Unassisted Birth During the Covid-19 Pandemic

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Document Control

Ownership

Role	Department	Contact
Clinical Lead and author	GMEC SCN	Eileen Stringer Eileen.stringer1@nhs.net Clinical Lead Midwife

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Contents

1 What is this guideline for?

This guideline is based on the RCM guidance on ‘Freebirth’, or ‘Unassisted birth’, during the Covid-19 Pandemic. The term ‘Unassisted birth’ will be used throughout the rest of the document.

As a result of service pressures in maternity and related services including the ambulance service during the Covid-19 pandemic, some maternity services have made the difficult decision to suspend the availability of home birth and/or midwife-led birth in some areas. This means that some women may not be able to access the type or place of birth that they had planned. In these circumstances, women will be supported to adapt their birth plan to birth in the hospital maternity unit or alongside midwife led unit.

Some women will find the alternative options on offer unacceptable or feel that they do not meet their needs and may choose to have an unassisted birth. Women may feel that unassisted birth is the only way that they can retain choice, control and autonomy during the birth process. Other reasons may be due to the woman’s concerns that the baby may contract the Covid-19 virus, or they fear that their partner may not be able to be with them during labour and the birth, particularly where the partner has symptoms of Covid-19.

The concern from maternity services is that birthing without midwifery assistance brings with it increased risks to both the mother and baby.

The guideline includes measures that maternity services may utilise if they become aware of a woman planning an unassisted birth. In addition, it lays out the legal stance for attending unplanned births at home once the maternity service becomes aware of it. It covers all care settings and is to be used by obstetric and midwifery staff so that they provide consistent and effective care and minimise harm to mother and baby.

2 Why do I need to know?

It is important to ensure that during the Covid-19 pandemic, maternity services can respond and adapt to the changing picture of health care, ensuring that the offer and options for care are acceptable to most women and that women and babies receive the best evidence-based care even in uncharted circumstances. This guidance will ensure that a standardised approach will be implemented across our region, to reduce variation in the quality of care delivered.

3 Establishing a dialogue

When a woman indicates that she plans to give birth without assistance, the maternity service should reach out to the woman to try and build a dialogue.

Arrangements should be put in place as soon as possible in order to establish a conversation with the woman and her partner. It is important to listen and understand more fully their concerns and reasons for choosing unassisted birth. This might be done virtually through a video call or if necessary, a meeting that observes social distancing guidance.

Where continuity of care exists utilise the existing relationship between the named midwife, woman and family. The midwife will have knowledge of the woman's circumstances and her needs. Ongoing continuity of care may help with dialogue and assist the woman in considering different options.

Where a known midwife is not available, consider using a midwife who is experienced in supporting women and their choices, for example a senior midwife, consultant midwife or Professional Midwifery Advocate.

Content of the discussions

It is important to listen to the woman and to give her the time to share what is important to her in relation to her psychological and physical safety.

Explore why she wants to have an unassisted birth.

Spend time explaining the evidence about any individualised risk factors for her and her baby of her intended birth plan.

Ensure that the woman and her partner are aware of the need for safety of midwives when providing care, particularly in relation to exposure to possible or confirmed Covid-19. This will include explanation of infection control procedures and the wearing of PPE by midwives in homes or hospital settings.

During the conversation(s), identify any previous trauma and consider the potential benefit of offering psychological support from an expert in birth trauma through an online conversation.

Identify any misconceptions or misunderstanding about current practice or service provision in the area and provide the woman with accurate information. This is likely to include the systems and policies in place in the maternity unit to reduce the risk of virus transmission in all settings and the possible timelines for the current service configuration. For example, if the homebirth service has been temporarily suspended, when it is likely to resume, if known.

Ask the woman what plan for the birth would feel safe and acceptable to her and consider options of how to provide an individualised plan of care for her, while considering and explaining the impact on safety for other women and staff.

Reassure the woman that she will continue to be offered usual antenatal and postnatal care even if she decides to have an unassisted birth.

Give the woman time to reassess her decision and review the conversation again. Inform the woman who she can call and how to access assistance in labour, during the birth or afterwards.

Inform the women that should urgent assistance be required during the birth, an ambulance can be requested via 999. An ambulance will attend in an emergency; however, response times are dependent on service pressures at the time.

Request that the woman notifies her maternity care provider when the baby has been born.

Advise the woman how to register the baby's birth, if she has had an unassisted birth.

All details surrounding discussion of the risks and benefits together with explicit details of proposed management must be documented contemporaneously, in both the Personal maternity record (hand- held notes) and the main notes as appropriate (NMC 2009).

4 Understanding the law

Midwives should ensure that women have an understanding of their own rights in relation to childbirth and about the law in relation to unassisted birth and place of birth.

It is not illegal for a woman to give birth unattended by a midwife or healthcare professional.

Women are not obliged to accept any medical or midwifery care or treatment during childbirth and cannot be compelled to accept care unless they lack mental capacity to make decisions for themselves (Birthrights, 2017).

It is not appropriate for healthcare professionals to refer a woman to social services with concerns about the unborn baby, solely on the basis that she has declined medical support, as she is legally entitled to do (Birthrights, 2017).

It is illegal for anyone present during the labour or birth to be undertaking the roles of a midwife or doctor. According to Article 45 of the Nursing and Midwifery Order (2001), it is a criminal offence for anyone other than a midwife or registered doctor to 'attend' a woman during childbirth, except in an emergency.

