TITLE: HOME BIRTH MANAGEMENT GUIDELINE

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Lead Specialty/ Department: (Or Division if 'divisionally' owned)	Maternity
Lead Author: (position/ role and name)	• [redacted] Matron for Community & Outpatients • [redacted] Deputy Head of Midwifery
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Sponsor (position/ role):	W&C Divisional Director Midwifery and Nursing

Name the documents here or record not applicable *(these are documents which are usually developed or reviewed/ amended at the same time – ie a family of documents)*	
Associated Policy	N/A
Associated Procedure(s)	N/A
Associated Pathway(s)	N/A
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Other associated documents e.g. documentation/ forms	• Homebirth home assessment form (Badgernet)

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Amendments from previous version(s)

Version	Issue Date	Section(s) involved (author to record section number/ page)	Amendment (author to summarise)
9.3	**April 2025**	• **Whole document**	**Inclusive language, BRAIN acronym added, and amendment to clarify offer of birth at home from 37/40**
9.2	August 2024	• Appendices	• Flowchart added at Appendix C for call to midwife to attend woman/ birthing person at home
9.1	July 2024	• 4.4, page 6	• First paragraph reworded for clarity
9.0	Feb 2024	• 4.2 Risk assessment • Whole document	• Paragraph added re PMA service • Grammatical changes

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1 INTRODUCTION/ BACKGROUND

There has been a longstanding expectation that women and birthing people should be given a full choice of place of birth: home birth, midwifery led setting and obstetric led setting, and this is endorsed by NICE guidance.[5] The recent 'Better Births- National Maternity Review' (2015)[1] supports this by remarking that women should be able to make decisions about where they prefer to give birth after a full discussion of the risks and benefits of their choice.

As a Trust we support that a home birth should be offered to all women and birthing people from 37/40 and at low risk of complications. We understand that this may confer considerable benefits for women, birthing people and their families. There is ample evidence to show that labouring at home increases a woman/ birthing persons's likelihood of a birth that is both satisfying and safe, with positive implications for their health and that of their baby.

In the presence of risk factors and aligned with the vision of the National Maternity Review[1], each midwife should facilitate women and pregnant people to make decisions about their care including place of birth, based on their individual needs and preferences. This is achieved by offering to provide a conversation to include material risks personalised to specific circumstances and by using unbiased information even if this means crossing traditional boundaries. Ability to access this information in the language or format required by the women or pregnant person must also be facilitated.

2 DEFINITIONS AND/ OR ABBREVIATIONS

Definitions:

Trust	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employers of the Trust including those managed by a third party on behalf of the Trust

Abbreviations:

MLC:	Midwifery Led Care
NICE:	National Institute for Clinical Excellence
SBU:	Sherwood Birthing Unit
EMP:	Electronic Maternity Pathway
KMH:	Kings Mill Hospital
BRAIN	Benefits, Risks, Alternatives, Information, Nothing

3 SCOPE OF DOCUMENT (including related Trust documents)

This clinical guideline applies to:

Staff group(s)
- Midwives
- Obstetricians

Clinical area(s)
- Community Midwifery
- Antenatal Clinic
- Pregnancy Day Care
- Sherwood Women's Centre
- Sherwood Birthing Unit
- Maternity Ward

Patient group(s)
Women and Birthing people
Exclusions
- None

Related Trust Documents

- Antenatal Care Provision Guideline
- Birthing Pool – Management guideline for labour and birth in a birthing unit
- Intrapartum fetal monitoring guideline.
- Normal Physiological Labour – Guideline for the Care of Women
- Pre-Labour Spontaneous Rupture of Membranes at ≥ 37/40 weeks guideline (at term)
- Placenta – Guideline for the Histological Examination
- Facilitating Choice Guideline

4 GUIDELINE DETAILS (including Flowcharts)

4.1 Choice of place of birth

As a Trust we support that home birth should be offered to women and birthing people >37 weeks pregnant at low risk of complications. There is ample evidence showing that labouring at home increases a woman/birthing persons's likelihood of a birth that is both satisfying and safe, with positive implications for their health and that of their baby. Midwives should facilitate informed decision-making based on individual needs. Every women and birthing person has access to personalised conversations specific to their own risk factors if they are considering homebirth.

