compliance with [Department of Health Patient Information Retention and Disposal Schedule](#)²²

9. Reporting, Evaluation and Audit

9.1 Clinical audit and clinical review process

Clinical audits are to be undertaken quarterly, at a minimum, to assess:

- documentation
- maternal and neonatal outcomes
- compliance against exclusion criteria
- Maternal and neonatal outcomes for mother and baby when there is transfer to a hospital - this includes all transfers at any stage of the woman's care. The notification is sent to the appropriate Manager

For further information regarding patient safety refer to [Australian Safety and Quality Framework for Health Care](#)²³.

9.2 Clinical incident reporting

Reporting and investigation of clinical incidents provides an opportunity to learn from incidents and put strategies in place to avoid their reoccurrence. It is vital this is done in a safe, non-judgemental environment.

All clinical incidents are to be reported via the Advanced Incident Management System (AIMS) to the relevant supervising midwife. For procedural guidelines see the [Clinical Incident Management Policy](#)²⁴.

Mandatory reporting is required for a sentinel event. Refer to the [Patient Safety Directorate](#), Department of Health Western Australia²⁴ for the criteria that define a sentinel event and the notification of a sentinel event.

[Open disclosure](#)²⁴ is the discussion that follows a clinical incident occurring.

A Clinical Advisory Group (CAG) will be established to conduct relevant clinical reviews. The CAG will operate within existing WA Health Area Health Services clinical governance structures.

The CAG membership will reflect the clinical expertise, knowledge and experience required to undertake maternal and neonatal clinical reviews.

See [Appendix 9](#) for a sample Terms of Reference and role of the CAG.

10. Evaluation

Monitoring and evaluation is important to provide continuous improvement of the care provided. Components of ongoing data collection should include:

- Quality improvement activities
- Documentation confirming that all clinical audit recommendations are implemented and evaluated
- Staff satisfaction surveys including retention rates of clinicians working in this model of care
- Regular evaluations of the service provided to women with a planned home birth are undertaken to monitor satisfaction
- Any complaints are to be managed in accordance with the [WA Health Complaint Management Policy 2009](#).²⁵

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Appendices

Appendix 1: Terms of Care – An agreement to provide community based midwifery care for planned home birth

TERMS OF CARE

An agreement to provide Home Birth Program care

The Home Birth program (insert name of program) will provide comprehensive midwifery services to you (insert name), as a low risk pregnant woman, throughout the continuum of your pregnancy, childbirth and the postnatal period.

The level of risk is determined on the current Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral and the WA Health Home Birth policy “Inclusion criteria for home birth”:

Women accessing publically funded planned home birth programs must be considered to be at low risk of pregnancy and birth complications and meet the following criteria.

- Is over the age of 18
- Has the capacity to give informed consent.10, 11
- Live within a geographical boundary no further than 30 minutes from a maternity service
- Has received regular antenatal care, with a health professional beginning in the first trimester, in line with recognised guidelines
- Has booked into the home birth program by 35 weeks of pregnancy
- Has a singleton pregnancy
- At the time of labour has a cephalic presentation of gestational age between 37 and 42 weeks
- Is free from pre-existing medical or pregnancy complications
 - Caesarean section
 - Postpartum haemorrhage in excess of 1000 ml
 - Shoulder dystocia
 - Retained placenta requiring manual removal
 - Perinatal death at term of a normally formed infant.
 - Pre-pregnancy BMI > 35
 - Any significant medical condition
 - Uncorrected female genital mutilation
 - Or social determinants of health:
 - Domestic violence
 - Alcohol and/or drug dependency of woman and/or family member
- Has current Ambulance Cover
- Has a suitable home environment including but not limited to:
 - Clean running water and electricity
 - Has easy vehicular access (that includes access by vehicles in the event transfer during labour is warranted)
 - General home cleanliness with ability to provide hygienic sanitation
 - A working phone (landline or mobile with adequate reception)

Other factors for consideration:

Where the following conditions apply to either the woman or the baby they should be referred for consultation with an obstetrician to determine the appropriate clinical pathway:

- Will not accept blood and blood products if required
- Previous baby with group b streptococcus (gbs) neonatal sepsis
- Newborn or other child/children at risk of harm

DECLARATION

- In the interest of my own and my baby’s wellbeing, I understand that my midwife is required to consult with my doctor or the medical staff at the hospital maternity support unit I have nominated, should either my own or my baby’s wellbeing is identified and confirmed as being clinically at risk.
- I agree to being referred for medical support if the level of risk, as determined by the current ACM National Midwifery Guidelines for Consultation and Referral and the WA Health Home Birth policy “Inclusion criteria for home birth” indicates that either my own or my baby’s wellbeing is identified and confirmed as being clinically at risk.
- I am aware that should I choose to decline the medical advice given at this consultation then I may have to withdraw from the Home Birth Program or may be required to birth in hospital as a condition of remaining on the Home Birth Program depending upon the circumstances.
- I will also ensure that my support persons, including doulas (if applicable), will respect this decision for referral to the hospital maternity support unit.
- I understand that the Home Birth program (insert name) reserves the right to refer my maternity care to my nominated doctor or hospital maternity support unit if the level of risk is determined as unsafe for a home birth.
- I have read and understood the WA Health “Having a homebirth” pamphlet and have had the opportunity to discuss its contents with my Doctor or Midwife and understand the risks as they have been explained to me.
- I have been informed of the risks associated with a home birth.

Name	Witness Name
Signature	Signature
Date	

TERMS OF CARE (2)

Agreement regarding the provision of Home Birth program care

(28 weeks)

The Home Birth Program (insert name of program) will provide comprehensive midwifery services to me, as a low risk pregnant woman, throughout the continuum of my pregnancy, childbirth and postnatal period.

