South Eastern Health Board
Waterford Community Care Area

DOMICILIARY MIDWIFERY
AND THE
PUBLIC HEALTH NURSING SERVICE

by

Anne Dempsey and Helen Mulcahy

January, 1998
Acknowledgements

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Anne Dempsey and Helen Mulcahy
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Introduction

Domiciliary midwifery and the Public Health Nursing service are not normally associated together although this was not always the case. Therefore the impetus for this project stems from a decision by the South Eastern Health Board (SEHB) to provide a service for a client who had applied for a home confinement. The health board is obliged to provide a service under the provisions of the Health Act 1970 (Department of Health, 1970, Appendix 1.), and the provision of domiciliary midwifery services remains one of the duties of Public Health Nurses (PHN’s) (Department of Health, 1966), despite negligible involvement in this area. The current role of the PHN is to deliver primary health care to the population of a defined geographical area within the context of the community care programme. The potential to care for pregnant women, according to the World Health Organisation (WHO, 1985) extends beyond the system present today, the shift of care must move from secondary to tertiary to primary care level. McMurray (1993) states that as responsiveness to the needs of the community is the key feature of primary health care, nurses working within this context must by definition “change and evolve in conjunction with the community and society” (p.320).

Childbirth trends have changed dramatically in the last few decades. The Department of Health (1995a) concluded that “as women have fewer children, they attach greater importance to the unique experience of childbirth for themselves and their partners” (p.34). The National Health Strategy (Department of Health, 1994a) recommended that maternity services should be more responsive to the needs of mothers who are seeking individualised care and encourage a greater involvement in decision making in relation to their care. As 72% of Irish women become mothers, meeting their childbirth needs becomes a significant issue (O’Connor, 1995). White (1988) suggests that nurses should
play a key role in shaping health care policies for women. It could be argued that it is not necessary to make further provisions for home births because the demand for them is so low. Home births account for 1.4% of total births in the United Kingdom (UK), (Chamberlain and Gunn, 1995), and only 0.4% in the Republic of Ireland (Central Statistics Office, 1996). It is the policy of the Department of Health (1995a) to discourage home births on the basis of safety, therefore it is not surprising that surveys have not been conducted to measure demand for a home birth service. One national (but unpublished) survey of women's health conducted by Dwyer (1994) found that 17% of low income and 13% of higher income women said they would like to have a home birth.

The key principles which underpin the delivery of an effective health service are equity, quality of services, and accountability (Department of Health, 1994a). However, the present domiciliary maternity services are not delivering on these principles because the service is only available in certain parts of the country, standards of care are not universal and fees are charged by independent midwives. Furthermore, these fees are not fully reimbursed by the health boards. The Southern Health Board (1996) found that women wanted access to a quality health service that affords them choice and control. However, the debate on place of birth remains dominated by the issue of safety. Many authors have suggested that it remains unresolved and open to interpretation (McFarlane, 1996; Ogden, Shaw and Zander, 1997b; Tew, 1995;). Nevertheless, recent health policy in the UK has endorsed and supported women's choice in relation to home births (Department of Health, 1993; House of Commons Select Committee on Maternity Services, 1992).
In sourcing material for this paper the authors used the computerised databases CINAHL and MEDLINE, in addition to manual searches. Section one explores the evolution of the maternity services both in Ireland and the UK. Section two examines the whole debate surrounding home birth versus hospital birth. Section three focuses on the issues involved in organising and delivering a domiciliary midwifery service. The paper concludes by summarising the salient points and making recommendations for service delivery.
Section 1. The Evolution of Maternity Services

Historically, childbirth was considered a dangerous time for mothers and babies. Henderson (1997) suggests that there can be "no doubt that the current complexities surrounding the organisation of care are inextricably linked to the changing place of birth" (p.201). These complexities are wide ranging and encompass issues such as perceptions of pregnancy, social and cultural factors and feminism. However, in this section the authors intend to focus on childbirth from the perception of policy makers and health professionals.

1.1 Development of Maternity Services

According to O’Connor (1995) most births occurred at home in the 1900’s, mortality rates were high, almost one child in ten died during their first year of life in Ireland. Urban poverty, inadequate nutrition, artificial feeding and unsanitary living conditions were cited as reasons for this high rate (O’Connor, 1995; Robins, 1995). The available hospitals, having developed from the Poor Law system in the 1850’s provided care for the destitute, and had very poor, unsanitary conditions. Furthermore, they were staffed by midwives who were poorly paid and trained (O’Connor, 1995). The maternal mortality rates remained virtually unchanged between 1900 and 1935 in the UK, despite measures put in place to combat it, such as raising the competence of midwives and doctors. The main cause of the high maternal mortality rates was puerperal sepsis and to a lesser extent toxaemia and haemorrhage (Robins, 1995). In fact the maternal mortality rate rose from 5.59 per 1000 total births in 1929 to 5.8 per 1000 in 1933. (Tew, 1995). A similar pattern of mortality was experienced in other industrialised countries. The mortality rate fell slightly in 1935 and thereafter it fell dramatically with the introduction of antibiotics to
treat puerperal infection. Improvements also occurred from the 1940’s in the treatment of
toaemia, haemorrhage and other causes of maternal death. Improvements in general
health and living standards also contributed to falling rates.

A report to the Government by the commission for the Relief of the Sick and Destitute
Poor in 1927 recommended that every county hospital have a maternity department of at
least two wards and district hospitals to have proportionate facilities (Robins, 1995). This
measure facilitated the slow but definite move from domiciliary to hospital confinement
throughout the 1930’s. The medical profession encouraged this trend by claiming that
better supervision and ante-natal care would reduce mortality rates. However, as
illustrated above, it was advances in pharmacology which precipitated the reduction
(Tew, 1995). In the latter part of the decade the Royal Academy of Medicine in Ireland
recommended that fifty percent of all Dublin births be in hospital. This goal was almost
achieved due to wartime shortages which encouraged women to seek the better
conditions that hospitals could offer (Robins, 1995). The decade between the 1950’s and
1960’s saw a massive shift from hospital to home birth. The Fitzgerald report in 1968
recommended centralisation of hospitals (Robins, 1995). As a result many women in rural
areas no longer had immediate access to maternity care. Many would argue that this
continues to occur with many women having to travel long distances, sometimes up to
one hundred miles or more. This practice results in many unplanned and unattended out
of hospital births that pose significant dangers to mother and child (Department of health,
1994 b). Similarly, in the UK, the Peel Report (Report of the Sub-Committee of the
Standing Maternity and Midwifery Advisory Committee, 1970) set out official
commitment to 100% hospital confinement, based on the premise that hospital delivery
was safer. However, in contrast to Ireland, the UK’s most recent reports had stated that
home births are as safe as hospital births (House of Commons, 1992; Department of Health, 1993).

Changing childbirth trends have also influenced the development of maternity services in Ireland. The birth rate has fallen, from 21.8 births per 1000 population in 1980 to 13.9 births in 1993. The total number of births in the same period has fallen from 74,064 to below 50,000. Fertility patterns are also changing rapidly (Department of Health, 1995a). In 1993 the total period fertility rate fell to 1.93 which is below the population replacement level for the first time. This figure is predicted to decline further. The number of births outside marriage continues to increase and the average age of first time mothers in Ireland is 28.2 years, which is older in other EC countries. The maternity services has traditionally used the indicators maternal mortality and infant mortality to audit quality of care. According to the Central Statistics Office (1993) maternal mortality has fallen from 31 to 2 per 100,000 live and stillbirths between 1970 and 1992 and infant mortality has fallen from 19.5 to 5.9 per 1,000 live births in the same period. The Department of Health (1995a) attributes these figures to the high standard of maternity services in Ireland.

1.2 Medicalisation of Childbirth

Historically and culturally the management of reproduction has been a female concern. Lovell (1996) states however, that modern childbirth practices have been structured primarily for the convenience of the health professionals, particularly doctors. Health care in general and childbirth in particular, in industrialised countries, have become the domain of male professionals. Over the past one hundred and fifty years or so, doctors in Western society “have successfully ‘medicalised’ a number of human phenomena ranging from
madness to childbirth" (Ungerson, 1985, in Daly, 1989, p.83). The specialism of obstetrics is a relatively modern one which emerged from male midwifery. It gained professional status in the 1920's when obstetricians campaigned for their independence and founded the British College of Obstetricians and Gynaecologists in 1929. Tew (1995) states that they built on their status, thus becoming very influential, ensuring their domination of maternity care.

The concept of the ‘Active Management of Labour’ revolutionised obstetric practice in Ireland, the United Kingdom and elsewhere, and remains a standard in Irish Maternity hospitals. Active management of labour was pioneered at the National Maternity Hospital, Holles St., by Obstetrician and Master, Kieran O’Driscoll and his colleague Declan Meagher (O’Driscoll and Meagher, 1980). The purpose was to shorten the ordeal of labour at a time when there was a dictum that ‘the sun should not set twice on a labouring woman’. It is interesting to note that while O’Driscoll and Meagher (1980) have no doubts about the principles of the active management of labour remaining true in all circumstances, they caution that their practice should only be considered in the context of a suitable hospital environment and never in the home.

