South Eastern Health Board

Home Birth Group

2/12/98

Home Birth Working Group

Introduction

The Report of the Maternity and Infant Care Scheme Review Group (1994) stated that Ireland is now the safest country in the world for giving birth, with a maternal mortality rate of two per 100,000 births. At present, most deliveries occur in hospitals, while antenatal care is either predominantly hospital based or shared care between General Practitioners and hospitals.

There are, however, other options, one of which is home (domiciliary) birth. Legally, a woman has the right by law under Section 62 of the Health Act 1970 to request a home birth. At present there appears to be little consensus on how to deal with such requests. In the interim report of the group established by the Chief Executive Officers (CEOs) of the Health Boards, following the Report of the Maternity and Infant Care Scheme Review Group the following three recommendations were made:-

- Each Health Board in recognising its responsibility under the Health Act would have a named Officer with responsibility for domiciliary midwifery service in the Health Board Area.
- Each Health Board in recognising its responsibility under the Health Act would standardise existing procedures into standard format.
- Each Health Board in recognising its responsibility under the Health Act would establish an audit group to oversee the operation of home birth services in the region.

It also recommended that a national standard in relation to the practice of home births should be devised which would address:

Protocols for managing labour in home births.

Protocols for managing transfer of mother and baby.

Arrangements for employment and payment of Domiciliary Midwife.

Protocol for in-training, including strict criteria that skills are updated on a regular basis.

It proposed a number of pilot schemes for delivering home births for evaluation throughout the country which took account of the different service needs of urban and rural communities, and the need for local services to be delivered in a manner which would allow national comparisons and evaluation.

At a local South Eastern Health Board level, a group was established whose terms of reference were:

- To review the pilot project operated in Waterford Community Care Area and to advise on its appropriateness as a model of service delivery in the South Eastern Health Board.
- To make recommendations of the necessary policy and procedural guidelines required to provide a Home Birth Service throughout the South Eastern Health Board.

The membership of the group was:

Dr. Conleth Murphy, Consultant Obstetrician, Wexford General Hospital (Chair),
Ms. Emer Carroll, Superintendent Public Health Nurse, Waterford Community Care,
Dr. John Carson, Consultant Paediatrician, Wexford General Hospital,
Dr. Mary Christie, Senior Area Medical Officer, Carlow/Kilkenny Community Care,
Ms. Joan Kealy, Assistant Matron, Waterford Regional Hospital,
Ms. Ann-Marie Lannigan, GP Unit Administrator, (Secretary),
Dr. Maire O'Connor, Specialist Public Health Medicine,
Dr. Margaret O'Riordan, GP Unit Doctor.

In view of the work already done by the national group and the fact that the local pilot scheme was already completed, this South Eastern Health Board group concentrated on exploring a number of issues around the South Eastern Health Board delivering a home birth service.

Safety

A most important issue for this group was safety for mother and child. It has already been stated that Ireland is one of the safest countries to deliver a child at the present time, with a very low peri-natal mortality rate and maternal mortality rate. These low mortality rates have allowed increasing attention to be paid to morbidity (physical and mental) and health (physical and psychological). Death as a negative outcome to a service is relatively easy to measure, less so morbidity and harder still is health. However, all services should be evaluated along risk assessment lines, taking the

continuum of health to death for both mother and child. Proposed changes in service should be able to show that the proposed changes perform better, or at least, do no worse than the existing services when so assessed.

However, while death as an outcome is easy to measure, as previously mentioned, the same is not true of morbidity and health. The morbidity and health variables measured in different published studies vary as do the populations included/excluded in such studies, the infrastructure and support services, and the training of the service providers, making comparisons between service types difficult. Hence, apparent contradictions in outcomes from different studies. Many of these studies are summarised and referenced in the report of the national group and so are not re-iterated here apart from two recent examples. One large single Australian study (Bastian et al, BMJ 1998:317:384-388) concluded that home birth was not as safe as hospital births. A large meta-analysis (multiple studies) by Olsen suggested that they were (Olsen O., Birth 1997:24:4-13). Olsen did, however, also conclude that it was difficult to compare like with like and that differing demographic, epidemiological, cultural and service factors made comparisons almost impossible. He suggested that larger studies were needed to draw firmer conclusions. Olsen is leading the international systematic review on home births on behalf of the Cochrane Collaboration which will take many of these factors into account. In view of this, this group agreed that while hospital births have a confirmed safety record in Ireland, home births could neither be designated safer or less safe than hospital births, when account is taken of the current literature.