I have agreed to participate in the program and have been made aware of the risks associated with having a home birth and the potential to be transferred from the Home Birth Program to hospital based obstetric services either during my pregnancy or during labour and birth.

The level of risk is determined in accordance with the current Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral and the WA Health Home Birth policy on "Inclusion criteria for homebirth":

Women accessing publically funded planned home birth programs must be considered to be at low risk of pregnancy and birth complications and meet the following criteria.

- Is over the age of 18
- Has the capacity to give informed consent.10, 11
- Live within a geographical boundary no further than 30 minutes from a maternity service
- Has received regular antenatal care, with a health professional beginning in the first trimester, in line with recognised guidelines
- Has booked into the home birth program by 35 weeks of pregnancy
- Has a singleton pregnancy
- At the time of labour has a cephalic presentation of gestational age between 37 and 42 weeks
- Is free from pre-existing medical/pregnancy complications or social determinants of health as listed in the Terms of Care Agreement 1. This applies to history of pre-existing and newly diagnosed medical/pregnancy complications.
 - Has current Ambulance Cover
 - Has a suitable home environment including but not limited to:
 - Clean running water and electricity
 - Has easy vehicular access (that includes access by vehicles in the event transfer during labour is warranted)
 - General home cleanliness with ability to provide hygienic sanitation
 - A working phone (landline or mobile with adequate reception)

DECLARATION

I acknowledge that in the interests of my own and my baby’s wellbeing, my midwife will consult with my doctor or the medical staff at the hospital maternity unit I have nominated, should the need arise.

I agree to being referred for medical support if the level of risk, as determined by the current ACM National Midwifery Guidelines for Consultation and Referral and the WA Health Home Birth policy “Inclusion criteria for home birth” indicates that either my own or my baby’s wellbeing is identified and confirmed as being clinically at risk.

I am aware that should I choose to decline the medical advice given at this consultation then I may have to withdraw from the Home Birth Program or may be required to birth in hospital as a condition of remaining on the Home Birth Program depending upon the circumstances.

I acknowledge that my maternity care will be transferred to my nominated doctor or hospital if the level of risk is determined as unsafe for a home birth.

I have read and understood the WA Health “Having a homebirth” pamphlet and have had the opportunity to discuss its contents with my Doctor or Midwife and understand the risks as they have been explained to me.

I confirm that I continue to meet the WA Health Home Birth Policy “Inclusion criteria for a planned Home Birth and that there has been no change to my planned place of birth.

Name	Witness Name
Signature	Signature
Date	

2nd Signing (28 weeks): _____

TERMS OF CARE (3)

Agreement regarding the provision of Home Birth Program care (36 Weeks)

The Home Birth Program (insert name of program) will provide comprehensive midwifery services to me, as a low risk pregnant woman, throughout the continuum of my pregnancy, childbirth and postnatal period.

I have agreed to participate in the program and have been made aware of the risks associated with having a home birth and the potential to be transferred from the Home Birth Program to hospital based obstetric services either during my pregnancy or during labour and birth.

The level of risk is determined in accordance with the current Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral and the WA Health Home Birth policy on "Inclusion criteria for homebirth":

Women accessing publically funded planned home birth programs must be considered to be at low risk of pregnancy and birth complications and meet the following criteria.

- Is over the age of 18
- Has the capacity to give informed consent.10, 11
- Live within a geographical boundary no further than 30 minutes from a maternity service
- Has received regular antenatal care, with a health professional beginning in the first trimester, in line with recognised guidelines
- Has booked into the home birth program by 35 weeks of pregnancy
- Has a singleton pregnancy
- At the time of labour has a cephalic presentation of gestational age between 37 and 42 weeks
- Is free from pre-existing medical/pregnancy complications or social determinants of health as listed in the terms of care agreement 1. This applies to history of pre-existing and newly diagnosed medical/pregnancy complications
- Has current Ambulance Cover
- Has a suitable home environment including but not limited to:
 - Clean running water and electricity
 - Has easy vehicular access (that includes access by vehicles in the event transfer during labour is warranted)
 - General home cleanliness with ability to provide hygienic sanitation
 - A working phone (landline or mobile with adequate reception)

DECLARATION

- I acknowledge that in the interests of my own and my baby’s wellbeing, my midwife will consult with my doctor or the medical staff at the hospital maternity unit I have nominated, should the need arise.
- I agree to being referred for medical support if the level of risk, as determined by the current ACM National Midwifery Guidelines for Consultation and Referral and the WA Health Home Birth policy “Inclusion criteria for home birth” indicates that either my own or my baby’s wellbeing is identified and confirmed as being clinically at risk.
- I am aware that should I choose to decline the medical advice given at this consultation then I may have to withdraw from the Home Birth Program or may be required to birth in hospital as a condition of remaining on the Home Birth Program depending upon the circumstances.
- I acknowledge that my maternity care will be transferred to my nominated doctor or hospital if the level of risk is determined as unsafe for a home birth.
- I have read and understood the WA Health “Having a homebirth” pamphlet and have had the opportunity to discuss its contents with my Doctor or Midwife and understand the risks as they have been explained to me.
- I confirm that I continue to meet the WA Health Home Birth Policy “Inclusion criteria for a planned Home Birth and that there has been no change to my planned place of birth.

