Thinking about your Birth Plan

INTRODUCTION

This booklet is designed to help you think through a lot of the options that may be presented to you, and consider which of them you may want to have or decline. It contains information on the following topics:

WHERE TO HAVE YOUR BABY:

One of the first things to think about, is where you want to have your baby. When considering this, think about what is important to you. Do you want to be in your own familiar environment with minimal disruption and aim for a birth with minimal intervention; or do you prefer a more clinical environment with epidural facilities in a hospital?

- HOME- For healthy women with a low risk pregnancy, home birth offers less intervention and higher rates of normal birth with no increase in maternal or neonatal adverse outcomes. There is a small increase in the risk of an adverse outcome for the baby should complications arise, but these complications are less likely to occur at home compared to hospital.

  For some women, home birth is their preferred choice even when there are known risk factors. In these circumstances, your midwife can work with you to come up with a plan that you are happy with.

  It is important that the people you choose to care for you, have the appropriate skills and experience. You need to have confidence in the care they provide and trust in their advice and judgement. At Private Midwives, all of our midwives are skilled and experienced at home birth care. They will give you their undivided attention, detect and problems early, act promptly and stay with you throughout. They are trainined to deal with any emergency situation in the home and will call an ambulance for you in the rare event that one may be needed. For more information on home birth, please see our resource page, home birth information booklet. https://privatemidwives.com/resource-library/

- Birth Centre- This is attached/associated with a local hospital and care is provided by hospital midwives. This environment is normally suitable for low-risk pregnancy and birth. Most (but not all) birth centres offer birthing pools and the ability to walk around. If a problem arises, transfer by ambulance may be needed. In some cases the birth centre is adjoined to the labour ward and ambulance transfer is not needed.

  In some hospitals, the birth centres close at busy times as staff are diverted elsewhere. Some have “criteria” that you need to meet to be able to birth there and sometimes, you may be advised this is not a suitable environment for you.

- Hospital Labour Ward- This is usually for higher-risk pregnancy and birth, or for birth where an epidural has been requested. Care is provided by Midwives, Obstetricians and Anaesthetists. It is usually a very clinical environment. This can slow the production of the natural hormones and the ability to move around may be reduced. However, for some women, the comfort of having medical personnel on hand should they need them is important and reassuring.

STUDENTS:

Midwifery Students spend about 50% of their time in the hospital and 50% in University. As most hospitals home-birth rate is quite low, students sometimes go all the way through their training without seeng a home birth. At Private Midwives about 50% of our clients choose a home birth and

so where we can, we offer student midwives the opportunity to "shadow" our midwives and observe care provided in an unhurried, continuity model of care where home-birth is embraced.

Medical Students, tend to do short placements and rotate between areas. They follow the obstetric team and usually come in small group. In some hospitals they may shadow a midwife for a shift. You can accept or decline to have ANY student involved in your labour and birth at any time.

COLOSTUM HARVESTING:

Mothers start to produce colostrum (early milk) while pregnant. Being able to express colostrum is a useful skill to have. We recommend colostrum harvesting from 36 weeks of pregnancy.

Saving your expressed colostrum is very useful for almost all clients but may be particularly beneficial if your baby is likely to need special care after birth, if your baby is expected to be small or you have gestational diabetes. It is also useful for babies that are more challenging to breast feed as using saved colostrum is preferable to resorting to formula. We also find that clients who express colostrum are less likely to go "over due" and require induction of labour. It is important to discuss you plans to express antenatally with your Midwife. It may not be recommended if you've been at risk of preterm labour in previous pregnancies, or have a surgical stitch, for example.

Breastmilk is a complete food for your baby. Colostrum contains vital immunological properties and helps to colonise the baby's gut with healthy bacteria that protect against allergy and disease. It also contains the perfect balance of proteins, fats and micronutrients needed for human babies as well as acting as a laxative to help the passing of the first tarry meconium stools.

It is recommended to express antenatally by hand rather than use an electric or manual breast pump. If you hand express and use a syringe to draw up the individual drips of colostrum, you can use these syringes for storage prior to birth. You can pick up sterile syringes from most pharmacies or Amazon. We have a useful video on colostrum harvesting on our website resource page: https://privatemidwives.com/resource-library/

Storage of human breast milk

Colostrum can be collected two to three times each day in the same syringe. You will need to store the syringe in the fridge between uses. At the end of the collecting day, the colostrum can be frozen – place the syringe into a zip-lock bag before putting into the freezer. Label the syringe and bag (separately) with the date and time of when you expressed. The frozen colostrum can be stored for up to six months in the freezer. Once thawed, it should be used within 24 hours.