Midwives will provide opportunities to discuss these choices throughout the antenatal period, alongside continual oversight of the developing clinical picture and associated risk assessments. This should include any material risks, benefits and what is important to the woman/pregnant person including (but not limited to) previous experiences, culture, beliefs, hopes and fears. There should be no pressure on the woman/pregnant person to make

decisions regarding place of birth at booking; discussions should be offered throughout pregnancy with the reassurance that they can change their mind at any time[5]. It should be explained that for those with low risk of complications, home birth has a higher rate of spontaneous vaginal birth and lower rate of intervention with no difference in outcomes for the birthing parent and baby. Every woman and pregnant person will be offered a personalised care conversation and/or plan, to support discussions around place of birth and other preferences specific to their needs[1]

4.2 Risk assessment

All women and pregnant people must be formaly risk assessed by staff at each antenatatal contact to ensure they are offered continued and responsive access to care by the most appropriate health professional[6]. These choices should be fully informed and personalised to the individual circumstance of each pregnancy.

Assessment of risk is integral to every antenatal contact. A midwife must be able to provide appropriate care to mitigate those risks regardless of the setting, through care planning, knowledge of services and communication with colleagues and the woman/pregnant person and their family. All women/ pregnant peoplemust be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional. Risk assessment must include on-going review of the intended place of birth based on the developing clinical picture.[6]

4.3 Antenatal planning

Preparation for labour should be discussed fully with the woman/pregnant person and theirfamily at approximately 34-36 weeks gestation and a birth plan made. The Smart Homebirth Home Assessment Form on Badgernet should be completed to ensure that this discussion includes all issues necessary to be covered i.e. environmental factors, staff safety, on call arrangements, management of emergencies / transfer into hospital including when there is no midwife available to support the homebirth service etc.

There needs to be a frank discussion with the woman/pregnant person and their family regarding the practicalities of transfer to hospital. This discussion should include time for an ambulance to reach the home, estimated transfer time and which hospital they may need to be transferred to in an emergency. This discussion should also include the level of expertise and equipment available to the midwife and ambulance crew.

The midwife also needs to complete the Smart Homebirth Home Assessment Form on Badgernet and update the care plan to reflect that the intended place of birth is now Home.

4.4 Care Outside of Guidance (Non-normative care pathway)

Ideally women and pregnant people choosing home birth will fulfil the criteria for midwifery led care[7] (MLC) (see Provision of Antenatal Care Guideline). In some circumstances, those who fall outside these criteria will still choose to give birth at home. In this situation, the midwife should consider consulting an appropriate professional colleague including their Line Manager or Professional Midwifery Advocate for further advice/ support. Some circumstances may require a multi-disciplinary approach with support via the Birth Options Service. While it is important to avoid being perceived as bullying or coercive, it is vital that women and pregnant people are not 'protected' from understanding the potential implications of their decisions,

including morbidity, mortality and the possible legal repercussions for any lay caregivers. The BRAIN acronym is utilised by the PMA service in Birth Options services and can be used to share information between the woman/pregnant person
and the health care professional to communicate any available evidence and known risks in collaboration with what is important to the pregnant person. This supports informed decision-making principles.

There will be occasions where the woman/pregnant person will decide on a course of action that goes against midwifery/obstetric advice (also known as care outside of guidance or non-normative care pathway). Midwives will use their professional judgement to assess how best to support and continue to provide care for the woman/pregnant,
prioritising the relationship and communication between them both to maximise engagement. Where a pregnant person intends to give birth at home contrary to professional advice and local guidelines, the multi-disciplinary team should collaborate with the woman/pregnant person to draw up an action plan to explore the management of the request/choice. This must accurately reflect the birth-planning conversation including what is important to the individual and the material risks/benefits to both the woman/pregnant person and the baby. If PMA support or the Birth Options service is declined, the Consultant Midwife or the PMA can offer support to the midwife, to develop an action plan protecting the relationship between the midwife and the woman/pregnant person.

The plan should include:

- Ensuring the woman/birthing person has been fully informed of the potential risks and their consequences
- Ensuring that two skilled and experienced midwives are available to provide the necessary care
- Liaising with The East Midlands Ambulance Service regarding any transfer which may be required
- Liaising with the obstetric and neonatal teams to ensure appropriate back up is in place
- Ensuring a discussion of the potential risks and their consequences has been offered, structured around the BRAIN acronym. This discussion may be declined and this should be respected; thorough documentation must be ensured to accurately reflect this discussion.