Comparisons with other countries are frequently made. One such comparison frequently made is with Holland. However, such comparisons fail to take into account the longer period of training for Midwives, the excellent para-medical teams, road service and use of birthing centres (frequently categorised as home births). In Denmark a move to domiciliary midwifery was attempted in the 1970s. However, with changes in peri-natal mortality, this move slowed down.

Irish Situation

In an ideal world, this group believes it would be appropriate to offer the choice of delivering at home, under the care of an appropriately trained Midwife, or in a hospital based environment to a select group of presumed low risk women if the following criteria were in place (including in the SEHB):-

1. Sufficient number of trained Midwives, to provide all service options.
2. Sufficient para-medical services both personnel (numbers and training) e.g. ambulance personnel, and equipment.
3. An improvement in the current road structure.
4. An overall increase in the level of service within Community Care which would allow for the extra work which domiciliary births would bring to services such as General Practitioner, Public Health Nurse and Home Help. The increase in domiciliary birth activity in England occurred in the context of an extensive community care network (ref.).
5. Support from GPs and hospital based Consultants. Safety, skill updates, cover and locum implications are some of the issues, which need to be clarified.
6. Medico-legal issues for all professionals concerned including GPs, Obstetricians, PHNs, Midwives (hospital based, independent), Hospitals, and Health Boards.
7. Finance to support all these ventures.

Who Would Provide the Service?

1. Public Health Nurses.
2. Hospital based Midwives.
3. Independent Midwives.

During the group's discussions, it was accepted that each of the above professionals could make a reasonable case for providing domiciliary services. Public Health Nurses (PHN) have an extensive community network but their midwifery skills decrease with increasing years post graduation and in the future midwifery may not be a requirement for PHNs. Therefore while the Waterford project achieved the short term objective in providing home births for a small number of women, as a long term model, both in efficiency and effectiveness, the group felt it would probably not be appropriate throughout the health board.

In rural areas it would be difficult for independent Midwives to annually deliver a sufficient number of mothers to maintain their skills, and in view of their being independent it is difficult for the Health Board to supervise and evaluate their practice (appendix 1), in the absence of their being employed on a contract basis similar to General Practitioners (GPs). The efficiency and

effectiveness of employing independent Midwives, especially in a relatively rural area such as South Eastern Health Board (SEHB) is open to question.

Taking account of the population spread and geography of the region covered by the SEHB, the group recommends a hospital based midwife service providing home births once the criteria listed above are in place. Two of the pilot schemes recommended by the national group included home births delivered by hospital based midwives. In the SEHB, it would be preferable to await the outcome and evaluation of these pilots before embarking on such a service. The advantages of such a service include:-

1. The question of on going training would be addressed within the hospital environment.
2. Appropriate number of deliveries per annum could be achieved more readily.
3. The Midwives could be utilised in the hospital during periods of reduced activity.
4. In the event of complications or queries either in the antenatal, labour or post delivery period, continuity of care for the mother and child and transfer between delivery options would be seamless.

The Legal Situation

One of the documents included in the national group's report provides some information on indemnity issues for GPs providing Obstetric care to women who intend to have a home birth. These have implications not just for GPs, but also for the health board, Consultants, PHNs, and Midwives (independent and hospital based). There are many potential problems. One such example would be the situation where, if a Midwife was not happy with the progress of labour and was unable to obtain transport or to contact the hospital, or was unable to achieve rapid transfer in labour, where would responsibility lie in this eventuality? In this situation what are the legal implications for all professionals concerned, and the health board in facilitating the provision of a domiciliary service by hospital based Midwives, PHN Midwives or independent Midwives? While the Health Act gives women rights to home birth, in the event of an adverse outcome, legally it could be argued that the health board and all others concerned had facilitated in the provision of an untested service. This would be especially true if the criteria listed above were not fulfilled.

An option worth discussing at another forum is that of challenging the whole legal situation. A woman has a right to deliver at home, according to current legislation. What about the right of the

unborn child to be delivered in a safe environment? At present in Ireland, this can only occur in the hospital. This could be especially relevant in a high risk pregnancy or where a mother refuses to accept transfer to hospital even when advised by domiciliary Midwife or GP. Change in the law would be necessary, in order to implement such a change. The alternative is the provision of all criteria listed above, the opportunity cost of which was beyond the brief of this group.

Additional Options

In the current climate, where there are significant demands on all health care resources and financing, this group recommend that two further options should be addressed as part of the continuum of place of delivery option and as an interim (a) to achieving the resources needed to create a safe environment for home births and (b) pending the evaluation of the national pilots.