SIGNS OF LABOUR:

- SHOW- This is a jelly like substance that may or may not be discharged from the cervix before or during labour. It is often clear and mucous like. It can have red, pink or brown streaks in it. It's a good idea to tell you midwife if you have a "show" and if you are worried, don't be a fraid to take a photo so she can see what it looks like.
- BACK ACHE – Often occurs around the lower back and sacrum. It can be felt acutely in one place, or across the entire back. It can be continuous but usually occurs in waves.
- BOWEL MOVEMENTS – Some women experience loose or frequent opening of their bowels just before or during the early part of labour. This is entirely normal.

- NESTING – Some women will get the urge to nest just before labour. This can mean different things to different people but can often include cleaning, tidying and getting things prepared. It is often noted if it is an unusual activity at an unusual time for you.
- LOWER ABDOMINAL CRAMPS- These can feel like dull ache period type pain and again often start mildly and then build in intensity they can also come in waves.
- SURGES/CONTRACTIONS **–** These are caused by the muscles of the uterus working together. The long muscles of the uterus work by pulling and drawing upwards and the lower "round" muscles release and relax. Whilst the upper muscles are doing the work it is often felt lower in the abdomen.
  These come in waves and usually start slowly and are uncoordinated, coming closer together and then further apart. They can be short and then long and some are stronger than others. They then build up in their frequency, intensity and duration. Generally for first pregnancy's/births - 3 surges/contractions in 10 mins, lasting 45-60 seconds in length and requiring all of your attention, sustained for at least an hour will suggest this is definitely labour. For second and subsequent labours and births it's a little less, looking for 2 surges/contractions in 10 mins, lasting 30-45 seconds in length, sustained for 30-40 mins. These are general schools of thought and do not always apply to every woman or every labour. Contact your midwife when you feel it is the right time.
- WATERS RELEASING**-** Up to 1:5 labours start with the waters releasing. These can be very dramatic and release in a gush of fluid or can be less obvious and leak in small bursts as you move about. If you think this has happened put on a pad and let your midwife know. Colour is important. Clear/Straw/Pinkish is OK. Bright Red/Green/Brown is not and this could be bleeding, or meconium and you should call your midwife if you think this has happened.
  If your waters release you will quite often go into labour within the next 24hrs. If your waters have released it is important to monitor baby's movements and inform us if you have any concerns. If labour doesn't commence within 24hrs, there is a small increased risk of infection and it is recommended to also monitor your temperature 4 hourly. At this point most hospitals will advise your labour is induced, but this is your choice. You can discuss this with your midwife and if induction is not right for you, she will help you plan for the next few days.

ASSESSMENT DURING LABOUR:

Your midwife will offer a full holistic assessment when she arrives to care for you and then typically every 4hrs or so. This involved:

- A review of your history and any factors of note
- A review of environmental factors – the temperature, pool water temperature, environment in the home.
- Assessment of your emotional and psychological well being
- Behavioural cues that may indicate progress, abnormality, contentment, coping, etc
- Palpation – height of fundus (uterus), lie of baby, presentation, position, descent
- Monitor uterine activity (contractions): frequency, duration and strength of contractions.
- Temperature, pulse, blood pressure – (if concerned add respiration rate and/or capillary refill time).

- Fetal heart rate (FH). This is normally the midwife listening to baby periodically, using a plastic trumpet called a pinnards, or a fetoscope or a sonicaid. She is listening for the rate and the pattern.
- Vaginal examination: Can be offered every 4 hours. If undertaken, vaginal examination should aim to establish cervical position, length, consistency, dilatation, the presenting part, position of baby, application of cervix to presenting part, presence or absence of membranes, position of landmarks on baby's head, rotation or baby's head, descent of baby and any vaginal loss – blood, liquor, meconium, show. When a vaginal examination is offered to you, it is not just about how dilated your cervix is – the midwife is skilled at gaining a lot more information that this. This information can then help her to plan how best to support you over the next few hours.
- Fluid balance and urinalysis 4-8hrly
- Review of any identified specific risk factors

In between this full holistic assessment your midwife will still be monitoring you and baby to check all is well.