This plan should be carefully documented and communicated to all those involved, including the woman/pregnant person. Accurate records should be kept of the risk assessment and any discussions. At all times, great care should be taken to preserve the quality of the relationship and to sustain as much mutual trust and respect as possible.
Professional and personal support to help the midwife with any anxiety or distress she may experience will be provided if required.

4.4 Care in labour

Once established labour is suspected, the Sherwood Birthing Unit Coordinator will contact the community midwives on call, and two midwives will attend the home address (Appendix C). If the on call team are already in attendance at a homebirth, the woman/birthing person will be informed at the point they contact triage and advised to attend Sherwood Birthing Unit. The home birth service will be suspended in the event of unexpected staff sickness and the Sherwood Birthing Unit Coordinator and Bronze on Call will be notified. The

woman/birthing person will be advised to attend Sherwood Birthing Unit in this instance. All midwives are expected to attend with the appropriate equipment (Appendix A). The coordinator on Sherwood Birthing Unit (SBU) should be informed that a woman/birthing person is in labour at home, which staff are present and should be regularly updated on progress. Midwives should refer to Normal Physiological Labour – Guideline for the Care of Women and the Intrapartum fetal monitoring guideline.

All labour records should be maintained in the woman/birthing person's electronic pathway - Badgernet

In the event of new risk factors, or any concerning change of circumstance, the attending midwives must offer to summon help via EMAS and encourage transfer to hospital for ongoing care. Transfer for care should also be reported to the SBU Coordinator, so that appropriate preparations for arrival can be facilitated.

4.5 Management of women/birthing people with ruptured membranes at term with no contractions, who have chosen to labour at home:

Following spontaneous rupture of membranes in the absence of contractions or risk factors the Pre Labour Spontaneous Rupture of Membranes at ≥ 37/40 weeks guideline (at term), SFHFT (2021) should be adhered to and 24 hours post ruptured membranes the individual should be discussed with the neonatal team, SBU Co-ordinator and/or the On-call Obstetric Registrar and a plan developed.

4.6 Unplanned home births

Some women/birthing people although planning to birth their baby in the hospital environment may find themselves in advanced labour and wishing to remain at home/another venue to deliver their baby. This may be intentional or unintentional. For these people there may be unidentifiable risks.. When SBU is made aware of this situation, the initial pathway of care should be to encourage transfer to SBU for ongoing care via summoning of EMAS transfer. In instances where this is refused by the woman/birthing person,before contacting a community midwife to attend, it is important that the SBU coordinator ensures any risks have been identified and shared with the midwife before they attend the address. This includes neonatal, anaesthetic and safeguarding alerts along with any general medical/ social information that may have an impact on the safety of the mother/parent, baby and staff. This information should always inform the decision about whether a woman/birthing person and baby need to be transferred into hospital or can remain at home during the birth and after.

4.7 Babies born before arrival (BBA) of the midwife

On occasion SBU may be contacted by women/birthing people (or their family) when a delivery is imminent or once the baby has already been born at home without a midwife present. In response to all these calls an ambulance, if not already present, should be called by the coordinator of SBU. If this is a planned homebirth and a midwife is available to attend alongside the ambulance the woman/birthing person should be given the option to remain at home.

If this is an unplanned home birth the woman/ birthing person and baby are to be transferred into hospital via ambulance and a midwife is not to be sent out to attend the home. All BBA's will be reviewed via Datix.

4.8 Women reluctant to transfer into hospital

For any occasions where women/birthing people are reluctant to be transferred into hospital on the advice of a health care professional eg, unplanned BBA's or identified clinical risk this must be escalated to the SBU coordinator.
In the rare situation where the labouring person declines to enter an ambulance during an emergency or potential risk-to-life situation, this must be promptly escalated to the Senior Leadership Team (including Bronze/Silver on-call or Duty Nurse Manager) via SBU coordinator, to ensure appropriate and responsive guidance is provided to the attending staff. It is recognised that staff will require an ongoing offer of support, and this will be provided.