Name	Witness Name
Signature	Signature
Date	

3rd Signing (36 weeks): _____

Appendix 2: Information for women

1. Having a home birth
2. Routine ultrasound scans (USS) in pregnancy
3. Group B Streptococcus (GBS)
Information available at:
<http://www.kemh.health.wa.gov.au/brochures/consumers/wnhs0566.pdf>
4. Gestational Diabetes Mellitus (GDM)
5. My baby is overdue—what now?
6. Birth or Delivery of your Placenta (Afterbirth)
7. Water Birth
Information available at:
<http://www.kemh.health.wa.gov.au/brochures/consumers/wnhs0535.pdf>
8. Co-Sleeping/bed-sharing
Information available at:
<http://www.kemh.health.wa.gov.au/brochures/consumers/wnhs0489.pdf>

Newborn care information:

Child's Personal Health Record (purple book) and information regarding:

- Vitamin K administration—administered by midwife following the woman's consent
- Hepatitis B vaccination and ongoing immunisation program—Hepatitis B vaccination is administered by the supporting General Practitioner following the woman's consent
- Newborn Screening Test (Guthrie)—undertaken by the midwife (brochure)
- Newborn Hearing Screen – how to access the Newborn Hearing Screen
- Role and how to access the Child Health Nurse
- Advise the woman to have the baby examined by a General Practitioner within 10 days of the birth.

Further information regarding the care of the baby immediately following birth can be found at:
<http://www.health.wa.gov.au/havingababy/after/hospital.cfm>

Appendix 3: 'Role of the Support Midwife' Policy

All Home Birth Programs are required to have two appropriately qualified health professionals (one of whom must be a midwife experienced in home birth) present at homebirths.

This arrangement was put in place primarily to enhance the safety of all births.

Note: It is recommended that the two qualified health professionals present at all homebirths are both midwives.

Benefits that are provided when two midwives are present at each home birth:

- To work in partnership with the primary midwife
- To provide immediate support and clinical assistance in emergency situations
- To foster a collegial team spirit among midwives sharing births
- To promote opportunities for midwives shared learning within diverse clinical approaches to midwifery practice
- To provide capacity for improved documentation at births
- To enable safe working hours (i.e. no longer than 12 hours in a row)
- To provide an environment for consultation when/if care requirements deviate from the norm.
- To facilitate attention and surveillance for mother and baby immediately following the birth.

Antenatally

Upon booking onto the Home Birth Program, (insert name) the primary midwife will document the support midwife's contact details on the woman's Pregnancy Health Record and will explain the role of the support midwife, including their role when and if the primary midwife has worked 12 hours and the birth is NOT imminent.

During the antenatal period the primary midwife will contact the support midwife to arrange an appointment/visit convenient for both the woman and midwife between 35 and 37 weeks gestation either in the woman's home or in the clinic. Should contact not be possible, the woman is to be left instructions to contact the support midwife herself. The primary midwife must also notify the support midwife to expect a request for a support midwife appointment.

The support midwife will visit the woman in her home or the clinic on one occasion and provide the appropriate scheduled care.

The role of the support midwife is to be explained and any questions answered. This must include information on the responsibility and accountability for care during labour, how it may not be the primary midwife when and if he/she has worked longer than 12 hours and birth is not imminent or he/she is not on duty.

Should the support midwife detect deviations from the norm during antenatal assessment and the situation is not urgent, the primary midwife is to be consulted prior to referral occurring for consultation of appropriate management plan. Should the primary midwife be unavailable, the support midwife is to make a decision for consultation and referral as deemed appropriate.

The support midwife is to provide antenatal care in the absence of the primary midwife.

Intrapartum

During the day, the primary midwife will notify the support midwife of impending labour or birth.

During the night, the primary midwife will call the support midwife when required to attend.

The primary midwife is to call the support midwife to attend the labour when it is determined that birth will occur within one to two hours. As a guide: when a primiparous woman is fully dilated or when a multiparous woman displays signs of advanced labour.

The timing of calling the support midwife must be made with the consideration of travel time.

The support midwife must be called to attend if the primary midwife has worked for longer than 12 hours and birth is not imminent.

The support midwife is to take over and make all the decisions as primary midwife and the primary midwife must make the decision (following consultation with the on call midwifery manager) to stay as support midwife if birth is imminent (within 1-2 hours) or go home. If fatigue is of concern and the birth is imminent, another on-call midwife is to be called in so the primary midwife can go home. The support midwife may then recall the primary midwife for the birth, if the required amount of time free from duty has been observed.

Upon arrival to the home, the primary midwife will provide the support midwife with a verbal clinical handover (using the clinical handover guide) of the case and will hand over the case notes for continuation by the support midwife.

The support midwife will continue documentation as requested by the primary midwife identifying herself as the 'scribe' for care provided by '_____' (primary midwife's name).

Upon arrival to the home, the primary midwife will ensure the support midwife is aware of the location of equipment – including oxygen, oxytocic medications, PPH box, gloves, towels and blankets.

The support midwife will have his/her birthing equipment and oxygen in his/her car.

The support midwife will provide unobtrusive clinical support to the primary midwife during the labour, birth and postnatal period.

The support midwife will provide an objective clinical second opinion when requested by the primary midwife or if he/she deems a change in current care and management necessary.

The support midwife will assist with emergency situations.

Following the birth, the support midwife is to remain in the home until third stage is complete and maternal and neonatal observations are within normal ranges.

Following the birth of the placenta, the support midwife is to undertake the primary role if the primary midwife has been working 12 hours or greater and the primary midwife is to go home. Either the support or primary midwife is to assist with the 'clean up' of the home.

Prior to leaving the home, either the primary or the support midwife is to contact the Home Birth Program office (insert contact details) to advise of the birth.