The principles of the Active Management of Labour places a time limit of twelve hours on the duration of labour. This is achieved by accelerating delayed progress by administering oxytocin, or by caesarean section, if this does not succeed. Emphasis is placed on the correct diagnosis of labour, and amniotomy is performed to check for meconium (O’Driscoll and Meagher, 1980). According to Inch (1984) such a policy precipitates the ‘cascade of intervention’ and ‘diffuses professional responsibility’. The active management of labour has generated much debate (Bloomfield, 1997; Olah and
Gee, 1997). According to Olah and Gee (1996) evidence from the last twenty five years indicate that the concept of active management is simplistic and ‘failure to progress’ still plagues labour. They cite meta-analysis of the available randomised controlled trials which indicates that “oxytocin augmentation does not improve caesarean section rates, operative vaginal delivery rates or neonatal outcome” (p. 729). In addition, Olah and Gee (1996) question the implication that it is normal to require oxytocin in labour, as suggested by the fact that it was administered to 55% of nulliparous women in O’Driscoll’s original study. Furthermore, hyperstimulation of the uterus and the pain experienced by the mother was increased. Bloomfield (1997) criticised the meta-analysis as being used selectively to exclude or dilute data that might show the effectiveness of oxytocin. Bloomfield (1997) does admit however that the clinicians who developed the active management of labour paid little attention to physiology and pharmacology of which there is much to learn. Olah and Gee (1996) conclude that the heavy investment in active management has stifled research into the cause of prolonged labour and a greater understanding of the physiology of labour.

Many authors (Daly, 1989; Kitzinger, 1987, 1989; Oakley, 1984; Tew, 1995) have criticised the medical profession for creating a climate of fear around childbirth. Furthermore, it has been suggested by Kitzenger (1989) that the medicalisation of pregnancy and childbirth with its attendant technology has eroded the midwives role and depersonalised the service for women. These developments have also led to the growth in interest in what is termed ‘natural childbirth’, considered to be the opposite to the active management of labour, as it is non-interventionist in approach. For example, artificial rupture of membranes, which is a feature of all hospital labours is associated with a greater need for pharmacological pain relief. Kitzenger (1989) believes that home births is
as much a revolt against the obstetrical status quo as anything else. In Ireland alternatives are minimal; women either deliver in a high technology hospital or at home. The study conducted by O'Connor (1995) highlighted the interest women would have in low technology/low risk midwifery or GP units. Dilliner (1991) suggests that the public have a high expectation of care in pregnancy and therefore bad outcomes have result in increased litigation. Consequently, it is often the fear of litigation that encourages medical intervention. Garcia, Kilpatrick and Richard (1990) suggest that changes in polices for maternity services have led to a loss of opportunity for midwives, by curtailing freedom to exercise clinical judgement. Ni Maolruanaigh (1996) believes that nurses should grasp opportunities for research and apply the research to a rapidly changing health and social environment. According to the Department of Health (1995a) midwives in particular have a responsibility to women's changing childbirth aspirations and to facilitate an appropriate response to that change. British midwifery, according to Mason (1996) is firmly established within the biomedical paradigm of clinical practice. In addition, the WHO (1985) suggests that reliance on technology may have an adverse effect on midwifery skills. In their submissions to the Commission on Nursing (1997) midwives themselves have acknowledged the need to reclaim midwifery. The authors believe that valuing these skills is a valid and necessary objective for the profession.

1.3 Midwifery and Public Health Nursing

According to Gilligan (1991) the current public health nursing service evolved from provisions made for maternity and child care which commenced in the middle of the last, and the start of the present century. The Poor Relief Acts of 1861 enabled local authorities to appoint midwives to assist district medical officers. The Midwives Act of 1918 provided for the registration of all practising midwives, and only those who had
received formal education were eligible to be appointed to the dispensary system. Appendix 2 outlines the major landmarks in the evolution of the public health nursing service which shows that legislative change and the work of voluntary and religious organisations featured strongly in the development of the service. By the 1950's domiciliary midwifery practice had declined significantly and there was a recognition of the need to rationalise community nursing. At this time 400 midwives were attending 20 cases each per year of domiciliary births. The Health Act of 1953 paved the way for the initiation of the present Public Health Nursing service in 1956 following amalgamation of three separate services; voluntary district nursing services, dispensary midwives and nurses employed by the local health authorities (Department of Health, 1975).

The current public health nursing service is based on Circular 27/66 (Department of Health, 1966). The aim of this policy was to provide a public health nursing service to individuals and families throughout the country. It states that the PHN should provide such domiciliary midwifery services as required, general domiciliary nursing especially for the elderly, care of patients with mental illness and mental handicap and public health care of children from "infancy to the end of the school going period" (p.3). The Department of Health (1975) recommended that nurses being appointed as PHN's, should be also registered in the Midwifery Division. They acknowledged that the PHN has a great deal to offer but that the full potential in relation to midwifery services was not utilised. Difficulties also arise in relation to the provision of other services delivered by the PHN. It is widely acknowledged that the workloads of the PHN and the organisation of the service places unreasonable demands on the service and require review (Burke, 1986; Department of Health, 1975; O'Sullivan, 1995; Working Party Review on Public Health Nursing, 1997).
Burke (1986) recommended that maternity care should begin with and return to the community, commencing with preconceptual care. The service provision of domiciliary births is currently not being provided even though it is included in the job descriptions of all PHN’s (Department of Health, 1966). Consequently, An Bord Altranais (1994b) recommended that midwifery registration should no longer be a prerequisite for entry to public health nursing and suggested it’s replacement with a maternal and childcare module. This view was echoed by Working Party Review of Public Health Nursing (1997) and raised for discussion in the Commission on Nursing (1997). However, postnatal care and limited antenatal care still feature in the workload of the PHN and the authors believe that midwifery education is necessary for the provision and further development of this aspect of the service. The authors also believe that removing the midwifery prerequisite would be a retrograde step. One of the primary benefits of midwifery is its focus on health rather than illness. Educational preparation of PHN’s also centres on a psycho-social model of care with the focus on families and communities rather than just individuals. Mason (1996) states that midwives moving into community-based practice are often faced with complex social, political and economic issues which require a knowledge beyond the limitations of medical science. He suggests that those dissatisfied with the medical domination of reproduction “can develop a professionally independent, specialised culture by adopting a public health stance” (p.658).

Public health nursing is developing its services towards preventative rather than curative care. This preventative focus is echoed in the definition of a midwife adopted by the International Confederation of Midwives and used by An Bord Altranais (1994a):

“A midwife as a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully
completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post partum period, to conduct deliveries on her own responsibility and to care for the newborn and infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service” (1.1).

Kroll (1995) suggested that if maternity services become more women centred, the providers of care need to be aware of local population profiles and accurately assess the characteristics of the child bearing population. Services should be based on an understanding of the knowledge of local health, social and cultural needs. Providers of services should monitor and evaluate their services e.g. consumer satisfaction, perinatal reviews, standard setting, and audits. The Mid-Western Health Board (MWHB, 1992) identified the PHN as being in the ideal position to deliver holistic care, assuming that adequate resources are made available to supplement the services. As the PHN is geographically based the authors believe that with adequate resources and preparation she suitably placed to meet women's maternity needs.

1.4 Current National Childbirth Policy

In the past, Irish national childbirth policy focused on the medical model of care, which saw pregnancy and labour as being potentially hazardous. According to the Department of Health (1995a) “women, because of their reproductive role, are exposed to special risks during pregnancy and childbirth” (p.1). Official legislation regarding the care of mothers and their babies was introduced in 1954, in the Maternity and Infant Care
Scheme. It is currently operated under sections 62 and 63 of the Health Act 1970 (Department of Health, 1970) and provides for free GP care for all pregnant women and new-borns up to six weeks post delivery (see Appendix 1). The *Report of the Second Commission on the Status of Women* (1993) highlights the fact that many women are unaware of this scheme, which, if fully utilised would reduce the inconvenience of travelling and long hours of waiting in maternity units.

The Department of Health (1995a) acknowledges the many criticisms levelled at the maternity services. In particular, they cite the concerns expressed about the lack of respect for the childbirth experience as evidenced by lack of continuity in medical and midwifery care for public patients, lack of appointment system in ante-natal clinics, the lack of choice for women in relation to accommodation, pain control, birthing positions, unnecessary procedures and choice of companion in labour. They also began to question the frequency with which women with normal pregnancies were attending hospitals. (Department of Health, 1995a) A key component of the proposed changes was to strengthen the role of the family doctor, as mentioned previously, in the care of pregnant and post-partum women. This would improve continuity of care in all areas and allow more time for those requiring specialist care. The *Report of the Second Commission on the Status of Women* (1993) recommended that a task force be set up to monitor implementation of the Department of Health's recommendations on maternity services.

The Department of Health (1994 b) recommends that a mother may receive ante-natal care by her local PHN if she so wishes. However, from the amount of time spent on ante-natal care by PHN's according to Burke's (1986) study this does not seem to be a priority. However, it is not known how accurately this finding correlates with current practice, which may vary from area to area.
National Childbirth policy sets down guidelines mainly for hospital based maternity services. However, Section 62 of the Health Act 1970 also includes the provision of a domiciliary midwifery service (see Appendix 1). There are currently only two types of domiciliary midwifery services available to women in Ireland. It can be argued that because of location and/or cost, this is not an equitable or accessible service for many. There are fourteen independently practising midwives in Ireland, who are located mainly in Dublin and Cork. They operate a private practice, and charge fees of approximately £300 to £800. The second type of domiciliary service is available only to clients in the catchment area of Sligo General Hospital, in the North Western Health Board (NWHB). This service was established five years ago by a local general practitioner and a midwife from the labour ward (Fagan, 1998). It is now provided by three labour ward midwives only, who work an on-call rota, as well as being part of the labour ward staff.

A more equitable, accessible, patient centred approach will be required, if Ireland’s maternity services are to be developed in accordance with current legislation. The current Maternity service provision under the General Medical Scheme (GMS) includes ante-natal care, intra-natal care and post-natal care if the woman so wishes or if the medical practitioner "considers necessary" (Department of Health, 1995a, p10, Appendix 1). There have been calls by the Irish Medical Organisation on the Minister for Health to clarify women's rights on home births (Hegarty, 1994). The authors concur with this view and believe that whoever provides a woman's ante-natal care should ideally be responsible for her delivery.
Summary

The maternity services developed primarily to deal with high mortality rates, they were institution based and firmly grounded in the disease model. Public health nursing in Ireland has its roots in domiciliary midwifery. Currently, PHN's have a generalist role that encompasses preventive and curative responsibilities for all age groups in their areas. Ideally, a community midwifery service should be available that would provide a service for women opting for home delivery who were safe to do so. Such a service could be provided by a suitable Public Health Nurse, who is educated and experienced in community based practice.
Section 2. Home Births

For many women, choosing to have a home birth is a complicated process and involves going against the norm (Ogden, Shaw and Zander, 1997 a,b,c; Robinson, 1995). Kerssens (1994) suggests that women who opt for domiciliary confinement feel more in control in their own intimate home environment, than in a hospital setting. In this section the authors intend to examine the current trends in relation to home versus hospital births, the surrounding safety issues, continuity of care and the perspectives of women, the consumers of the service.