4.9 Transfer of Care from home to Hospital

If a woman/birthing person is labouring at home, or is postnatal, and transfer to hospital is necessary the midwife should telephone the SBU Coordinator on duty. The unit of transfer will normally be King's Mill Hospital (KMH) but in some circumstances may be a neighbouring unit. The woman/birthing person and baby will be transferred to the SBU / labour ward together wherever possible. It is the responsibility of the attending midwife to assess the requirements for transfer dependant on circumstances and to arrange the transport if an ambulance is required. Depending on clinical circumstances the midwife may accompany the woman/birthing person to the hospital in the ambulance or may choose to follow in their own transport.

If a baby requires transfer to hospital, then the ambulance is to take the baby directly to the Emergency Department and ensure that they have rung ahead to inform them of their pending arrival. A midwife should remain with the woman/birthing person and arrange a further ambulance to transfer them in to be with the baby if it is not appropriate for them to attend with the baby.

A request for an ambulance needs to be made via a 999 call. The times of request and arrival of an ambulance should be documented.
Any decision to transfer care of the woman/birthing person or baby should be clearly documented, together with the date, time and reason for transfer of care.

4.10 Emergency situations in the home

In the event of an emergency situation for the woman/birthing person or the baby, the midwife is to immediately call for the emergency services and then follow Trust guidelines as appropriate given the limitations of a home confinement. The midwife is to keep the woman/ birthing person and family as updated as possible in these situations. The SBU Red phone should be used to inform SBU Coordinator and Acute MDT Teams of the impending transfer and SBAR handover completed. Please see Appendix B for how to request for help in an emergency.

4.11 Post delivery

The midwife is to contact the coordinator on SBU to inform them of a safe birth.

Following routine postnatal care on leaving the home the midwife will ensure that the mother/parent and their families have contact numbers for advice and emergency numbers

for the hospital. The woman/birthing person should also be aware of the next expected visit from the midwife.

The midwife should leave an appropriate amount of time between birth and leaving the women/birthing person and baby unattended at home. Postnatal assessment should be performed for mum/parent and baby prior to leaving and parents be given information on important signs and symptoms to observe for mum/parent and baby.

4.12 Records

The midwife must ensure that the Electronic Maternity Pathway (Badgernet) has been completed in full. Following the birth ensure correct transfer/ disposal of used equipment and the placenta is disposed of at either KMH or Newark Hospital. Please refer to Placenta – Guideline for the Histological Examination, SFHFT (2021) to clarify if the placenta may need to be retained.

The NHS number and birth centile for baby are to be generated and documented on the EMP (Badgernet). The bar-coded labels for Newborn Blood Spot are printed and placed in the red book which will be given to the woman at the first postnatal home visit.

5 EDUCATION AND TRAINING

No education or training is required for the implementation of this guideline.

6 EVIDENCE BASE/ REFERENCES

1. Better Births: improving outcomes of maternity services in England- A five year forward view for maternity care (National Maternity review Team, 2015)
2. DH (2007) Maternity Matters: choice, access and continuity of care in a safe service. Department of Health. London
3. NMC Code of Conduct (2015) NMC. London
4. NHS Choice Framework (2016)
5. National Institute for Clinical Excellence (2014) (Updated 2022) Intrapartum Care For Healthy women and babies. Clinical Guideline 190. NICE. London
6. Ockenden,D. (2020) Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust
7. Royal College of Midwives Position Paper 25. HOME BIRTH. June 2008. RCM. London
8. Royal College of Midwives, ‘Guidance for midwives, student midwives and maternity support workers providing community-based care during the COVID-10 pandemic. (2020)

7 MONITORING COMPLIANCE AND EFFECTIVENESS

No specific monitoring is required for the implementation of this guideline, the homebirth rate is monitoring via the Maternity Dashboard.

8 EQUALITY IMPACT ASSESSMENT

- Guidance on how to complete an Equality Impact Assessment
- Sample completed form

Name of service/policy/procedure being reviewed: Home birth management guideline			
New or existing service/policy/procedure: Existing			
Date of Assessment: 23/06/2025			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None	N/A	N/A
Gender:	None	N/A	N/A
Age:	None	N/A	N/A
Religion:	None	N/A	N/A
Disability:	None	N/A	N/A
Sexuality:	None	N/A	N/A
Pregnancy and Maternity:	None	N/A	N/A
Gender Reassignment:	None	N/A	N/A
Marriage and Civil Partnership:	None	N/A	N/A
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None	N/A	N/A