POSTURE AND POSITIONS **–** you will be encouraged to mobilise and arrange the environment to your taste and how you feel, e.g., move furniture, and use of bean bags, mattresses, birth balls etc.

EATING AND DRINKING:

It is SO IMPORTANT to eat and drink well and regularly from very early on in the labour. Ideally high carbohydrate and high protein foods.
Easy to prepare, easy to eat, easy to digest, and nothing too spicy or greasy are good things to keep in mind, just in case, as you may feel nauseous and may vomit during labour.

- PROTEINS**-** Greek yogurt, nut butter, protein shakes, and cheese will all go down easy and offer your body the protein it needs to help you through labour.
- COMPLEX CARBOHYDRATES **-** Multigrain bread or crackers, whole-wheat pasta, brown rice, and oatmeal are good sources of fibre and offer carbohydrates that will provide energy during a long labour. These can often be combined with your protein source and create a nutritious meal. An early labour task might be to cook up a big pot of chicken noodle soup/Pot of pasta, that will be available later when you are working hard.
- OTHER FOODS**-** Assorted berries, grapes, melons, and the "easy on your stomach' banana are good fruits to have on hand. Some women even find freezing berries, grapes, and other grab and go fruit makes for a soothing, cool treat when you are working hard. A smoothie is another way to consume the fruit and you could add protein powder for additional energy.
- DRINKS**-** It is important to stay WELL HYDRATED throughout. Water is good, also Coconut water provides you with the important electrolytes you need, or any other fluids with additional electrolytes in it are good. Putting your drink into a sports water bottle with a straw function makes them easy to drink no matter what position you are labouring in.

PAIN RELIEF:

HOT WATER BOTTLE- Easy to apply where needed, no contra-indications.

MASSAGE/AROMATHERAPY- Massage especially done well can be great to help in releasing positive endorphins and displace discomfort. Good firm pressure applied to the sacrum/ lower back and hips are often welcomed.
Ensure you consult an aromatherapist to check for any contraindications to particular scents/oils. Some are not safe to be used in labour.

SHOWER OR BATH – The warm water may provide some rest and relaxation. With a shower you can use the handheld attachment to direct the jets where required. You can use a small stool to sit in shower. Keep water clean and clear, best not to add anything to it, especially if your waters have released.

BIRTH/ YOGA BALL- Ensure you have the right size ball. Your knees should be IN LINE or JUST BELOW hip level. When on the ball rock side to side, forwards and backwards and in figure of 8 movements. You can also use this to lean on/over when kneeling

REBOZO – This is a beautiful, long, woven piece of fabric. It can be used to apply pressure to your hips/pelvis that can help relieve discomfort and help labour to progress.

DANCING – Any way you want to, to whatever music works well for you and encourages positive endorphins and high oxytocin levels.

TENS – TENS (Transcutaneous Electrical Nerve Stimulation) is a device that emits low-voltage currents, and which has been used for pain relief in labour. The electrical pulses are thought to stimulate nerve pathways in the spinal cord which block the transmission of pain. In labour the electrodes from the TENS machine are usually attached to the lower and upper back – approximately around the knicker line and Bra line and sit one either side of the spine (and you control the electrical currents using a hand-held device).
It is advisable to use early on in labour before the contractions/surges build up and become stronger and co-ordinated. It is NOT ADVISABLE to use in water. You can purchase a TENS machine from Private Midwives if you wish.

BIRTH POOL – Similar to bath and showers the warm water can help to relax, soothe & comfort you. Being supported by the water allows you to move freely and explore different positions. Being upright in the water helps to facilitate gravity which in turn enables the baby to move down towards the birth canal. Water can lower your blood pressure and reduce feelings of anxiety, making your body more able to release endorphins, which can help to ease pain. The water can help with back pain and the feeling of pressure when you are nearing the end of the first stage of labour. Being in water during labour & birth can be a “cosy” experience giving you a sense of feeling safe. Finally, water can help the perineum stretch gently as the baby is being born, reducing the chance of injury.