2.1 Place of Birth

The table illustrated below indicates that approximately 200 babies per year are presently born outside of hospital in Ireland. However, these figures do not communicate the number of planned or unplanned home births. This factor is very significant as outcomes differ greatly between planned and unplanned home births which will be discussed in section 2.2.

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital (%)</th>
<th>Home (%)</th>
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<tr>
<td>1956</td>
<td>69.3%</td>
<td>30.7%</td>
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<tr>
<td>1966</td>
<td>91.5%</td>
<td>8.5%</td>
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<tr>
<td>1976</td>
<td>99.5%</td>
<td>0.5%</td>
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<tr>
<td>1990</td>
<td>99.67%</td>
<td>0.33%</td>
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<td>1993</td>
<td>99.6%</td>
<td>0.4%</td>
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<td>1996</td>
<td>99.6% (50,390)</td>
<td>0.4% (206 births)</td>
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In the USA in 1940, 44% of all births were outside hospital, declining to 1% in 1970. In the UK the rate dropped from 50% in the 1940’s to less than 10% in 1970. The Netherlands has shown the slowest decline where planned home births represented 70% in 1963, 32% in 1982 and 35% in 1990 (Wagner, 1994). In contrast, all births in Finland take place in hospital, and Weale and Wildman (1995) state that there is no indication that the situation is likely to change. Furthermore, they suggest that a move toward domiciliary births would be a retrograde step in maternity care. The Department of Health (1995a) believe that the health of the new born child is at greater risk in the home than in a well staffed and equipped maternity unit, therefore home births should be discouraged by the health services. The House of Commons (1992) challenged the view that all deliveries should take place in a hospital setting, because of safety issues alone. This study the Winterton Report proposed that the Medical Model of care alone was no longer valid (House of Commons, 1992). In 1993, another expert group published the Cumberledge Report (Department of Health, 1993). It concluded that the evidence for the relative safety of home compared to hospital delivery does not justify a general recommendation for hospital delivery (Dowswell, Thornton, Hewison and Lilford, 1996). The Royal College of Obstetricians and Gynaecologists (R.C.O.G., 1994) were more cautious by stating that while home birth was an acceptable option and that appropriate information should be provided, it was nevertheless impossible to reproduce in the home the same standard of equipment and response that is available in the hospital.

2.2 Safety Issues

It has been suggested by Van Teijlinjen and Bryar (1996) that childbirth has two current models of care. The first approach is based on the belief that medical control is required in normal childbirth in order to guarantee safety. Every pregnancy is considered
potentially dangerous therefore early intervention is facilitated by close monitoring. This model, the medical model believes a pregnancy is only safe in retrospect, and risk selection is not possible. The second approach, or model of care, has been described by Wendy Savage, an English obstetrician. Savage (1986) describes pregnancy as a physiological event, rather than an illness, that is normal, unless there are indications that something is wrong. This second model also encompasses a more psychosocial or holistic approach, it looks at the mother, her family, her environment and beliefs. (Savage, 1986) This holistic approach respects the interaction of mind, body and environment. Regardless of the benefits inherent in the latter model, the medical model which questions the safety of home confinements, continues to dominate childbirth.

A very large randomised control trial is still required to make any definite statements about the safety of home births. Such a study would require hundreds of thousands of participants (Lilford, 1987). It would involve assigning women to either have a home or hospital delivery, which would remove the very important element of choice and control, which could affect the outcome of the pregnancy. It could also be deemed unethical (Campbell and Macfarlane, 1987). Observational studies have therefore been carried out to determine if home births are “less safe” compared with hospital births, by examining perinatal mortality data (PNMR). This is the most commonly used indicator of pregnancy outcome as maternal deaths are rare in today's developed countries. Furthermore, Young (1993) states that there is no data to show that maternal mortality is affected by place of birth. Perinatal mortality rate is the number of all stillbirths and all deaths in the first week of life per 1000 registered total births (Sweet, 1997).
The Northern Region’s Perinatal Mortality Survey Co-ordinating group (1996) examined “Perinatal Loss in Planned and Unplanned Homebirths” in 500,000 births from 1981-1994 in the north of England. Confounding variables of obstetric outcome were removed, which included; prematurity, low birth weight, antepartum death and congenital abnormality. This allows for increased generalisation of the study. There were fourteen perinatal deaths in the 2,888 women who had booked for home birth. Eleven of the deaths occurred after transfer into hospital. Only one of the deaths was found to be associated with inappropriate management in the home. The PNMR for planned home births was low (4.8 / 1,000), when compared with the rate for all births in the region (9.7 / 1,000). While this result only approached statistical significance it was important in that it illustrated that home births were at least as safe as hospital deliveries, in a low risk pregnancy (Northern Region’s Perinatal Mortality Survey Co-ordinating group, 1996). It is acknowledged that the hospital births included high risk pregnancies. It is interesting to note that the PNMR for unplanned home births was very high (four times higher than the average for all births in the region at that time).

Opponents of the above findings compare it’s results with those of the Confidential Inquiry into Stillbirths in Infancy, cited in British Medical Journal (BMJ, 1996) which occurred from January to December 1993. National data included all deaths at 0-6 days, while the Northern Region’s study included all deaths from 0-27 days, this difference has also been highlighted by Dr. Edmund Hey, consultant paediatrician, one of the authors of the Northern Region Study (Hey, 1997). The relative risk of intrapartum death of a term infant, at that time, in the Northern Region, in hospital, was greater than the national average (Persad, 1997). However, as Hey (1997) also highlights, his study was carried out over a fourteen year period, while the time span reported on by the BMJ (1996) was
only one year. It can further be argued that the Northern Region’s Study was carried out during a time when the overall perinatal mortality rate was itself dropping, particularly in the latter years of the study. Consequently, Hey (1997) concluded that ‘like’ was not being compared with ‘like’. In addition, the actual time of death, whether before or during labour, was not detailed in the Confidential Inquiry, for example with cases of abruptio placenta. The Confidential Inquiry also examined data on those booked and delivered at home, while the Northern Region Study examined those booked for home birth wherever they delivered. As Hey (1997) has suggested, the above criteria serve to invalidate comparisons that are drawn between both sets of data. Tew (1995) suggested that while the confidential enquiries may be useful as a means of examining inefficiencies in the service they do not give impartial answers about evaluating the effectiveness of treatments or directing policy towards providing the best options for clients.

The findings of the Northern Region Study were mirrored in the Cardiff births survey where 25,449 deliveries were analysed for the years 1991-1995. Similar exclusion criteria were used by Thomas and Bethel (1997) i.e. babies born weighing less than 2500 grammes and those born with congenital abnormalities were not included in the study. No perinatal or neonatal deaths occurred in the planned home delivery group, who delivered at home. One stillbirth occurred in the forty three transfers to hospital. Overall, the data presented in this study upheld the opinion that planned home delivery can be just as safe as hospital care (Thomas and Bethel, 1997). Six women who made no arrangements for any care during pregnancy delivered at home and accounted for 2% of all home birth deliveries. Two stillbirths occurred in this unbooked group, which again highlighted the serious problems which arise when women choose not to receive professional help. This was also illustrated in an Irish Study on babies Born Before Arrival (BBA) to the
Coombe Women’s Hospital, Dublin, in 1996 (Spillane, Khalil and Turner, 1996). In O’Connor’s (1995) study unattended births were associated with more complications requiring medical assistance (O’Connor, 1995). Campbell, McDonald and McFarlane’s (1984) survey found that of 1849 BBA’s, 5% were considered to be ‘accidental on purpose’ and their research showed that homebirth is often a response to a bad hospital birth.

The Netherlands has one of the highest rates of planned home deliveries in the industrialised world (31% of all births in 1991). A prospective study carried out from 1990-1993 studied the relationship between perinatal outcome and intended place of birth using specific controls for background variables (Wiegers, Keirse, van der Zee, and Berghs, 1996). While it can be acknowledged that the number of women studied was small (n= 1836), both primiparous (t=1.99, P<0.05) and multiparous women (t=5.56, P<0.001) with a planned home birth, scored better in relation to perinatal outcome than those with planned hospital deliveries. Studies in Australia, Canada and the United States state that in some areas midwife managed home birth can be as safe as a hospital birth when perinatal mortality rates are compared. (Anderson and Murphy, 1995; Durand, 1992; Tyson, 1991; Woodcock, Read, Bower, Stanley, Moore, 1994). There are no studies examining the safety of home births in Ireland (Hegarty, 1994).

Allison (1992) studied data on 35,000 home births. She identified that the rate of stillbirth and neonatal death were consistently less at home than in hospital despite the fact that 50% of women who gave birth at home would be considered “unsuitable” for home birth under current criteria. (Allison, 1992). Campbell and MacFarlane (1987) suggest that policies about place of delivery have tended to be formulated without either examining
existing evidence or performing new research. Many analyses do not take into account selection bias or differences in the incidence of malformations or different birth weights among babies born in different settings. They state that there is no evidence to claim that the move to hospital confinement is the reason behind the declining perinatal mortality rate in England and Wales, nor is it the safest policy for all women to be delivered in hospital (Campbell and MacFarlane, 1987).