What consultation with protected characteristic groups including patient groups have you carried out? • None
What data or information did you use in support of this EqIA? • None required

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? • None

Level of impact From the information provided above and following EqIA guidance document please indicate the perceived level of impact: ***Low Level of Impact*** For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: [redacted]
Signature: [redacted]
Date: 23/06/2025

9 APPENDICES

Appendix A – Home birth kit list

Appendix B – Calling for help in an emergency

Appendix C– Homebirth Declaration and Consent Form

Appendix D – BRAIN decision making tool

Appendix E – Flowchart for requesting attendance at home

Appendix A – Home Birth Kit

<table>
<tr><td><u>Suturing Bag:</u>
Suture Pack
10ml Syringe
Green Needle x3
3x 2ml syringes
2/0 suture
3/0 suture</td><td><u>Resus/ Baby Bag:</u>
Red & Green Hats
Tape Measure
Size 0 and Size 1 face masks
Igel
Laryngoscope
Orange Needle
1ml syringe
1x filter needle</td></tr>
<tr><td><u>Intrapartum Bag:</u>
Catheter/VE pack
In-out catheter
Indwelling catheter
Catheter bag
Instilagel
10ml Syringe x2
2x 10ml saline
Jug
MSU pot
Charcoal Swab
Optilube
Amnihook
Entonox Mouthpiece
Sterile Gloves (sizes 6/6.5/7/7.5)</td><td><u>PPE/ Bloods Bag:</u>
Non sterile gloves box
X2 aprons
Pink x2/purple x1/gold x1 blood bottles
10 ml syringe
Green needle
Vacutainer
Venepuncture needle
Tourniquet
Clinical waste bag x2</td></tr>
<tr><td><u>Spare Bag:</u>
Delivery Pack

Each Bag must be checked by x2 RM

Community Midwives will continue to carry Emergency Drugs (Oxytocin and Ergometrine), Vitamin K and Lidocaine as well as their Entonox cylinders</td><td><u>Front Pack:</u>
10x INCO pads
Sharps Bin
Red Book + Discharge pack
Placenta Box
Printed Guidelines for emergencies
1x HHR</td></tr>
</table>

NB.
Each Homebirth Bag is fitted with x2 tamper seals. When the bag is dropped off or collected from a designated point, it is the responsibility of the midwife to ensure the 'Declaration and Consent Form' is completed, uploaded to badger and the physical copy left with the parents. The patient details and bag provided are added to the database for tracking purposes.
If staff have any queries regarding the homebirth bags these should be discussed with their Team Leader, Jess Busby or Katie Cattermole (Leads for the Homebirth Bag QI Project).

Appendix B – Calling for help in an emergency situation at a homebirth

Calling for Help in an Emergency situation at a Homebirth

CAll 999

- STATE- **"I am a Midwife on scene with immediate threat to life . I require immediate paramedic help and immediate transfer to hospital"**

Call RED phone SBU

- SBU RED PHONE **01623 672529**
- Speak to **SBU Coordinator** direct to inform of situation and so SBU Team ready to receive or liaise with Emergency Department (ED)

Appropriate Dept

- Baby requiring Resuscitation or ventilatory support to Emergency Department (ED) Resus
- Maternal Collapse - Cardiac Arrest /Unconscious - transfer Mother to Emergency Department (ED)
- Other Obstetric Emergencies - transfer to Sherwood Birthing Unit

Sherwood Forest Hospitals
NHS Foundation Trust

Sherwood Forest Hospitals NHS Foundation Trust:
Homebirth consent and declaration

Homebirth Boxes:
We at Sherwood Forest Hospitals are delighted to be able to support your preference to birth at home. To support our homebirth service, this homebirth box contains medical equipment and supplies required by the community midwives that attend your homebirth. This box has been fitted with tamper seals to protect the integrity of the kit and also support facilitation of your homebirth with appropriate care and access to required equipment. We kindly ask that you ensure this box is accessible for staff when they attend to support your homebirth.

Implications of evidence of tampering:
If, on arrival at your homebirth, community midwives suspect there has been evidence of tampering, the trust deems this to be sufficient reasoning for transfer into hospital to provide labour care. This is because evidence of tampering could mean certain kit has been removed, which could mean care cannot be appropriately facilitated by staff.