References	Vedam.S, Goff.M, Mamin, V. Closing the Theory – Practice Gap: Intrapartum Midwifery Management of Planned Homebirths. Journal of Midwifery & Women's Health 2007. Vol 52, No3, 291-300
Legislation	Nil

Standards	ANMC 2008 Code of Ethics for Midwives ANMC 2006 Competency Standards for the Midwife
EQuIP Standard	EQuIP 2008 Continuity of Care 1.1.2, 1.1.8 EQuIP 2008 – Corporate Functions 3.1.2, 3.2.1
Other Related Documents	CMP Midwifery Guidelines 2.2.5 Midwifery Care During Labour Dystocia in the Second Stage of Labour 2008 CMP Roster Agreement 2006 CMP Directive on working hours and rostering Sept 2009 Australian Commission on Safety and Quality in Health Care (2009);OSSIE Guide to Clinical Handover Improvement

Appendix 4: Essential equipment for a home birth

The health professional/s attending a home birth is required to have a kit packed with all the essential equipment. Progress notes for contemporaneous documentation are to be included with this kit.

Maternal Pack

- Pregnancy wheel
- Electronic fetal doppler, lubricant gel and spare batteries
- Pinnards stethoscope (only to be used in event of failure of electronic device)
- Sphygmomanometer and adult stethoscope
- Thermometer
- Urine dipstix
- MSU containers and urine cups
- Sterile gloves and box of examination gloves
- Obstetric cream or sterile lubricant
- Amnihook/amnicot
- Pathology request forms

Vaginal Screening Box

- Speculum
- Sterile lubricant
- Amnicators
- Sterile swab and medium
- Specimen bags
- Penlight torch

Blood Screening Box

- Tourniquet
- Blood collection syringes, needles, bottles and antiseptic swabs
- Butterfly needles
- Micropore tape
- Cotton wool balls
- Specimen bags
- Sharps disposal container

Birth Pack

- Disposable birth pack
- Instruments to include:
 - Artery forceps
 - Episiotomy scissors
 - Cord scissors
 - Bottle of antiseptic preparation
 - Cord clamp
 - Cord blood collection bottles
- Disposable sheets
- Sanitary napkins

- 2 mL syringe, antiseptic swab, drawing up and intramuscular needle
- Medical waste hazard bag (for placental disposal if not wanted by parents). Refer to section below for information regarding waste disposal.

Catheter box

- Disposable dressing pack
- Urethral catheter – indwelling and straight
- Sterile lubricant
- 10 mL syringe and sterile water
- Urine bag
- Tape for anchoring catheter

Perineal infiltration and suturing box

- Bottle of antiseptic preparation
- Instruments to include:
 - Needle holder
 - Dissecting forceps
 - Scissors
- Clean drape or dressing towel
- Sterile swabs
- Suture material
- 10 mL and 20 mL syringes, drawing up and infiltration needles
- Sharps disposal container
- Adequate light source

Baby Pack

- Mucous extractor
- Paediatric stethoscope
- Paediatric thermometer
- Baby weighing scales
- Tape measure
- 2 mL syringe, antiseptic swab, drawing up and intramuscular needle

Resuscitation Pack (Maternal and Infant)

- Infant Laerdel bag and mask with oxygen tubing
- Adult Laerdel bag and mask with oxygen tubing
- Oxygen cylinder and regulator
- Adult oxygen mask and tubing
- Twin-o-vac set-up with tubing for suction
- Infant and adult disposable suction catheters
- Infant and adult plastic airways
- Tourniquet
- Blood collection syringes, needles, bottles and antiseptic swabs
- Intravenous cannulation equipment (size 16 gauge cannulae)
- Dressing and securing tape for intravenous sites
- Intravenous giving sets

- Two litres of intravenous solution

Drug Pack

- Syntocinon ampoules of 10 units
- Syntometrine (oxytocin 5 units and ergometrine 0.5 mg) ampoules
- Ergometrine ampoule 0.5 mg
- Misoprostol 1000 micrograms
- Konakion ampoule 0.2 mg
- Local anaesthetic (20 ml ampoules 1% Lignocaine with adrenaline 1:200,000)

Waste Disposal

With the exception of waste containing pathogenic cultures or excreta of infected patients, the microbial load of healthcare wastes is generally not very high.

All clinical waste is to be taken to the relevant Area Health Service and disposed of into designated Clinical Waste bins that meet the labelling and colour coding requirements of AS/NZ 3816.

Refer to the WA Health Clinical Waste Management Policy available at:

www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12605

Sharps Disposal

An approved sharps disposal container must be used for all sharps. The container must be disposed of at an approved site.

Appendix 5: Oxygen cylinder safety

All reasonable and practical precautions are to be taken to prevent the occurrence of an accident through fire, explosion or leakage of the gases when handling or transporting gasses, such as portable oxygen cylinders.

The health professionals responsible for storing or using an oxygen cylinder should be trained and familiar with current cylinder handling regulations and emergency procedures if required.

Compressed oxygen is classified as a Class 2.2 (non-flammable non-toxic gas) Dangerous Good, according to the Australian Code for the Transport of Dangerous Goods by Road and Rail.

This Code states that:

- Oxygen cylinders are transported in a safe and standardised manner
 - Equipment for transportation and storage is routinely used
- Systems are in place to monitor the condition of cylinders and storage areas.