Morbidity refers to the susceptibility of a population to a certain disease. Although it is known that women suffer from childbirth-related problems, there have been very few studies examining long-term morbidity related to childbirth (McArthur and Bick, 1997). Caesarean section is associated with greater morbidity which is a significant factor when one considers that the Caesarean section rate in at least one Irish Hospital was 20% (O'Connor, 1995). It is significant therefore that even for low-risk women having an epidural increases by four the likelihood of caesarean section. Drugs are used in labour much more commonly in hospital births and according to MacArthur, Lewis and Knox (1991) will indubitably have side effects. Wagner (1994) states that there is no question but that drugs affect the unborn baby. Consequently, although perinatal morbidity from home deliveries has not been examined to a large extent, Young, (1992, 1993) has therefore suggested that home birth appears even less likely to contribute to neonatal morbidity than previously thought. A prospective cohort matched pair study in Switzerland (Ackermann-Liebrich, Vogeli, Gunter-Witt, Kunz, Zullig, Schindler, Maurer, 1996), matched 214 women opting for home birth and 214 women opting for hospital birth. Strict comparisons within each pair included the following factors: age, parity, gynaecological and obstetric history, social class and partner status. The caesarean section rate for those starting labour in hospital was double that for those starting labour.
at home (12% v 6%). The intact perineum rate was much better at home (36% v 9%).

Average Apgar Scores at five minutes were all better in the home births group (Ackermann-Liebrich et al., 1996) Cord pH's were slightly lower in this study, which may be attributed to delay in getting the cord blood to a machine on time, or because of late clamping of the cord, which according to Young (1993) is more common in home deliveries. For this particular study the lower rate of interventions in home births meant a significantly lower risk of ensuing complications for the mother.

Limitations have been acknowledged in relation to all the above studies especially in relation to randomisation and selection bias. Women opting for domiciliary deliveries in many western industrialised countries, are a self selected, low risk group, with a good educational background, good health and living in urban areas (O'Connor, 1995; Young, 1996). This creates difficulties when trying to make comparisons between women booking for home birth and those booking for hospital delivery. The Black Report (Townsend and Davidson, 1982) in England highlighted that the highest fetal and perinatal mortalities were associated with the lower socio-economic groups. With the exception of the Northern Regions Perinatal Study (1996) in 1981-1994, inadequate sample sizes were used. Difficulties include the low frequency of disastrous events, the lack of universal definitions, standards, policies and settings for home and hospital births and the varying degrees of experience of the attendants at deliveries (MacFarlane, 1996)

This has been also highlighted in the analysis of American studies (Raisler, 1996). Morbidity which was discussed above, also refers to the extent to which patients are satisfied with the care received during and after pregnancy, and as such is difficult to quantify. Nevertheless, it is an important factor to be taken into account when examining
the safety of home births and it will be discussed in greater detail in the following sections which examine continuity, choice and control.

2.3 Continuity of Care

Titheridge (1994) states that “although home birth may not be the right choice for many, individualised care is” (p.45). Hobbs (1993) suggested that for some women, continuity of carer is often more important than place of birth. Both the Cumberledge Report (Department of Health, 1993) and the Winterton Report (House of Commons, 1992) identify continuity, choice and control as important aspects of maternity care in the UK and have made recommendations for improvements. It is also widely acknowledged that both providers and consumers want these aspects of care (McLean, 1980; O’Connor, 1995; Prendergast, 1997; SHB, 1995). Tew (1995) stated that hospital care is generally fragmented with professionals working in specific areas and responsibility ending with shifts. This lack of continuity causes well-recognised distress for women resulting in many calls for the re-organisation of perinatal care (Flint, Poulengeris and Grant, 1989). It has also been suggested that poor continuity has an adverse effect on midwives leading to stress and poor job satisfaction (Flint et al, 1989; Hundley, Milne, Glazener and Mollison, 1997).

According to O’Connor (1995), women have traditionally “drawn on a network of family and sisterhood help in the community before, during and after childbirth” (p. vii). Continuity of carer, therefore refers to persons outside this network and is defined as personal care given by one individual (or the same couple, if the midwife works with a partner), throughout her pregnancy, labour and puerperium (Flint, 1989; Oakley, 1984). Inch (1984) sees continuity of care as a process which allows women “to develop a
trusting relationship with the people who will help her during labour” (p.194). Prendergast (1997) in a small scale (n=10) qualitative study hypothesised that continuity of care is beneficial for both mother and baby to experience. Prendergast’s (1997) concept of ‘beneficial’ refers to a safe birth, a physiologically positive outcome and a psychologically rewarding experience for all involved. However, she concludes that these benefits are probably immeasurable. Prendergast (1997) found that continuity of care, as defined above, was not found in Cork maternity hospitals, and described “a stream of unfamiliar faces” or “assembly-line type care” from her own personal experience (p.48). In addition, differences existed in the care received by private and public patients. Flint (1989) suggests that care given by a single carer is safer because the carer has a more intimate knowledge of the woman’s history, and therefore more likely to identify changes more easily.

O’Connor (1995) described a study carried out by her over the previous five years. This study was unique because it was the first of its kind, to qualitatively examine birth experiences of women who had homebirths. Out of the 969, listed ‘out of hospital’ births from 1990 to 1995 a random sample (n=138) was selected. These included planned and unplanned homebirths, but did not include women with planned homebirths who ended up in hospital. O’Connor (1995) stated that the majority of women felt vulnerable in labour and not able to assert themselves. In addition, many women felt that if they were in control they could cope with anything. In the home situation where the midwife is a guest in the house this feeling of control was heightened (O’Connor, 1995). O’Connor (1995) concluded that if women wanted to enjoy the experience of giving birth ‘in their full senses’, drug free, and out of the ‘public gaze’ then the obvious place to have the baby would be at home.
There have been many schemes developed in an effort to improve continuity of care. Flint et al (1989) described the ‘Know Your Midwife’ (KYM) scheme which was set up in 1983 in St. George’s Hospital, London. The aim was that a team of four midwives, with the back up of hospital obstetricians, would give continuity of care during pregnancy, labour and the puerperium to 250 women each year. The scheme was introduced as a randomised controlled trial and subsequently evaluated in relation to feasibility, acceptability and outcome of perinatal care. It was acknowledged in relation to the latter, that a trial of the size envisaged would only provide imprecise estimates. The study sample were randomly allocated to either the KYM scheme (n=503) or standard care scheme (n=498). Findings revealed that the KYM scheme appeared to be more acceptable in nearly every aspect investigated. It was characterised by greater continuity of care, and less obstetric intervention. Statistically significant differences were noted in the augmentation rate, need for intramuscular and epidural analgesia, and episiotomy rate. Labours tended to be longer in the KYM group but neonatal outcomes were generally similar. In relation to feasibility, Flint et al (1989) found that the scheme demanded additional responsibility from the midwives, both those implementing the scheme and those administering it, and that this change in practice was sometimes stressful, particularly at first. The provision of continuity of care over a 24-hour period also meant that occasionally a midwife worked for long hours without formal back-up, particularly at night or at weekends. However, the KYM midwives were very supportive of each other, sometimes to the exclusion of other personnel. Despite the positive outcomes in Flint et al’s (1989) study, Lovell (1996) states that it is important to remember that not all women want the same things. Therefore, caution needs to be exercised before forcing
women to make choices or decisions who might otherwise prefer to let the professionals take charge.

In contrast to the above, the ‘One-to-one midwifery’ project in west London in 1993 involved each midwife managing her own caseload. According to McCourt (1996) ‘One-to-One midwifery’ woman centred care was achieved by focusing on continuity of carer. McCourt (1996) described a comparative study evaluating women’s response to the scheme. Women preferred having a named midwife and the benefits included more flexible and convenient community based care. In addition they felt more supported and confident facing labour.

Hundley et al. (1997) conducted a pragmatic randomised controlled trial of low risk women (n=2844) in Aberdeen to explore whether differences existed in women’s satisfaction with care in a consultant led labour ward compared with a midwife managed delivery unit. Factors relating to continuity, choice and control were also compared between the two groups. Results revealed that there was no difference in overall satisfaction. However, satisfaction with management of labour and delivery was slightly higher in the midwives group although it was not statistically significant. Satisfaction in this instance related to continuity, choice and control. Hundley et al (1997) suggested that measurement of satisfaction requires further investigation as current measures are not sensitive enough to examine the factors which indicate a positive childbirth experience. Nevertheless, they stated that the morbidity results confirmed that women allocated to standard consultant led care had a higher rate of intervention than low risk women in a midwife-managed care. They concluded that “care in midwife managed delivery unit is as safe as care in a consultant-led labour ward” (Hundley et al, 1997, p.1273).
Graham (1997) states much confusion now exists over the different types of maternity services provided, when the fact remains that regardless of the name of the facility virtually all deliveries are undertaken by midwives. Use of the terms ‘led’ or ‘managed’ tend to be highly loaded and militate against healthy debate. Furthermore, the House of Commons (1992) emphasised that monopolies should not exist in relation to provision of services and that women should be able to consult obstetricians, general practitioners and midwives. The Department of Health (1995a) concluded that if maternity units facilitated women by providing domestic style surroundings, greater choice, minimum intervention and early discharge there would be less demand for home birth.

2.4 Consumer Perspective

Women want accessible, quality health services which provide them with control, continuity and choice (SHB, 1996). Ideally these services should be community based, be women friendly, research based and adopt a holistic approach. Specifically in relation to maternity services women want decentralisation of maternity units, a choice of home births, midwifery-led services making greater use of midwifery skills, post-natal visits to the home by community midwives for ten days, more visitation by the PHN (SHB, 1996). O’Connor (1995) found that only a third of women in her study were visited by the PHN within ten days. The importance of postnatal care by the PHN was also highlighted by Robinson and Thompson (1991). In relation to antenatal care, Coleman (1987) suggested that the PHN could work in co-ordination with hospital staff, to establish a relationship with the mother at an early stage, in order to adequately inform the woman of services available, and provide continuity of care. Home births may become a significant option, either the development of the independent midwives or a community midwifery system.
with good interdisciplinary liaison between the PHN and midwives. As women demand more choices health care will have to respond to provide such choices and care.