Damage suspected prior to homebirth:
If prior to your homebirth you suspect the box provided is damaged or has been tampered with, we kindly ask that you contact us via the **Triage Service Line** **01623 676170** as a matter of urgency to avoid any potential implications.

Declaration and Consent:
I confirm that I have read the above declaration and that by signing I am acknowledging that I take responsibility for this homebirth box within my home. I accept that any evidence of tampering to this homebirth kit prior to attendance of my homebirth by the Sherwood Forest Community Midwifery Team may result in a transfer into hospital. I accept that I will ensure this box is kept safe within my home and will be accessible for staff when they attend to support my homebirth.

Signed: ____________________ (Birthing Individual) Print: ____________________

Signed: ____________________ (Birth Partner) Print: ________________________

Signed: ____________________ (Midwife) Print: ___________________________

Date: ____________________

Please note one copy should be scanned on to Badgernet records and one copy should remain in the plastic wallet attached to the homebirth box at the home of the birthing individual.

Appendix D BRAIN Acronym informative poster

Making Choices:

Supporting you to make personalised,informed decisions about your pregnancy and birth.

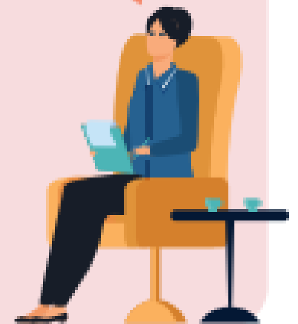
Understand my options:

- Information should be easy for you to understand.
- Information can be provided in your first language or in easy-read format.

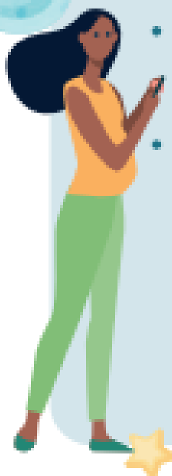
Explore my options:

The BRAIN tool may help you to make a decision:

BENEFITS
RISKS
ALTERNATIVES
IMPORTANCE
NOTHING/
NEED MORE TIME



Personalise my options:



- Share what is important to you.
- We will support you with your individual needs and personal circumstances.

You are the right person to make the right decision for you.

Your personal history, values and culture shape you and your decision-making.

We will respect your choice

Email a Professional Midwifery Advocate: For Sherwood Forest Hospital: **sfh-tr.pmateam@nhs.net**
or for Nottingham Hospitals: **AskAPMA@nuh.nhs.uk**
Email MVP: Nottingham & Nottinghamshire Maternity Voices Partnership: **nnicb-nn.maternityvoices@nhs.net**
Email any feedback, complaints or concerns: Sherwood Forest Hospital Patient Experience Team: **sfh-tr.pet@nhs.net**
or Nottingham Hospitals Patient Advice & Liaison Service: **PALS@nuh.nhs.uk**

Appendix E – Flowchart for requesting attendance at home

A BIRTHING PERSON/WOMAN PHONES THE EMERGENCY MIDWIFE NUMBER REQUESTING MIDWIFE TO ATTEND HER AT HOME

Triage midwife to do a full telephone assessment and ascertain if the birthing person/woman is still fit for a home birth and if a face-to-face assessment is required. The midwife will check if FM are present and normal, if any loss PV or SROM, liquor colour meconium/blood stained, frequency and strength of contractions, any other concerns, including safeguarding issues. This will then be documented on Badgernet and the coordinating midwife informed.

Check White Board:

Is Home birth service suspended /Are MWS already out at homebirth?

If BBA send 999 ambulance to attend woman and bring to SBU

Yes

No

Is woman on Homebirth List?

No

Yes

Woman to attend SBU

declines

Assess if req[illegible]ance sending immediately?

In hours – Inform CMW Team Leaders & send 2 MW's if available

OOH – Inform Bronze on Call & DNM

In Hours - SBU coordinator to inform CMW Team Leaders who will dispatch community midwives.

Out of Hours – SBU coordinator to contact and dispatch on call community midwives

SBU Coordinator to update and maintain the White Board with the birthing person/woman's name, who is in attendance and time of call.

Two Community Midwives should attend the birthing person/woman's home address and perform a full AN/Labour assessment. Findings to be shared with SBU Coordinator

Regular updates of progress and or any concerns to be shared with SBU Coordinator

Once baby is born and placenta birthed SBU Coordinator should informed

Inform SBU coordinator when departing the address.