ENTONOX- This is a mixture of oxygen and nitrous oxide gas. Gas and air will not remove all the pain, but it can help reduce it and make it more bearable. Many women like it because it's easy to use and they control it themselves. You breathe in the gas and air through a mask or mouthpiece, which you hold yourself. The gas takes about 15-20 seconds to work. You breath it in via a tubing and mouthpiece connected to the tank. It works best if you take slow, deep breaths. **Side effects -** there are no harmful side effects for you or the baby, it can make you feel lightheaded, some women find that it makes them feel sick, sleepy or unable to concentrate – if this happens, you can stop using it. Within a minute or two it will have left your system.

PETHIDINE/DIAMORPHINE – Not available at home. It is an injection given in the thigh or buttocks. It is an Opioid and it crosses the placenta which can cause baby to be sleepy after birth, can delay breast feeding, and baby may need support following birth to breath. It takes about 20 minutes to become effective and lasts about 2-4 hours per dose given. Not ideal as a form of analgesia once in good established labour (usually after 7-8cm), and not recommended to be given if you are close to birthing your baby, but it can be a useful tool if long latent phase and you have not been able to rest/sleep or eaten well and are exhausted. It allows the muscles to relax and soften and can help with getting rest/sleep.

EPIDURAL - An epidural is a type of regional anaesthetic. It numbs the nerves that carry the pain impulses from the birth canal to the brain. It should not make you sick or drowsy. For most women, an epidural gives complete pain relief. However it's not always 100% effective in labour. The Obstetric Anaesthetists Association estimates that 1 in 10 women who have an epidural during labour need to use other methods of pain relief. An anaesthetist is the only person who can give an epidural, so it will only be available on Labour Ward.
How much you can move your legs with an epidural depends on the local anaesthetic used. Some hospitals offer "mobile" epidurals, meaning you can walk around.

It takes about 20 minutes to set up the epidural, and another 10-15 minutes for it to work. It does not always work perfectly at first and may need adjusting.

There are some side effects to be aware of:

- An epidural may make your legs feel heavy, depending on the local anaesthetic used.
- Your blood pressure can drop (hypotension), but this is rare because the fluid given through the drip in your arm helps to maintain good blood pressure.
- Epidurals can prolong the second stage of labour. If you can no longer feel your contractions, the midwife may have to tell you when to push. This means that forceps or a ventouse may be needed to help you birth your baby. Often with an instrumental birth you may need an episiotomy (discussed below)
- You are likely to find it difficult to pass urine as a result of the epidural, especially if the block is heavy and you are unable to move. If so, a small tube called a catheter may be put into your bladder and will stay there till after birth to keep your bladder empty.
- About 1 in 100 women gets a persistent headache after an epidural. If this happens, it can be treated.
- Your back might be a bit sore for a day or two, but epidurals do not cause long-term backache.

HOW YOU BIRTH YOUR BABY:

For all types of birth, there are some risks to the mother and the baby.

VAGINAL BIRTH

- **ADVANTAGES** For many women, a non-medicalised, vaginal birth gives them a sense of achievement and fulfilment. One of the benefits of having a vaginal birth is that it has a shorter hospital stay (if you haven't given birth at home) and recovery time. Women who have vaginal births avoid having major surgery and its associated risks,

such as severe bleeding, scarring, infections, blood clots, reactions to anaesthesia and longer-lasting pain. Normally, your birth is less medicalised and calmer. You have less medication in your system and can initiate breast feeding sooner. The muscles involved in the process are more likely to squeeze out fluid found in baby's lungs, which is beneficial because it makes babies less likely to suffer breathing problems at birth. Babies born vaginally also receive an early dose of good bacteria as they travel through their mother's birth canal, which may boost their immune systems and protect their intestinal tracts.

- **DISADVANTAGES** Going through labour and having a vaginal birth can be a long process that can be physical and is hard work for the mother. During a vaginal birth, there is a risk that the skin and tissues around the vagina can stretch and tear as baby moves through the birth canal. If stretching and tearing is severe, a woman may need stitches. In a small number of cases, longer term problems with incontinence can occur. There is a risk to the baby of shoulder dystocia that is not present for caesarean section.