According to Lovell (1996) mothers are faced with a myriad of choices and decisions during pregnancy and childbirth, including where to have the baby, what kind of pain relief to use and who is to be with her during labour. However, not all women are ‘allowed’ to make these decisions. The Department of Health (1993) in Changing Childbirth stated that a woman’s choice about the place of birth should be respected, and every practical effort made to help her achieve the outcomes which fulfil her expectations. Lovell (1996) points out that genuine sharing of information is required so that mothers can make informed decisions about her pregnancy and childbirth. Ogden et al (1997b) found that the decision to have a homebirth is a complex process and involves ‘going against the norm’. The factors which women found facilitated the homebirth choice “included the benefits of being in their own home, the perceived negative aspects of being in hospital, and the relative safety of their home environment” (p.215). Obstacles which hindered homebirth included unsupportive partners, midwives, G.P’s and unenthusiastic family and friends. Although hospitals were considered necessary for emergencies they were associated with illness and disease. Many women face strident opposition when they opt for a home confinement (Titheridge, 1994). O’Connor (1995) conducted a study in 1992 which found overwhelming support for home birth particularly from women who had experienced hospital births before.

Ogden et al (1997a) conducted a qualitative study examining the perceptions of women (n=25) who had home births 3 - 5 years previously. The findings revealed rich, evocative and positive accounts of the home birth experience. Positive attitudes to pain as a
functional concept, and feelings of being in control were frequently recurring themes. Although there were no negative attitudes to homebirth, the authors acknowledge the possibility of a selection bias. The experiences also had a long term impact on personal development, self-concept, coping skills and relationships. (Ogden et al, 1997c). One of the most important benefits associated with homebirth is breastfeeding. O’Connor (1995) found breastfeeding rates of 75% at 6 months, compared with national average of 5%. Evidence from the literature would indicate that this is not an uncommon finding among women who have homebirths. It has been suggested that childbirth in general changes how women feel about themselves. Ogden et al (1997c) suggests that the results of their study supports this and that homebirth may make the experience even more rewarding. It has been suggested in maternity folklore that pain and other negative experiences of childbirth are forgotten. However, Lovell (1996) concludes that evidence from the literature suggests that this is not the case and that negative experiences have ‘knock-on’ effects. O’Connor (1995) found in her study that of the eleven women in the sample who had postnatal depression following a previous birth, ten had experience of a traumatic hospital birth. This issue has important implications for care-givers. O’Connor (1995) stated that one of the disadvantages of homebirths was having no help in the house placing extra stresses on a tired mother who may be breastfeeding in addition to looking after young children.

The Dutch obstetric service is distinctive from the point of view that childbirth is perceived as a normal physiological event with home births encouraged. Consequently, there are a large number of home births and a low rate of medical intervention. 80% of those who deliver in hospital are discharged after 24 hours. Maternity home care assistants comprise a fundamental and unique component of maternity services in the
Netherlands (Kerssens, 1994). Their duties include assisting the domiciliary midwife, caring for the mother and baby in the post-natal period, and carrying out household duties, either full-time or part-time (depending on availability) up to eight days. Kerssens (1994) conducted a quantitative study examining the quality of care in relation to availability, continuity, interpersonal relationships, outcome and assistant’s expertise. Studies examining patient satisfaction and evaluating quality from the consumer perspective are acknowledged as recent departures. The study found that the maternity home care service was of good quality in relation to the above criteria but was not sufficiently accessible. Dutch Government policy states that a system of home deliveries is inconceivable without good quality maternity home care (Kerssens, 1994). However, efforts to control health expenditure have led to a rationalisation of the service. This erosion of maternity home care can according to Kerssens (1994), “eventually undermine the Dutch system of Home confinements, resulting in a less agreeable and more expensive post-natal maternity care” (p. 349).

Summary
The majority of births now take place in hospitals making homebirths the exception rather than the rule. Safety of domiciliary confinements remains a contentious issue. However evidence from the literature that it is as safe for most women to give birth at home as in hospital. Continuity of carer, choice and control have been identified by women as the priority areas for development in maternity services.
Section 3. Structure of Domiciliary Midwifery Services

Domiciliary midwifery services are not publicly provided by the Department of Health, with the exception of the North Western Health Board. Therefore, the policies which are suggested here are based on; (a) general guidelines from An Bord Altranais (1997, 1994a, 1988), which are acknowledged as being deficient (Department of Health, 1995) in relation to domiciliary midwifery, (b) discussions with a domiciliary midwife from Sligo, (c) discussions with practising independent midwives in Cork, (d) the available literature, which is mainly international in origin, and (e) issues and practicalities which have arisen as a result of both authors involvement in the development and provision of a service for one client in the South Eastern Health Board.

3.1 Professional Issues

The practice of midwifery in Ireland is governed by An Bord Altranais. Guidelines on specific issues are dealt with in the relevant publications (An Bord Altranais, 1997; 1994a; 1994b; 1988). Therefore, although domiciliary midwifery is not common in Ireland, An Bord Altranais (1994a) has issued a directive that the midwife is accountable for her practice in whatever practice environment she may find herself. However, An Bord Altranais (1988) cautions all nurses to acknowledge the limits of their competence, and in such cases refuse to accept delegated functions until she has received instruction and has been assessed as competent. This being the case, the South Eastern Health board in conjunction with the Southern Health Board, School of Midwifery prepared a programme of theoretical and practical midwifery instruction covering two and a half months, for both authors involved in this project. As neither of these two health boards provide a domiciliary midwifery service the educational programme involved a large input from two
experienced independent midwives in Cork. The objective of the educational programme was to update both authors on current evidence based midwifery practice. This complies with An Bord Altranais's (1994a) recommendation that the delivery of midwifery care be of a high standard and based within the context of current knowledge and clinical developments. The authors, cognisant of this fact have examined the literature in depth, and continue to do so in an effort to develop evidence based practice. They note in particular the forms of maternity care that should be abandoned in light of current evidence (see Appendix 3). The NWHB (1997) recommended that midwives operating the domiciliary midwifery scheme in their area should have a minimum of five years midwifery experience. The NWHB (1997) also recommended that its midwives conduct at least 12 deliveries per year. These criteria were set down by the hospital management and are not based on the literature reviewed by the authors. Campbell (1995) in the UK described the desirable attributes in the midwives recruited in the One-to-one midwifery project as having a minimum of nine months experience as an F grade, evidence of sound clinical practice, ability to participate in research, exposure to deliveries and possessing the right attitude, meaning that they should be ‘in tune’ with the women.

An Bord Altranais (1994a) stated that where maternity care is undertaken by a midwife she shall be responsible for the provision of care to the woman and fetus / baby during the antenatal, intrapartum and postnatal periods. The NWHB (1997) adopted this philosophy in their scheme and further stated that care should be provided in conjunction with the PHN. An Bord Altranais (1994a) stated that the midwives role in relation to perineal infiltration, episiotomy and perineal repair shall be conducted in accordance with local policy. Although midwives in Waterford Regional Hospital do not have a policy of conducting perineal repair, it was considered important in the interests of holism and
continuity for both authors to be proficient in this area. Therefore they both received practical instruction and theoretical updates in suturing techniques.

3.2 Organisational Issues

In this section the authors examine the relevant issues which arise in the daily operation of a domiciliary service. They both acknowledge their limited experience in this area and have therefore returned to the literature and other experienced sources to inform practice.

3.2.1 Supervision

In the UK, supervision of midwives is well-defined concept (Hobbs, 1993). A statutory framework provides for the appointment of midwifery supervisors by the Local Supervising Authority (LSA). These supervisors must be registered midwives who are eligible to practice. Their function is to safeguard standards of practice and to support and guide midwives (Tiran, 1997). Patton (1995) describes a distance education course for the preparation of midwife supervisors run by the English National Board. This course which is a requirement of the United Kingdom Central Council for Nurses, Midwives and Health Visitors, was established because despite the level of development in the UK supervision is not without its problems. Davis (1994) suggests that preparation and mentoring of supervisors is sometimes poor which can lead to an inability to distinguish between management and supervisory roles. According to Tiran (1997) supervisors of midwives who are also managers sometimes find it difficult "to balance the economic demands of service provision with the legal requirements of safe midwifery practice" (p.1019). There may also be a perception that supervision should be applied in a punitive and destructive way (Davis, 1994). This approach damages confidence and adversely affects personal and professional development. According to Davis (1994) supervision is
concerned with strengthening midwives, developing and enhancing practice through identifying continuing professional and educational needs, providing support and distinguishing midwifery as a profession. Patton (1995) described a six point plan for improving supervision which is shown in full in Appendix 4. This includes different aspects of selection, education, communication, managing conflicting roles, clinical caseloads and accountability.

An Bord Altranais (1994a) states that it shall be the duty of the Health board to exercise general supervision and control over midwives practising outside institutions. This includes independent midwives and those employed by a health board. The Superintendent Public Health Nurse is the person designated by the Health Board to exercise this supervision and control. Both Superintendent Public Health Nurses and midwives have voiced their concerns at this arrangement, as most PHN’s have not practised in midwifery for years (Commission on Nursing, 1997). The Department of Health (1995a) stated that it was examining the role of midwives in domiciliary midwifery in the context of a review of the Nurses Act, 1985 because it was felt that An Bord Altranais (1994a) Guidelines for Midwives was insufficient to monitor and deal with domiciliary midwifery.