Transportation of Cylinders

1. Transport only one cylinder at time. Additional cylinders must be delivered by another staff member(s).
2. Prior to transporting or using a cylinder:
 - Check to ensure there is no damage or leaks to the cylinder. Any significant dent on the exterior of the cylinder or hissing sounds may indicate that the cylinder is damaged and must not be used.
 - Observe the expiry date.
 - Remove regulators or other equipment attached to cylinder.
 - Check the valve to ensure it has not been inadvertently turned on.
 - Secure cylinder in a designated transportation bag or holder - it is recommended that all cylinders be transported in an Air Liquid cylinder transportation bag, Oxypac.
3. During transportation:
 - The cylinder must be firmly secured in a vehicle during transport.
 - A transportation bag with straps is to be used to restrain the cylinder in an upright position behind the vehicle's front passenger seat.
 - If standing the cylinder upright is not possible, lay the cylinder down on the car floor behind the front passenger seat.
 - Ventilation must be available at all times when the oxygen cylinder is located in a vehicle. At least one window must be open together with the ventilation fan on and if the air-conditioner is being used it must be set to 'fresh air intake.'
4. Smoking in vehicles is strictly prohibited while transporting oxygen cylinders.
5. Ensure that no oil, grease or lubricant comes into contact with oxygen.
6. Ensure that a Material Safety Data Sheet (MSDS) accompanies the oxygen cylinder whilst in transit.
7. Oxygen cylinders must be removed from vehicles when not being transported.

Storage of oxygen cylinders at a designated healthcare base

All cylinders must be:

- Restrained in a purpose built, individual storage cylinder apparatus
- Stored upright in a cool, dry and well-ventilated place away from heat sources, sources of ignition and combustible materials
- Checked to ensure they comply with the inspection schedule
- Kept away from oil, grease or lubricants
- Stored with appropriate and clear signage in accordance with WorkSafe WA and standards Australia and have appropriate material safety data sheets (MSDS) easily accessible.

Any damaged or leaking cylinders **must not** be used and shall be tagged and reported to line Management—complete an Occupational Safety and Health Incident and Hazard form. Inform supplier of damage or leak.

Storage of Oxygen cylinders during on-call

All cylinders must be stored in the same environment as per a healthcare base - purpose built transport trolleys are considered a suitable storage restraint.

Appendix 6: Midwifery care when women make a decision not to follow the recommendations of the Home Birth Policy and Guidance

Title:	<p>Midwifery Care when women make a decision that is inconsistent with the Home Birth Program midwifery standard of practice</p> <p>This policy is to be read in conjunction with the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (2013) and the WA Health Home Birth policy.</p> <p>http://midwives.rentsoft.biz/lib/pdf/Consultation%20and%20Referral%20Guidelines%202010.pdf</p> <p>As a primary caregiver, the midwife must provide midwifery care that is consistent with the national professional standards for midwives and is within the scope and boundaries of his/her practice and those endorsed by the WA Health Area Health Services. When a woman's decision is at a variance from professional advice or guidelines, the midwife must consult and document accordingly.</p>
Policy Statement:	<p>The woman has the right to give and to rescind consent at any time and the decision made needs to be acknowledged and supported.</p> <p>Midwives are to provide information and inform the woman of the scope of their practice and its limitations and ensure that all conversations are documented accordingly.</p> <p>In the course of labour or urgent situations when the steps for discontinuing care have not been undertaken or completed, as stated in this policy and the letter of withdrawal, the midwife may not refuse to attend the woman. Equally where a woman refuses emergency transfer of care in the course of active labour, the midwife must remain in attendance. Documentation of the ongoing consultation with the obstetrician/specialist throughout the labour and birth is essential.</p>
Applies to:	<p>All midwives working in the publically funded home birth program</p>
	<p>Antenatal</p> <p>On booking: the client must meet the inclusion criteria for entry onto the Home Birth Program (insert name of program) according to the WA Home Birth Policy.</p> <p>The woman must discuss with their midwife and sign the Terms of Care document at booking and at 28 weeks and 36 weeks gestation.</p>
Procedure:	<p>If there is any variation from low risk during the woman's pregnancy that has been identified by the midwife, the WA Home Birth Policy must be referred to and complied with.</p> <p>If a woman consults with a medical practitioner, it is to be made clear and documented accordingly whether primary care and responsibility :</p> <ul style="list-style-type: none">a) Continues with the midwife ORb) Is transferred to the medical practitioner/hospital. <p>The planned place of birth must be clearly documented in the woman's notes and</p>

discussed with the woman.

Any antenatal woman who is declining referral for consultation must be discussed with the Clinical Midwifery Manager (CMM) or Clinical Midwifery Consultant (CMC) of the Home Birth Program and the back up Obstetric team.

Following the Midwife's consultation with the hospital health care team, the woman and her support people are to be advised regarding care recommendations.

Documentation of the consultation process – with whom the consultation occurred, the recommendations arising from the consultation, the time when the woman was advised of the recommendations and the woman's response, must be clearly articulated in the medical health records. The woman and her partner may also meet with the CMM/CMC to assist in achieving a suitable resolution.

If after the above process has occurred and a satisfactory resolution has not been achieved, care with the Home Birth Program will be discontinued. A written letter confirming discontinuation of Home Birth Program care (see below) accompanied by a copy of antenatal care records to date will be sent to the woman, her General Practitioner, the hospital maternity support unit and a copy retained in Home Birth Program records.

Intrapartum

Planned home birth:

During labour and birth if a woman's situation has varied from normal as per the WA Home Birth Policy and the woman has declined transfer at the recommendation of the attending midwife, the following actions must be taken by the Midwife;

1. The woman must be referred to the Terms of Care document
2. Consult with another midwife and share the advice of that midwife with the woman and her support people.
3. Document in the woman's health records the consultation process, recommendations arising from the consultation and the woman's response to the advice.

Should the woman continue to decline the professional advice of the midwives, the midwife must:

4. Request the attendance of a midwifery colleague
5. Notify the on-call Midwifery Manager
6. Notify the woman's back up hospital Obstetric team of preceding events and seek advice
7. Share the advice with the woman and her support people and document in the woman's medical health records the consultation process – with whom the consultation occurred, the recommendations arising from the consultation, the time when the woman was advised of the recommendations and the woman's response
8. Advise the on-call Midwifery Manager and the hospital maternity support unit Obstetric team of the woman's response and keep them informed of progress.