1. An alteration of present hospital facilities to make them more women and family friendly. This would include a flexible approach to time spent in hospital, an openness with regard to information sharing and communication at all levels, a move to make the clinical aspects more acceptable, pain relief choices and alternate birth options. Issues such as crèche facilities for older children would also be reviewed.
2. A domino approach, this is probably the most obvious compromise to an actual home birth, whereby, a pregnant woman would only have to spend a short time in hospital during her delivery and be cared for before, during and after by the same Midwife. Such a service has implications for hospital based staff, community care staff and GPs.

Conclusion

A hospital based delivery service provides a proven safe environment to deliver a child. In order to create that safe environment in a community setting, there would have to be a significant expansion of the community service infrastructure with increase in numbers of personnel and training. The legal implications for all involved professionals including GPs would have to be addressed. Factors outside the direct remit of the health services such as road structure and housing conditions all impact on the feasibility of providing safe home birth services. Any decisions should be based on a National Strategy and must take account of the differences between urban and rural settings and should await evaluation of national pilots. It is difficult to assess the risk involved in view of the different demographics. We urge caution in interpreting the experiences of other countries as such comparisons are often invalidated by differences in services, structures and supports.

Recommendations

While awaiting the implementation and evaluation of national pilots, the South Eastern Health Board should:-

*Fulfil the first three recommendations of the interim national group which were:

- Each Health Board in recognising its responsibility under the Health Act would have a named Officer with responsibility for domiciliary midwifery service in the Health Board Area.
- Each Health Board in recognising its responsibility under the Health Act would standardise existing procedures into standard format.
- Each Health Board in recognising its responsibility under the Health Act would establish an audit group to oversee the operation of home birth services in the region.
- Apply the above three recommendations to any person seeking maternity services.

*Willingly provide information for women seeking any maternity services by leaflet, meeting, telephone (see Appendix 2).

*Ensure procedures are in place to evaluate all aspects of all maternity services provided or funded by the South Eastern Health Board taking the continuum from death to health of the mother and child as outcome measures and incorporating process evaluation.

*In the event of the SEHB continuing in the short term to provide payment to independent midwives, it is recommended that the SEHB discuss with their legal advisers and the relevant professionals the implications of this.

*In the event of the SEHB continuing in the short term to facilitate women to employ independent midwives, it is recommended that the SEHB review the information returns obtained from independent midwives and standardise these on the basis of service inputs, medical and obstetric profile of women accepted for home births, outcomes, and liaison arrangements with PHNs, GPs, and hospital.

*Pending the implementation, completion and evaluation of the national pilots, it is recommended that baseline data in a standard format is gathered on a prospective basis for a minimum period of at least six months (preferably one year) throughout the SEHB on the number of enquiries about alternative birth settings, the number of requests for same, the number who actually avail of same, reasons for the choice of birth setting and type of preferred birth setting.

*Actively seek to involve all concerned staff (hospital and community) and consumer by means of a structured process to improve the existing services in all aspects (health and hotel).

*Implement the results of the national pilots as soon as available.

REFERENCES available on request

Appendix 1 SUPERVISION OF MIDWIVES

1. It shall be the duty of a Health Board in whose functional area a Midwife practises or proposes to practice to exercise in accordance with regulations made by the Minister. (Guidelines An Bord Altranais 1994).
2. General supervision and control over such a Midwife.
3. To establish a position of Supervisor of Midwives who would undertake the Clinical supervision and monitoring of the service under the general supervision of the Superintendent Public Health Nurse or Hospital Director of Nursing.

PROPOSED CRITERIA FOR DOMICILLIARY MIDWIVES

QUALIFICATIONS OF MIDWIVES

1. Registered Midwife with An Bord Altranais and operate within its code of professional practice.
2. Up to date in safe Clinical Practice and recent experience in domiciliary setting.
3. Professional Practice up-date and training in the following areas as the Midwife must deem herself competent to practice in this way.
   a. Intravenous Canulation and proficiency in the use of I.V. Drug Therapy.
   b. Cardiotocagrophy.
   c. Neonatal Resuscitation.
   d. Breast feeding as per SEHB policy.
   e. Suturing proficiency.
   f. Legal and Ethical issues e.g. Midwives will only deal within the realms of normal midwifery care.
   g. Records and record keeping e.g. Birth Notification etc.
   h. Competency with all equipment.

Comply with current E.U. Midwifery Directives as outlined in Guidelines for Midwives Issues by An Bord Altranais 1994.