3.2.2. Application for services

Application for domiciliary midwifery services are usually made to, or directed to the Superintendent Public Health Nurse in the relevant health board area. According to Fagan (1998) prospective clients in the NWHB scheme are first met in the ante-natal clinic, where their suitability is assessed. An application form for the service is sent to the local Superintendent Public Health Nurse and the Director of Community Care is informed of
the intended Home Birth. Ante-natal visits are made by each of the midwives at different intervals, who in turn liaise with the GP and obstetric team if necessary. This ensures that the client, her family, and the midwives get to know each other. Two midwives attend each delivery and are contactable by mobile phone. Ambulance control is informed when the woman goes into labour and an ambulance is kept on stand-by until after the delivery. The attending midwives stay for up to three hours after the delivery, providing there are no problems. A post-natal visit is made again within eight hours. Notification of the birth and Registration is carried out. An early first visit is made by the local PHN. This team of midwives delivered fifteen women in 1996 and fifteen in 1997. They are currently in the process of writing up standard statements and policy manuals. Problems highlighted by them informally were; the on-call rota, provision of cover for the labour ward when out on a delivery, occasional lack of medical and midwifery/colleague support (Fagan, 1998).

3.2.3 Booking criteria and antenatal care

For the South Eastern Health Board project the authors decided to utilise the documentation developed by the North Western Health Board for the application and consent for Home Confinement (see Appendix 5). Although Section 62 of the Health Act (1970) entitles all applicants access to a home confinement, it is widely believed that only women of low obstetric risk should be considered for a home confinement. This however remains a contentious issue, as it is suggested by many that this can only be stated in retrospect. James (1988) has defined an ‘at risk’ pregnancy as one in which the risk of an adverse outcome in either the mother and/or baby is greater than the incidence of that outcome in the general population. Flint et al (1989) described low obstetric risk as:

- no serious medical problems
- no previous uterine surgery
- over 5 feet tall (152cm)
- no Rhesus antibodies in the current pregnancy
no past obstetric history of more than two miscarriages or termination of pregnancy, or of stillbirth or neonatal death, or of a baby with intrauterine growth retardation, or preterm delivery.

According to Springer (1991) the most widely accepted and effective criteria are that which are decided upon by all those involved in the client’s care i.e. midwives, GP’s and obstetricians. In the Netherlands, the criteria used is the ‘Kloostermanlist’ which is used routinely in the community as a national reference for risk assessment or referral protocol (Ziekenfondsraad, 1987). Unfortunately, this was unavailable to the authors at the time of writing. Some authors cite primigravidae as unsuitable for home confinement. O’Driscoll and Meagher (1980) went as far as to suggest that “primigravidae and multigravidae behaved as different biological species” (p. 9). In the experience of the independent midwives, a large proportion of their clients are primigravidae. Although they have a higher transfer rate in labour for pain relief, obstetric outcomes are similar (Cronin, 1997; O’Toole, 1997). Floyd (1995) states that if low risk women are to be given information, about the options available to them and choose to deliver their babies at home. Midwives have to have the necessary support skills and knowledge to uphold their decision.

Cronin (1997) and O’Toole (1997) also state that early booking forms a central component of domiciliary midwifery as it allows a relationship based on mutual trust to be developed. This is necessary should problems arise requiring transfer to obstetric care. Sweet (1997) suggests the following protocol for the frequency of antenatal visits; every four weeks until the 28th week, every two weeks until the 36th week and every week until the onset of labour. She also highlights recent research indicating the positive effects of providing psychological and social support antenatally. The content of antenatal care should address all those issues related to maternal and fetal well-being. Specific preparation for home birth is provided which will involve detailed discussions of the
client’s experience of and expectations for the birth. O’Connor (1995) found that in general, women who opt for home birth tend to be healthy, they are especially concerned about what they eat, they are interested in alternative medicines and therapies such as yoga, homeopathy, shiatsu and massage, visualisation or self hypnosis, baths and thermal compresses as methods of pain relief rather than drug therapies. The value of many of these alternative therapies tend not to be appreciated by conventional medicine although this situation is changing. Indeed, some remedies such as Arnica and Raspberry leaf have been scientifically evaluated and are widely used. The authors have no qualifications in alternative therapies and therefore acknowledge that giving prescriptive advice in this area would be beyond the limits of their competence. Nonetheless, they would have no difficulty liaising with the relevant practitioners to add to their knowledge on the subject.

The management of pregnancy and birth in hospital is also discussed during antenatal care should referral or emergency transfer be necessary.

3.2.4 Transfer criteria

According to An Bord Altranais (1994a) the midwife shall procure appropriate medical assistance in accordance with health board and / or employing authority policy in the event of an emergency or where the she detects a deviation from normal in the health of the woman and / or fetus / baby. Anderson (1993) highlights that total midwifery care, which is outlined in Changing Childbirth depends on the midwives ability to recognise any potential or deviation from normal in order that she may transfer the woman to the care of that specialist. Hobbs (1993) discusses the issue of honorary contracts which relates to the arrangements which may be made with maternity units in the UK for the midwife to accompany and remain with the client should emergency transfer in labour be
required. The NWHB (1997) identified the following criteria as the usual reasons for transfer:

- Breech presentation
- Fetal distress
- Bleeding
- Meconium stained liquor
- Failure to progress
- Raised blood pressure
- Prolonged ruptured membranes
- Cord Prolapse
- Maternal exhaustion

The majority of the above lend themselves to easy definition. However, in the case of ‘prolonged rupture of membranes’ and ‘failure to progress’ which resist uniform definition, management needs to be discussed. O’Driscoll and Meagher (1980) defined the duration of labour as the number of hours spent by a woman in the delivery unit, from the time of admission until the time of delivery. They make no allowances for the time spent labouring at home. This indicates therefore that prolonged labour is defined as greater than 12 hours in the hospital setting only. The authors have used the above criteria in this project and fully realise that these issues need to be explored in depth in the future. This would require the involvement of all members of the maternity services in the area.

3.2.5 Documentation

An Bord Altranis (1994) states that the midwife shall ensure that all necessary records are maintained in accordance with health board policy. In relation to clinical records, the authors modified the maternity notes used by Waterford Regional Hospital and decided in the interests of continuity, (should transfer be necessary) that they should be held by the client for the duration to the pregnancy. Maternity hospital staff also like to have a chart
on file on women booked for home confinement in the area, should emergency transfer be required. This can save valuable time, obviously, as information is immediately available regarding blood group, date of delivery, etc. Notification and Registration of the Birth are addressed in accordance with the relevant legislation and policy.

In relation to medical preparations An Bord Altranais (1997) states that they shall only be administered in accordance with the direction of a medical practitioner’s written prescription. Appendix 6 shows an example of a letter used by the authors in seeking a prescription from the General Practitioner. An Bord Altranais (1997) also states that midwives practising in the community should comply with the other guidelines relating to supply, administration, documentation, and storage of drugs which may be used by midwives. The drugs obtained for this delivery, for emergency use only, were stored in a locked secure box, in the clients home, from 37 weeks onwards.

3.2.6 Emergency Support Services

Close co-operation with members of the other health professions, was emphasised by An Bord Altranais (1994 a) in order to promote community and national efforts to meet the health needs of the public. The NWHB (1997) also highlight the importance of maintaining open lines communication between domiciliary midwifery staff and hospital maternity staff. This was also echoed in interviews with independent midwives in Cork (Cronin, 1997; O’Toole, 1997). A good working relationship is needed with; general practitioners, ante-natal clinic staff, labour ward midwives and sisters, obstetricians, obstetric registrars and ambulance staff. It is essential that the domiciliary midwife be able to refer a client to the GP or a hospital doctor at registrar level, if the midwife deems this necessary, either antenatally, intra-natally or postnatally. Referral procedures should
be decided upon early, in the establishment of any domiciliary service. There is much evidence from the literature of women transferred antenatally or in labour who were treated with contempt, or left waiting for long periods, because they had booked for home confinements (O’Connor, 1995; Wesson, 1995). It is of paramount importance that all staff work as a team, having mutual respect for one another. Professional care must be assured at all times, whatever problems are encountered.

The Department of Health (1994 b) in the *Report of the Maternity and Infant Care Scheme Review Group* recommended that emergency services “may have to be provided for both planned and unplanned domiciliary births” (p.24) These author would argue that they *have* to be provided, because of the duty of care and the constitutional entitlement of a woman to have a home confinement (Department of Health, 1970) Post-partum haemorrhage and neonatal asphyxia have been identified as the two most common obstetric emergencies. In the past the obstetric flying squad was the service mobilised to deal with these emergencies. However, the *Review Group* discuss the abandonment of the Flying squad service in the UK (even in rural areas) and its replacement by paramedical teams, who had extended obstetric and neonatal training. The UK experience has been that Flying squads are an “expensive and potentially dangerous practise in modern day obstetrics”. (Department of Health, 1994 b; Cocks and Cocks, 1994). It was found that the response time was poor and that senior staff leaving to attend a delivery were gone on average of two hours, thereby depleting the labour ward staff. The call out rate was very low, at two per thousand deliveries.

In Waterford Regional Hospital most of the ambulance personnel have completed a neonatal resuscitation training programme in line with guidelines from the report of the
recommend that practising midwives shall be proficient in neonatal resuscitation techniques. Furthermore, Cocks and Cocks (1994) state that the skills of many midwives who undertake home confinement extends to intubation. They consider this level of skill sufficient as they conclude that medications play a relatively small role in early neonatal resuscitation. As two midwives attend each home confinement under normal circumstances a conflict of interest between mother and baby is not envisaged. In order to prepare for maternal and neonatal emergencies the authors completed programmes in intravenous cannulation and neonatal resuscitation. With reference to the present confinement the authors decided to inform the ambulance services of the impending delivery, and of its location. It is deemed unsafe for midwives to transfer labouring clients in their own vehicles.