9. If an emergency situation is anticipated, an ambulance should be called to be in attendance. The cost of call out fees and transfer for St John Ambulance services will be at the expense of the Home Birth Program.

Planned Hospital Care

If the birth is planned to take place in the hospital maternity support unit due to prior recognised risk factors, the obstetrician remains the primary care giver and the woman is to make her own way to hospital and meet their midwife at the hospital.

It is understood that the Home Birth Program midwife will not attend the woman at home if the woman believes that she is in labour but will direct her, or her support person that the midwife will meet her at the hospital.

Establish if an Ambulance is required and advise the woman or support person that one will be called for her if necessary.

Postnatal Care

If there is any variation from the low risk during the postnatal period that has been identified by the midwife, the WA Home Birth Policy must be referred to and complied with.

The plan of care must be clearly documented in the woman's notes and discussed with the woman.

Any postnatal woman who is declining referral for either herself or her baby must be discussed with the CMM/CMC of the Home Birth Program and the back up Obstetric/Neonatal or Paediatric team.

Following the Midwife's consultation with the hospital health care team, the woman and her support people are to be advised of the care recommendations.

Documentation of the consultation process – with whom the consultation occurred, the recommendations arising from the consultation, the time when the woman was advised of the recommendations and the woman's response, must be documented in the woman's records.

If after the above process has occurred and a satisfactory resolution has not been achieved, care with the Home Birth program will cease to be available. A letter confirming discontinuation of Home Birth Program (see below) accompanied by a copy of antenatal care, birth outcomes and postnatal records to date will be sent to the woman her General Practitioner, and the Child Health Nurse and a copy retained in Home Birth program records.

References	National Guidelines for Consultation and Referral 2008 CMP Midwifery Guidelines for the Community Midwifery Program
Legislation	N/A
Standards	ANMC Code of Professional Conduct for Midwives in Australia 2008 ANMC Code of Ethics for Midwives in Australia 2008 ANMC National Competency Standards for Midwives 2006
EQuIP Standard	EQuIP4 Clinical Function – Continuity of Care, Health Record 1.1.8 EQuIP4 Consumer Focus – Involvement of Consumers 1.6.1 EQuIP4 Consumer Focus – Rights and Responsibilities 1.6.2
Other Related Documents	Appendix A When a Woman Chooses Care outside the Recommended ACM National Guidelines for Consultation and Referral

Letter of Withdrawal from the Home Birth Program

I, _____ have decided to withdraw from the Home Birth Program. I am withdrawing from the Home Birth Program as I have decided to _____.

I confirm withdrawal from the Home Birth Program. I understand that I am no longer eligible for care, advice or assistance to be continued with the Home Birth Program and that all responsibilities owed to me by the Home Birth Program and midwives have ceased.

I have discussed and understand the possibility and implications of complications arising from my choice to labour and birth without the presence of a suitably qualified health care provider. The complications potentially include but are not limited to:

- Abnormal presentation
- Fetal or neonatal death
- Fetal or neonatal hypoxia
- Gestational hypertension (GH)
- Intrapartum haemorrhage
- Placental abruption and/or praevia
- Postpartum haemorrhage
- Pre-eclampsia
- Preterm labour <37 weeks
- Preterm pre –labour rupture of membranes (PPROM) before 37 weeks
- Prolapsed cord or cord presentation
- Retained or incomplete placenta
- Shock/Maternal collapse
- Shoulder dystocia
- Third or fourth degree perineal tear
- Uterine inversion
- Uterine rupture
- Vasa praevia

I am aware of the support available by emergency services by dialling 000 to seek emergency assistance; King Edward Memorial Hospital, GP services, Child Health Nurse Services, and Community Midwifery WA support.

I confirm that I understand that by relinquishing the support of the Home Birth Program, I am taking full responsibility for any consequence that may arise.

I have been given a photocopy of my antenatal records to date, in order to assist any future health care provider. I am aware that my supporting maternity unit, _____, King Edward Memorial Hospital, my General Practitioner and Child Health Nurse for my residential area will be notified of my decision. I have a copy of this document.

Name	Witness Name
Signature	Signature
Date	

Support Person: I acknowledge that I have read and understood the document and support my wife/partner in her decision to withdraw from the Home Birth Program.

Name	Witness Name
Signature	Signature
Date	

Appendix 7: Transfer from Home to Hospital Procedure

Title: TRANSFER FROM HOME TO HOSPITAL

Protocol: The provision of safe, timely and appropriate transportation for women and or the neonate from her home to hospital whilst maintaining continuity of midwifery care/support where possible.

Applies to: All midwives working for Home Birth Program. To be read in conjunction with the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (2013) and this policy.

Procedure:

How to transfer from home to hospital

Discussions with the woman and her support person(s) should have occurred prior to the decision being made about transfer to hospital. If this has not occurred, communication with the woman and her support person needs to occur as soon as practical. The Clinical Guidelines folder is to be available to the midwife at all times.

Consult with the receiving hospital Consultant, Senior Registrar/Registrar, GP obstetrician or neonatologist and the Midwifery Co Coordinator of the receiving Labour and Birth Suite, the need for/or intent on transferring the woman from home to hospital as soon as practical.