Birth partners, including doulas and family members, may be present during childbirth, but must not assume responsibility, assist or assume the role of a midwife or registered medical practitioner or give midwifery or medical care in childbirth.

Where English is a second language, it is important that interpreting services are utilised rather than relying on family members for the discussion. The midwife must feel confident that the woman and her family fully understand all the information given, including risk factors.

If a woman chooses to have an unassisted birth, the service will need to ensure that the woman is informed that a midwife may not be available to be sent out to her at home during labour and birth, if she changes her mind and wishes attendance during the birth. If the woman decides she wishes to have professional care during labour and birth, she may need to attend the maternity unit.

5 Role and responsibilities of the midwife

A number of key sections of the NMC Code set out the responsibilities of midwives, that can be related to caring for women who identify that they wish to give birth without assistance or choosing to give birth at home outside of recommendations for home birth. They include the following:

Prioritise People

- Treat people as individuals and uphold their dignity; treat people with kindness, respect and compassion
- Listen to people and respond to their preferences and concerns; respect, support and document a person's right to accept or refuse care and treatment

- Act in the best interest of people at all times. To achieve this, you must always balance the need to act in the best interests of people with the requirement to respect a person's right to accept or refuse treatment (sections 1, 1.1, 2, 2.5, 4 and 4.1 of the NMC Code, NMC, 2018)

Preserve Safety

- Recognise and work within the limits of your competence.
- Always offer help if an emergency arises in your practice setting or anywhere else. To achieve this, you must:
    - Only act in an emergency within the limits of your knowledge and competence.
    - Arrange, where possible, for emergency care to be accessed and provided promptly

(Sections 13, 15, 15.1, 15.2, NMC, 2018)

It is natural that midwives will feel anxious about the safety of women and families in their care and have a sense of responsibility for outcomes, even if they have no control over them.

- Women have the right to choose care that goes against the advice of their midwife. If a woman chooses to have an unassisted birth, the midwife has a responsibility to inform her about the risks of that decision.

- The midwife is not responsible for the outcome of the unassisted birth.

- If a midwife is caring for a woman planning to have an unassisted birth or wishing to have a homebirth with risk factors that would suggest she would be safer to give birth in a hospital, the midwife should be offered the opportunity to discuss their concerns and plan of care with their manager. Midwives will also benefit from seeking support through midwifery supervision or professional midwifery advisors (PMA) or other peer support.

6 Provision of assistance at an unplanned home birth

Once a maternity service becomes aware that there is a woman labouring at home who wishes to have the attendance of a midwife, the maternity service has a duty of care to provide assistance.

Senior midwifery managers should be informed of any woman who is planning to have an unassisted birth. The senior midwifery management team should then assess what individualised, flexibility of service provision might be possible to avoid an unassisted birth as far as possible. The type of assistance during the Covid-19 pandemic might need to reflect the level of acuity and capacity within the service at that point.

The rights of women to choose their preferred place of birth will need to be balanced against the rights of all women to receive a safe level of midwifery care.

If a woman has indicated in the antenatal period that she wishes to have an unassisted birth, the service will have ensured that the woman is aware that a midwife may not be

available to be sent out to her at home during labour and birth. If that is the case at the time the maternity service is informed of the labour, the woman will be offered the opportunity to receive professional care during labour and birth within the maternity unit.

Where the maternity service is informed after the birth of the baby, a midwife may be requested to attend either by the woman directly or via the ambulance service. Care will be provided as per local Born Before Arrival (BBA) guidelines.

NWAS uses the Advanced Medical Priority Dispatch System (AMPDS) triage system. The different response times based on the national Ambulance Response Programme (ARP) are as follows:

Categories – response times

C1 – mean - 7 min / 90th Percentile 15min
C2 – mean -18 min / 90th Percentile 40 min
C3 – mean - 1hr / 90th Percentile 2 hrs
C4 – No mean / 90th Percentile 3 hrs

Mean is the average time of all incidents in that category. 90th Percentile is response target met in 9 out of every 10 incidents in that category.

From a maternity perspective, the following points are classified as a Category 1 emergency.

- Breech
- Head visible
- Cord Prolapse
- 3rd trimester haemorrhage
- Baby born, complications with the mother

(the ambulance service might have other criterion). These conditions remain during the Covid-19 pandemic, as well as during usual service provision.

7 Service provision during the COVID-19 Pandemic

Midwifery service leads will need to use judgement and seek guidance to provide safe, high quality maternity services during the pandemic for the women in their care and this will, on occasion, require making difficult judgement calls about what services can be safely provided.

Where a service lead is making a decision about temporary suspension of some services including homebirth, as a result of the pandemic, they should inform their Trust Board or NHS Board and commissioner and seek advice from their local legal department.

Maternity service leads should ensure that clear information is provided to all women booked to give birth in their service about current service configuration that is updated regularly, through the service website, social media and through the local Maternity Voices Partnership (MVP) and via the GMEC *My Birth My Choice* website: https://www.mybirthmychoice.co.uk/coronavirus-and-pregnancy/

Where services have been reconfigured based on judgements around staffing shortages, skill mix and the accessibility of paramedic and ambulance services in an emergency, it is important that any cessation of homebirth or midwife led services is only short-lived and the provision is reassessed continually. Such an approach should reduce the possibility of an increase in unassisted birth.

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