3.2.7 Equipment

The Report of the Confidential Enquiry into Facilities Available at the Place of Birth, conducted by The National Birthday Trust (Chamberlain and Gunn, 1994) highlighted that without proper equipment the best midwifery skills cannot be offered. It was deemed reasonable that items of vital resuscitation were available (Chamberlain and Gunn, 1995). These included mobile telephones, doppler / ultrasound, neonatal laryngoscope, oxygen for both mother and baby, intra-venous giving sets and fluids. In addition to these items, the American Heart Association (1994) recommended suction equipment. It identified neonatal asphyxia as the most likely neonatal emergency, as already mentioned. Complete lists of equipment required are detailed in The Independent Midwife, a handbook used by community midwives in the UK (Hobbs, 1993). See Appendix 7 for equipment lists.
obtained by the authors. This equipment was left in the client’s home from 37 weeks gestation onwards.

3.2.8 Time factors

The scheduling of ante-natal visits has already been outlined in section 3.2.1. The authors believe flexibility is a key component of care provision. Flexibility, in this context, refers to the actual time allocated to each visit. As care is individualised, cognisance needs to be taken of the different needs of women in their preparation for childbirth. Similarly, flexibility is also required around the time of delivery. The timing of delivery is unpredictable, necessitating 24 hour on-call provision from 38 weeks to 42 weeks gestation. Managers need to make provision for all these eventualities in assisting practitioners in managing their caseload. In this case the authors alternated first on-call with the intention of both being present at the delivery.

There are no specific guidelines indicating the optimum distance a domiciliary midwife should reside from her client. Therefore it can only follow that each case should be assessed individually. In this instance, the authors lived 20 minutes drive from the client, which was considered satisfactory by all concerned. An Bord Altranais (1994a) considers it important that the practitioner be accessible to the client. For the purposes of this project the authors were issued with mobile phones by the Health Board, and this proved to be a satisfactory arrangement.

The literature does not indicate an optimum schedule of postnatal visits. The NWHB (1997) adopted a system which fitted in with their workload commitments in the maternity unit. According to Magill-Cuerdin (1996) postnatal visitation is a very
important part of the community midwives role in the UK. The UK is considered unique in its schedule of visits which occur for a minimum of ten and a maximum of twenty eight days. Many countries have no scheme for visiting mothers and babies at home. Consequently the practice is being questioned in the UK in relation to outcomes and cost effectiveness. The paramount objective of postnatal care appears to emphasise the physical well-being of the mother and baby as evidenced by the format of maternity records. This, according to Magill-Cuerdin (1996) occurs at the expense of monitoring social, cultural and psychological adjustment which are often poorly understood and may therefore be neglected. Furthermore, she suggests that postnatal care has not realised its full potential in providing women with the appropriate knowledge and support to adapt to the changes brought about by new motherhood. This is far more important now than it was in the past because as family ties and traditions are lost, mothers may not have observed parenting patterns which nurture the growth of the child and the family.

Summary

Domiciliary midwifery services in Ireland are confined to those provided by independent practitioners and an isolated health board service in the north west. Provision of a health board service requires an analysis of professional and organisational issues which comply with official guidelines. It is vital that this service is characterised by evidence based practice, good interdisciplinary communication and flexible use of resources.
Conclusion

Dilliner (1994) believes that the future market leaders in pregnancy will be those who can offer a community based service providing sound evidence based practice and good continuity of care. Public health nursing in Ireland has a strong historical connection with domiciliary midwifery. However, demographic changes and shifts in health policy led to the decline of homebirths and subsequent PHN involvement. Current health policy promotes hospital births thereby suggesting that domiciliary confinements are unsafe. However the literature does not support this view.

Women have identified continuity of carer, choice and control as priority areas for improvement in maternity service provision. Domiciliary midwifery provides these important and beneficial elements of care but provision in Ireland is not widely accessible. Services are confined to those provided by independent practitioners and an isolated health board service in the north west. This is not an equitable service and therefore does not comply with the key principles of the National Health Strategy (Department of Health, 1994 a).

The WHO (1985) recommended that in the future the medical and social approach of services during pregnancy and birth should be united, and that careful scientific evaluation should be advocated regarding all levels and types of care. The PHN's practice uses aspects of nursing, social and medical models of care. Therefore, it would be feasible, with appropriate preparation, for some PHN's to become involved in a community midwifery service. In conclusion, the authors believe that it is vital that any community based midwifery service is accessible, responsive, cohesive, flexible and quality driven.
**Recommendations**

- The domiciliary midwifery service should remain with the Public Health Nursing service.
- Public Health nurses providing the service should have recent midwifery experience.
- Regular theoretical and practical refreshers are necessary. These should have a domiciliary midwifery component.
- A third PHN will need to be prepared to provide backup for sick leave and annual leave and any other unforeseen circumstances.
- Additional study leave would be required which could be used flexibly to maintain midwifery skills.
- Supervision needs to be knowledgeable, supportive and flexible.
- Communication needs to be open, honest and accessible.
- Cognisance needs to be taken of the unpredictable nature of maternity and the need for resources to be deployed accordingly i.e. time, resources and personnel.
- Every effort needs to be taken to foster good working relationships with other health professionals involved in maternity services.
- The decision to book prospective clients should remain with the PHN's providing the service.
- In view of the fact that home confinements are infrequent and easily identified the importance of confidentiality becomes greater in order to protect the privacy and interests of the client.
- The content and timing of antenatal and postnatal should be at the discretion of the PHN's.
- Should communication with hospital services be necessary, this should occur at Registrar level.
• In the interests of accessibility and maintaining the interprofessional relationships already developed, the authors recommend that the service in its present format be confined to Waterford Community Care area.

• Ambulance control should be informed of any impending home deliveries so that an ambulance and paramedic driver would be kept on standby for the duration of the labour.

• That service providers be assigned time to set standards relevant to the service.

• Regular review and evaluation of service provision.

• In the interests of accessibility and maintaining the interprofessional relationships already developed, the authors recommend that the service in its present format be confined to Waterford Community Care area.
References


O'Toole, B. (1997). *Series of Lectures as part of the Back to Midwifery Course.* Cork: Southern Health Board College of Midwifery.


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Bibliography


Appendix 1. Legislation concerning provision of maternity services

Health Act, 1970

“Section 62. (1) A health board shall make available without charge medical, surgical and midwifery services for attendance to the health, in respect of motherhood, of women who are persons with full eligibility or persons with limited eligibility.

(2) A woman is entitled to receive medical services under this section may choose to receive them from any registered medical practitioner who has entered into an agreement with the health board for the provision of those services and who is willing to accept her as a patient.

(3) When a woman avails herself of services under this section for a confinement taking place otherwise than in hospital or maternity home, the health board shall provide without charge obstetrical requisites to such extent as may be specified by regulations made by the Minister.

Section 63. (1) A health board shall make available without charge medical, surgical and nursing services to children up to the age of six weeks whose mothers are entitled to avail themselves of services under section 62.

(2) Services under this section shall be provided for a child by any registered medical practitioner whom the parent of the child has chosen, who has entered into an agreement with the health board for the provision of those services and who is willing to accept the child as a patient.” (Department of Health, 1970)

“In addition, section 61 (1) of the Health Act, 1970 states that a health board may make arrangements to assist in the maintenance at home of a woman availing herself of a service under section 62, or receiving similar care, or a dependant of such a person”.

“The services available from the general practitioner free of charge under the current scheme are as follows:
1. Initial examination, to be made as near as possible to the sixteenth week of pregnancy, but not later than the twenty-eight week of pregnancy;
2. Five ante-natal examinations in addition to the initial examination (Where possible, at least one of these examinations should be carried out in each of the last three months of pregnancy);
4. “Attendance at the confinement (if the medical practitioner considers it necessary or if his/her services are called for by the midwife attending on the patient);
5. Attendance on at least one occasion in the week following delivery;”

2.7 Midwifery services (consisting of initial antenatal visit, attendance of confinement and any other necessary care during pregnancy, labour and the lying-in period) are provided for under the scheme. Where a domiciliary birth is involved these services are provided, where available, either through health board domiciliary midwives or private midwives who have entered into an agreement with the health board for the provision of services” (Department of Health, 1994 b, p. 9-10)
Appendix 2. Landmarks in the Evolution of Public Health Nursing

1851 Poor Relief (Ireland) Act. Midwives were appointed by local authorities to act as auxiliaries to district medical officers.

1876 Lady Plunkett established a training school for district nurses at St. Stephen’s Green.

1887 The Queen Victoria Jubilee Institute for nurses was founded - a voluntary which trained and employed district nurses.
Voluntary district nursing service also provided by the Sisters of Mercy, Irish Sisters of Charity, Little Sisters of the Assumption and other religious.

1903 Lady Dudley Scheme founded. Lady Dudley nurses worked under the direction of the dispensary doctor, supervised by the Jubilee Institute.

1907 Notification of Births Act signalling the beginning of the child welfare service.

1915 Notification of Births (Extension) Act, which through grants, provided for the employment of nurses to visit children under 5 years.

1919 Public Health Medical Treatment of Children (Ireland) Act, which was the foundation of the School health service.

1924 School health examinations, as provided for under the above Act commenced.

1947 Health Act 1947 (Section 102) provides for health authorities to arrange a home nursing service. (Section 22) provided for monitoring and improving the health of children, detection of mental deficiency and health education.

1953 Health Act 1553 (Section 18) repealed section 22 as above and obliged health authorities to provide medical, surgical and nursing services for children under 6 years. Midwives permitted to attend short PHN courses.

1956 The Minister of Health urged health authorities to make home nursing and midwifery services to all families.

1966 Ministerial circular 27/66 laid down the duties of the PHN and provided for appointment of Superintendent PHN’s.
A six month training course for PHN’s instituted under the auspices of An Bord Altranais. Later extended to 12 months.

1970 Health Act 1970 (Section 60) obliged health boards to provide a nursing service to all persons with full eligibility and to other categories as specified by the Minister. (Section 62) related to provision of midwifery services. (Section 70) related to screening to be carried out.