ROLE OF MIDWIFE

1. The Midwife operating the domiciliary scheme should have a minimum of five years recent experience having conducted at least 12 deliveries in the previous year.
2. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and post partum period.
3. To diagnose pregnancy and monitor normal pregnancies.
4. To advise on the examinations necessary for earliest possible diagnosis of pregnancies at risk.
5. To care for and assist the mother during labour and to monitor the condition of the foetus in womb.
6. To conduct spontaneous deliveries.
7. To recognise warning signs of abnormality in the mother or infant which necessitates medical intervention to Doctor or Hospital.
8. To be competent and prepared for immediate resuscitation if required and to examine and care for the infant.
9. Procurement of Medical Assistance and the execution of emergency measures in the absence of medical help.
10. To care for the mother in the post natal period and to give all the necessary advice on infant care to enable her to ensure optimum progress of the new born infant. To advise on infant feeding and also the importance of vaccinations P.K.U. and B.C.G. etc.

The Midwife has an important task in health counselling and education for her patients and also within the family and the community. This role extends to such areas as Family Planning and Child Care.

Appendix 2 PROTOCOL AND PROCEDURES FOR REQUESTS ABOUT DOMICILIARY (HOME) BIRTHS

Initial Contact

The Superintendent Public Health Nurse in each area should be the named person for ensuring any woman enquiring about a Domiciliary Birth, receives correct and prompt information. Therefore, all avenues through which enquiries may come should be aware of this including Hospital Maternity Services, GPs, Health Centres and Headquarters in Lacken. Any person receiving such a query should have available to them the name, address and telephone number of the Superintendent Public Health Nurse for the Community Care Area of the person making the enquiry and should pass this on to the person making the enquiry. They should also post out this information to the person making the enquiry.

Action: *Memo at each switch/reception with reminder "Queries about Home/Domiciliary Births refer to Superintendent Public Health Nurse with list of who they are and where located.*

Advise to Expectant Mothers

On receipt of an enquiry about any aspects of a Domiciliary Birth the Superintendent Public Health Nurse should make available to the person making the enquiry a leaflet containing details of the various options around birth i.e. hospital complete care, shared care with GP and Domiciliary Birth giving details of what each involves, what is available, how to access each and cost and other administrative details of each. The leaflet/information pack should also state "It is the policy of the SEHB to provide consultant staffed maternity units which are deemed safest in all circumstances".

Action: *Provision of leaflet/information pack.*

In addition to making this written information available to the person making the enquiry, for those who wish to discuss the option of Domiciliary Birth further, the Superintendent Public Health Nurse should arrange, as soon as possible, a meeting with the person making the enquiry to further discuss pros and cons and facilities available in greater detail. This should include discussing the woman's previous experience with maternity services and a discussion of all options available.

Support for Expectant Mothers

For those who wish to pursue the option of a Domiciliary Birth, the facilities available locally for Domiciliary Births once again should be made known to the woman, in a written format, with details on how to access such services, what she can expect in terms of antenatal and post-natal care and how to access the named Officer under Section 62 of the Health Act to ensure payment purposes.

Action: *Written details of above.*

** It is important to note here that the role of the Superintendent Public Health Nurse as envisaged here is solely to ensure that the person making the request receives the desired information.*

The following could be incorporated into the information provided by Supt PHN (from Southern Health Board);

- On enquiring, an applicant is informed that the Board is not in a position to provide a Midwife from its own resources for a home confinement or to direct anybody to provide this service.
- Details of Midwives who have notified their intention to practice in the administrative area forwarded to the applicant who is advised that should she wish and be able to obtain the services of one of these Midwives, the Health Board would be willing to engage her to act as Midwife for the applicant and to pay her the statutory fee plus travelling expenses incurred by the Midwife in providing the service.
- The applicant is advised to discuss with her medical advisors the suitability of a home confinement in her particular case and to make suitable arrangement in advance to ensure adequate attendance by them at the confinement.
- On receipt of an application signed by the Midwife, the Midwife is written to separately indicating that the Board is willing to engage her to act as a Midwife in the particular case and to pay her the statutory fee plus travelling expenses. She is informed that in undertaking to act as a Midwife, she does so in her own professional judgement and responsibility and that the Board will arrange its own insurance against any liability it may have in the matter.
- Arrangements are made to provide a regulation maternity pact.
- Payment is made directly to the Midwife in due course (average cost to the Board approximately £450).

(This does not preclude the Supt PHN delegating to another PHN)