Transport arrangements, appropriate to the level of assessed risk, needs to be organised as follows:

Urgent Ambulance Assistance

DIAL '000'

- If you do not have coverage on your mobile phone, try '112' or use woman's home phone.
- Have woman's medical records with you whilst talking on the phone
- When you call '000' you will be asked:
 - Do you require Police, Fire or Ambulance?
 - What is the exact location of the emergency?
 - You may be asked for the nearest cross street or land mark
 - What is your call back number?
 - What is the nature of the emergency?
- Provide your mobile phone number or woman's home number if you do not have reception.
- Identify yourself as "a Community Midwife working with the Home Birth Program. I have a woman (give name), gestation and problem. I require urgent transfer to designated hospital name.
- Ensure you are wearing your name badge so that Paramedics can easily identify you as a health care provider.

- Document time of call and ensure all events leading up to the decision to transfer have been documented correctly.
- Turn on front house lights if it dark and if appropriate have someone wait outside for the ambulance.
- Ensure the front door is unlocked so that Paramedics may enter the house.
- Provide a clear, concise handover to Paramedics immediately upon their arrival and document time.
- At all times the midwife remains the lead health professional and in urgent situations where there is a clear requirement for ongoing care, such as resuscitation, labour, fetal distress, the Midwife is to accompany the woman in the Ambulance. In the circumstance where the Neonate is requiring resuscitation, one midwife is to remain with the woman whilst one is to remain with the Neonate to provide ongoing care. Ensure continual liaison with the Paramedics as to plan of care.
- A support person may accompany the woman in the Ambulance at the discretion of the Paramedics.
- Notify the receiving hospital that the woman is in the Ambulance and provide an expected time of arrival.
- Pack away all your equipment and follow the Ambulance in your work vehicle to hospital in order to provide continuity of care as appropriate.
- Ensure clients' pregnancy records accompany them to the hospital and the transfer summary document is completed.
- Notify on-call Midwifery Consultant/Manager.
- Complete clinical incidence form (refer to your line manager for this form) and hand to CMM/CMC of the Home Birth Program within 48 hours of incident.

Non- Urgent Ambulance Assistance

Dial '131233'

- Identify yourself as a Community Midwife working with the Home Birth Program requesting a non-urgent ambulance transfer.
- Advise operator of clients name, address and reason for transfer and the receiving hospital.
- Provide your contact phone number.
- Prepare woman for departure from home.
- Ensure documentation is complete.
- Pack away equipment.
- Ensure you are wearing your name badge so that Paramedics can easily identify you as a health care provider.
- Ensure woman's pregnancy records accompany them to the hospital and the transfer documentation is completed.
- Notify receiving hospital when the woman is in the Ambulance and the expected time of arrival.
- Follow ambulance in your work vehicle.
- Complete clinical incident form (refer to your line manager for this form) and hand to CMM/CMC of the Home Birth Program within 48 hours of transfer.

Private Vehicle Transfer

- There may be situations either in the antenatal, intrapartum or postnatal periods where the clinical situation does not warrant the use of Ambulance services. Examples include but are not limited to the following:
 - Antenatal: e.g. reduced fetal movements, antenatal assessment/investigations
 - Intrapartum: e.g. for pain relief, at less than 7cm dilated with good FHR pattern
 - Postpartum: e.g. wound breakdown, mastitis.
 - Neonate: Ongoing jaundice, raised temperature, decrease in weight >10% birth weight, signs of infection.
- Advise receiving hospital of woman's details and time of arrival.
- Ensure clients' pregnancy/neonate records accompany them to hospital and the 'transfer summary document' is complete.
- At no time is the woman to drive herself or the neonate to the hospital. Ensure there is an adult to drive and accompany the woman into the hospital.
- If it is felt that the support person is too sleep deprived or not coping with the situation, the woman has no other forms of transportation and an ambulance transfer is deemed unnecessary, the midwife may drive the woman in their work vehicle.
- Ensure all documentation is completed.

Arrival at hospital

On arrival at hospital it is the responsibility of the Home Birth Program Midwife to provide a thorough verbal and written clinical hand over using the appropriate Home Birth Program Clinical Handover document. The Clinical Handover document is to be photocopied and retained for the Home Birth Program Midwifery records; the original is to be retained by the receiving hospital for their medical records.

References	St John Ambulance – www.ambulance.net.au/content CMP Guidelines
Legislation	N/A
Standards	Australian Nursing and Midwifery Council National Competency Standards for the Midwife 2006
EQulP Standard	Equip 4 Clinical Standard 1.1: Equip 4 Criteria 1.1.5, 1.1.2, 1.1.3, 1.1.6 Equip 4 Clinical Standard 1.3: Equip 4 Criteria 1.3.1 Equip 4 Clinical Standard 1.4: Equip Criteria 1.4.1
Other Related Documents	Sentinel Event recommendations 2010

Appendix 8: WA Health Competency Requirements for publicly practising midwives providing home birth services

WA Health competency requirements for publicly practicing midwives providing home birth services		
Competencies & Timeline	Competencies	Recorded
WA Health General Competencies		
Competencies in Obstetric emergency procedures	Shoulder Dystocia Cord Prolapse Postpartum Haemorrhage	
Competencies to be completed within 6 months of commencing with a Home Birth Program	Intravenous cannulation Neuraxial Blockade introduction and clinical competency Basic Life Support Obstetric emergencies (in-home scenarios) Perineal suturing Water birth	
Competencies to be completed annually	Basic Life Support Neonatal resuscitation Documentation update Breastfeeding update Fetal monitoring introduction (then annual updates to include K2, or similar e-learning package) Mandatory up-skilling in the back up hospital Perineal suturing Intravenous cannulation Newborn examination	
Competencies to be completed two yearly	Neuraxial Blockade update	
Competencies to be completed three yearly	Emergency obstetric management (e.g. In-Time, ALSO)	
Competencies to be completed five yearly	Advanced Fetal Assessment Neonatal Resuscitation Program	

Appendix 9: Sample Clinical Advisory Group Terms of Reference

1. Purpose

To oversee the compliance of the Home Birth Program clinical governance policies and reporting processes and to provide an additional and independent line of clinical advice to both the Home Birth Program and the relevant Area Health Service in relation to adverse events, and other matters referred to them by either party.