1975 Department of Health review of the workload of the PHN.

1980 The Institute of Community Health Nursing founded.

1982 Senior Public Health Nurses appointed.

1986 The General Medical Service Division of the Department of Health issued a discussion document on Public Health Nursing Services in Ireland.

1986 The Institute of Community Health Nursing published a survey on the workload of the PHN.

1987 An Bord Altranais course was replaced by the National University of Ireland, Diploma in Public Health Nursing at University College, Dublin.

1994 National University of Ireland Diploma in Public Health Nursing commenced in University College, Cork.

1995 Proposed discussion document on the role of the PHN.

### Appendix 3. Forms of care which should be abandoned in light of current evidence

**Care in pregnancy and childbirth: a synopsis for guiding practice and research**

Forms of care that should be abandoned in the light of the available evidence

<table>
<thead>
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<th>Forms of care</th>
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Appendix 4. Six point plan for supervision. The main points of consensus.

1. Selection.
Supervisors should:
• be nominated for their personal characteristics
• understand the role
• be reselected every five years
• not supervise more than 20 midwives

Supervisors could:
• be nominated from other disciplines
• be of a higher grade

2. Preparation and education.
Supervisors should demonstrate:
• interpersonal skills
• negotiating skills
• political awareness
• that they are advocates for midwives and women
• that they are open and, flexible and approachable

ENB Distance Learning Course
• reported as more beneficial than a three day course
• needs more interaction built into the pack
• needs to be developed continuously
• needs more refreshers and updating.

3. Communication needs
Supervisor and midwife:
• open door policy
• wide understanding of what a supervisor is there for
• named supervisor with a right to change
• right of access to another
• audit to evaluate supervisor’s activities
• 24-hour supervisory advice and access.

Supervisor and general management:
• regular meetings
• management understanding of the supervisor’s role
• contracts recognising the authority, value and purpose of supervision.
• supervising input into policy and risk management
• supervisors consulted on all midwifery issues

Supervisor and supervisor
• regular meetings - local and regional LSA
• access to link supervision
• all supervisors to have a right to attend all LSA supervisory meetings
• publish anonymised supervisory investigation results (continued overleaf)
Supervisor and midwifery teachers
• channels of communication very important

4. Conflicting roles of ‘policeman’ and ‘friend’.
• reject term ‘policing’
• raise public image of supervision
• make it clear to midwives in which capacity supervisor is acting.
• ideally, supervisor should be guide and friend - if disciplinary action required another supervisor should take this on.

5. Clinical caseloads.
• do not necessarily enhance supervisory roles
• supervisors need mixture of experience and expertise
• midwives should be able to question credibility

6. Accountability
• supervisor should be visibly accountable to both the LSA and Health commission / consortium level and to the midwives for practice in accordance with agreed national standards which are audited annually.
• Health commission / consortium funds the LSA post which should be a midwife.
  Purchasers will require that providers pay the midwives for their supervisory role as specified in contracts which are supervised by the MSLC.
• midwife should be able to choose a named supervisor who is not her line manager.”

(Patton, 1996, p. 6)
Appendix 5.

SOUTH EASTERN HEALTH BOARD
WATERFORD COMMUNITY CARE AREA

INITIAL APPLICATION FORM FOR HOME CONFINEMENT

This form when completed should be returned to the Director of Community Care or the Superintendent Public Health Nurse, Community Care Offices, The Mall, Waterford.

Name: __________________________ Partners name: __________________________

Address: __________________________ Next of Kin: __________________________

Address: __________________________ (if different)

Date of Birth: __________ Telephone No. __________

Estimated Date of Delivery: __________

General Practitioner: __________________________

Address: __________________________

GP for confinement: __________________________

Address: __________________________

Number of previous pregnancies: __________________________

Attached is an information leaflet on criteria which will be used to assess suitability for home confinement.

I hereby make application to have my suitability assessed for home confinement.

Signature: __________________________ Date: __________________________
It is the policy of the South Eastern Health Board that all births take place in properly equipped and staffed maternity units. However, it is acknowledged that some women may wish to give birth at home and the health board will endeavour to facilitate this.

The following general conditions apply to all applicants for home delivery:

- It is desirable that the applicant enlist the services of a General Practitioner who will support her decision to seek a home confinement.
- Applicant should be in good health with no underlying medical conditions.
- Pregnancy should be progressing normally, within normal parameters.
- A mother having her first baby should be under 35 years.
- It is desirable that the GP and/or a consultant Obstetrician, in addition to the Public Health Nurses, be involved in the ante-natal care of the applicant.

On receipt of the initial application form, the following will take place:

- The Public Health Nurse/Midwife will visit you in your home and answer any questions you may have regarding your pregnancy, labour and delivery.
- An assessment for suitability will be made under the following:

**Mothers Health**

- Current Health

- Past obstetric history i.e. number of previous normal deliveries, previous complications of pregnancy, labour, delivery and post delivery and previous caesarean section.


**Home Environment**

The home should be clean and have adequate heating, water supply, adequate lighting and sufficient room for delivery.

**Location and Accessibility**

Distance from nearest Maternity unit will be considered and the home must be accessible to motor vehicles.
Transfer to Hospital

The applicant must be agreeable to transfer into hospital immediately on the advice of the attending midwife. Examples (not exhaustive) of reasons for transfer into hospital include:

- Breech presentation
- Fetal distress
- Bleeding
- Meconium stained liquor
- Failure to progress
- Raised blood pressure
- Prolonged ruptured membranes
- Cord Prolapse
- Maternal exhaustion

Please note that the following are not suitable for home delivery.

- Multiple pregnancy; Abnormal presentations of baby e.g. breech.
- Suspected “Small for Dates” baby.
- Placenta Praevia - (afterbirth presenting first)
- Any known or suspected abnormality of the baby.
- Sixth and subsequent deliveries.
- Previous abnormal pregnancy affecting mother and baby.
- Previous caesarean section.

Maternal conditions

- Medical conditions e.g. Raised Blood Pressure, Pre-Eclampsia, Diabetes, Tuberculosis, Epilepsy.
- Any infectious diseases.
- Renal disease.
- Heart disease.
- Anaemia.
- Rhesus disease.
(Not an exhaustive list).

Following the assessment visit by the Public Health Nurse / Midwife, a report and recommendation will be forwarded to the Superintendent Public Health Nurse. A decision regarding provision of Midwifery services for Home Confinement will be made following discussion with the personnel involved. You will be informed of the decision in writing.
CONSENT FOR HOME CONFINEMENT

We the undersigned, having received full information on the risks involved with a Home Confinement, and understand them fully, agree to accept responsibility for our decision

Signed: ____________________________

Date: ____________________________
Appendix 6. Letter to GP requesting prescription for drugs

Waterford Community Care Offices,
32 The Mall,
Waterford.

Dr. ......................
General Practitioner,
........................................
Co. ........................

Dear Dr. ......................,

We are two Public Health Nurses currently employed by the South Eastern Health Board to carry out a home confinement for your client Mrs. ......................, ......................, Co. ...................... We would be grateful if you would provide her with a prescription for the following medications, which may be required at the time of delivery: -

- Two ampoules of Ergometrine maleate 500 micrograms.
- Four ampoules of Syntocinon 10 International Units
- One, 10 millilitre bottle of Lignocaine 1%
- One ampoule of Konakion 0.2 milligram.

Thank you for your assistance in this matter, and we will inform you Mrs. ...................... progress.

Yours sincerely,

Anne Dempsey & Helen Mulcahy.
Appendix 7.
EQUIPMENT OBTAINED FROM WATERFORD REGIONAL HOSPITAL, LABOUR WARD FOR HOME CONFINEMENT.

1 Delivery set
1 Suture set
2 sachets of Dexon (2/0)
2 sachets of Vicryl
3 Cord Clamps
2 Identity bracelets for baby
10 Sterile Microtouch Gloves (size 7)
4 Sachets of Hibitaine
1 Mucus aspirator
1 Meconium aspirator
1 Amnihook
3 Amniconator sticks
4 Venflons (size 18g)
1 Tourniquet
2 Vacutainers
1 Blood giving set
3 Opsites for I/V site
1 each of blood bottles and forms
1 Litre of Hartmans solution
2 10 ml ampoules of Nacl for injection
1 Feeding Tube (size 8)
1 Suction Tube (size 10)
1 Oxygen Tubing for suction machine
1 Endotracheal tube (size 3.5)
1 Yankauer suction tube
1 Maternal airway
1 Infant airway
10 Sachets of KY Jelly
1 Urinary Drainage bag
1 Self retaining catheter (size 12)
1 Roll of Dermocel tape
1 Packet of Gauze swabs (4x4)
10 Inco Pads
Selection of syringes and needles

PRESCRIPTION FROM GP REQUESTED FOR THE FOLLOWING:

- Two ampoules of Ergometrine maleate 500 micrograms.
- Four ampoules of Syntocinon 10 International Units
- One, 10 millilitre bottle of Lignocaine 1%
- One ampoule of Konakion 0.2 milligram.
EQUIPMENT TO BE PURCHASED:

- Huntleigh Dopplex II Fetal sonicaid £331.55
- Laerdal self-inflating resuscitation bag (240ml) with Oxygen reservoir and cushioned anatomical mask (size 1) £95
- Portable Mechanical suction £146.58
- Neonatal Laryngoscope with size 1 Miller Blade. £197.84
- Two Mobile telephones at £99 each

EQUIPMENT OBTAINED FROM COMMUNITY CARE

2 Small Cylinders of Oxygen
2 Oxygen flow meters indicating cylinder volume and litres per minute
1 Oxygen mask (maternal) 40% (red)
1 Baby scales (local health centre)
1 Dressing Pack (for catheterisation)
1 Pack of equipment for Guthrie
2 Thermometers
1 Scissors
1 Sharps container
1 Stethoscope
1 Sphygmomanometer