The Clinical Advisory Group (CAG) will use the following steps as a framework for meeting clinical governance and risk management targets:

- 1.1 Build a safety culture.
- 1.2 Lead and support staff.
- 1.3 Integrated risk management activity.
- 1.4 Promote reporting.
- 1.5 Involve and communicate with women and the public.
- 1.6 Learn and share safety lessons
- 1.7 Implement solutions to prevent harm

2. Terms of Reference

- 2.1 To meet on an as-needs basis to review cases resulting in unexpected program outcomes referred to them by the relevant Area Health Service.
 - a. The Clinical Advisory Group (CAG) will review clinical incidence forms Level 7 and above, as required.
 - b. The CAG will investigate adverse events referred to it, and develop recommendations relating to clinical practice, policies and/or procedures that will assist the Home Birth Program maintain and improve outcomes.
 - c. The Home Birth Program Midwifery Manager will create an action plan in response to the CAG recommendations in consultation with their clinical line manager within relevant Area Health Service.
 - d. Where it is deemed constructive, the Home Birth Program Midwifery Manager may invite CAG members to provide verbal feedback to the midwives involved in the case/s reviewed.
- 2.2 To meet annually with the Home Birth Program Midwifery Manager, the relevant Area Health Service as appropriate with a view to having a general discussion on issues and matters of clinical importance and interest.

3. Reporting

Reports generated from the review of clinical incidence forms Level 7 and above will be submitted to the relevant Area Health Service 45 days from the time of the request for review is received.

A report of the action plan will be provided by the Home Birth Program Midwifery Manager to CAG three months from the date of receiving the recommendations.

A final report will be submitted to CAG once outcomes have been achieved.

4. Confidentiality

The proceedings and records of the group are confidential to members and shall not be disclosed except to the extent required of members to enable them to comply with the group's decisions and directions.

For guidelines and the link to the WA legislation see section 6.4 Analysis and Investigation of the [Clinical Incident Management Policy](#)²⁴ available at:

www.safetyandquality.health.wa.gov.au/docs/aims/Incident_Reporting_policy.pdf

5. Membership

- 5.1 The composition of the CAG should include:
- six to eight members with at least one obstetrician; two senior midwives, one of whom has home birth experience; consumer; GP obstetrician; and neonatologist or paediatrician
 - half of the membership are individuals independent of the specific home birth program
- 5.2 A quorum will consist of the Chairperson or his/her proxy, who must be a member of the committee and 50% of the committee membership.
- 5.3 Terms of office for CAG membership will be one year with the possibility of re-appointment.
- 5.4 The CAG will invite input from appropriate practitioners and other stakeholders in order to fully review cases when required.

6. Chair

The Clinical Advisory Group will elect a Chair from its membership.

7. Secretary to the Group

Upon request by the Chairperson, secretariat services will be provided by the relevant Area Health Service for the purpose of taking minutes and the write up of reports.

Appendix 10: Useful links

http://www.healthnetworks.health.wa.gov.au/docs/Improving_Maternity_Choices-A_Policy_Framework.pdf

http://www.healthnetworks.health.wa.gov.au/docs/Models_of_Maternity_Care_Review_of_Evidence.pdf

http://www.healthnetworks.health.wa.gov.au/publications/docs/11284_HOMEBIRTH.pdf

<http://www.healthnetworks.health.wa.gov.au/publications/docs/plannedhomebirthsafety.pdf>

http://www.health.wa.gov.au/publications/documents/perinatal/13th_report_perinatal_infant_mortality_2005-7.pdf

<http://www.healthnetworks.health.wa.gov.au/publications/docs/plannedhomebirthsafety.pdf>

<http://www.midwives.org.au/scripts/cgiip.exe/WService=MIDW/ccms.r?pageid=10037>

http://www.health.wa.gov.au/publications/documents/perinatal/13th_report_perinatal_infant_mortality_2005-7.pdf

<http://www.commerce.wa.gov.au/WorkSafe/>

<http://www.midwives.org.au/scripts/cgiip.exe/WService=MIDW/ccms.r?pageid=10037>

<http://www.ranzcog.edu.au/publications/pdfs/ClinicalGuidelines-IFSSecEd.pdf>

http://whqlibdoc.who.int/hq/1989/WHO_MCH_89.2.pdf

<http://www.nhmrc.gov.au/guidelines/publications/cp124>

<http://www.midwives.org.au/scripts/cgiip.exe/WService=MIDW/ccms.r?pageid=10038>

<http://www.nursingmidwiferyboard.gov.au/Codes-and-Guidelines.aspx>

http://www.kemh.health.wa.gov.au/development/manuals/O&G_guidelines/sectionb/10/b10.1.1.pdf

<http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx>

<http://www.nursingmidwiferyboard.gov.au/Codes-and-Guidelines.aspx>

<http://www.ahpra.gov.au/Education/Continuing-Professional-Development.aspx>

<http://www.health.wa.gov.au/CircularsNew/pdfs/12403.pdf>

<http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/NSQF>

http://www.safetyandquality.health.wa.gov.au/clinical_incident_man/clinical_risk_man.cfm

http://www.safetyandquality.health.wa.gov.au/clinical_incident_man/sentinel_events.cfm

http://www.safetyandquality.health.wa.gov.au/involving_patient/open_disclosure.cfm

<http://midwives.rentsoft.biz/lib/pdf/Consultation%20and%20Referral%20Guidelines%202010.pdf>

http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12605



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