WATERBIRTH - Water Birth is the process of giving birth in water using a deep bath or birthing pool. Babies do not need to breathe when they are first born. In the uterus they get their oxygen from the blood that comes via the umbilical cord through the placenta. When a baby is born into water, they behave as if they were still in the womb, and continue to get oxygen via the umbilical cord until they take their first breath of air. It is at this point that their lungs open up. Your baby is only at risk if their head is brought out of the water and then goes back under, there is a sudden change in temperature or the blood from the placenta is affected.
The pool is about the size of an average dining room table. It comes with an air pump and a water pump. We can advise on where to put it, how to inflate it and how to fill it.
Please consider possible water damage as we cannot be responsible for this. We advise against using a pool that has been used by someone else previously due to infection risks.
Please see our leaflet on water birth for more details: https://privatemidwives.com/resource-library/

VBAC – Vaginal Birth After Caesarean- There is a general consensus amongst professional bodies that planned VBAC is clinically safe for the vast majority of women with success rates 72-75%, increasing to 85-90% if there has also been one vaginal birth. However, these recommendations do advise a birth in an obstetric unit with intravenous access and continuous electronic fetal monitoring due to the very small risk of uterine rupture. Approximately 0.5% risk of uterine scars rupture. If this occurs, it is associated with maternal morbidity and fetal morbidity/mortality. The risk of maternal death with planned VBAC is 4/100000. When considering a VBAC it is important to think about why you had a caesarean section in the past, what the chances are of this happening again and how that may be avoided. We are happy to share our VABC policy will all of our VBAC clients and discuss this with you in greater detail.

INSTRUMENTAL BIRTH - An assisted birth (also known as an instrumental delivery/birth) is when forceps or a ventouse suction cup are used to help you to birth your baby.
Assisted birth is less common in women who've had a spontaneous vaginal birth before.
Your obstetrician or midwife should discuss with you the reasons for recommending an assisted birth, the choice of instrument and how it will be carried out. Your consent will be needed before the procedure can be carried out.
You'll usually be given a local anaesthetic to numb your vagina and the skin between your vagina and anus (perineum) if you have not already had an epidural.

It is likely a cut (episiotomy) will be needed to make the vaginal opening bigger. Any tear or cut will

be repaired with stitches. Depending on the circumstances, your baby can be placed on your tummy, and your birth partner may still be able to cut the cord if they want to.

- **Ventouse** -A ventouse (vacuum cup) is attached to the baby's head by suction. The cup fits firmly on to your baby's head. During a contraction and with the help of your pushing, the obstetrician should gently pull to help you birth your baby.
  If you need an assisted birth and you are giving birth at less than 36 weeks pregnant, then forceps may be recommended over ventouse. This is because forceps are less likely to cause damage to your baby's head, which is softer at this point in your pregnancy.
- **Forceps -** Forceps are smooth metal instruments that look like large spoons or tongs. They're curved to fit around the baby's head. The forceps are carefully positioned around your baby's head and joined together at the handles. With a contraction and your pushing, an obstetrician gently pulls to help you birth your baby.
  There are different types of forceps. Some are specifically designed to turn the baby to the right position to be born, such as if your baby is lying facing upwards (occipito-posterior position) or to one side (occipito-lateral position).

An assisted birth is used in about 1 in 8 births, and may be needed if:

- you have been advised not to try to push out your baby because of an underlying health condition (such as having very high blood pressure).
- there are concerns about your baby's heart rate.
- your baby is in a non optimal position.
- your baby is getting tired and there are concerns that they may be in distress.
- you're having a vaginal birth of a premature baby – forceps can help protect your baby's head from your perineum.

A children's doctor (paediatrician) is usually present to check your baby's condition after the birth. After the birth you may be given antibiotics to reduce your chance of getting an infection.

These are some risks associated with assisted birth.

- Vaginal tearing or episiotomy - This will be repaired with dissolvable stitches.
- 3rd or 4th degree vaginal tear -There's a higher chance of having a vaginal tear that involves the muscle or wall of the anus or rectum, known as a 3rd- or 4th-degree tear. This kind of tear affects:3 in every 100 women having a vaginal birth/4 in every 100 women having a ventouse birth, 8 to 12 in every 100 women having a forceps birth.
- Higher risk of blood clots - After an assisted birth, there's a higher chance of blood clots forming in the veins in your legs or pelvis. You can help prevent this by moving around as much as you can after the birth. You may also be advised to wear special anti-clot stockings and have injections of heparin, which makes the blood less likely to clot.
- Urinary incontinence - Urinary incontinence (leaking wee) is not unusual after childbirth. It's more common after a ventouse or forceps birth. You should be offered physiotherapy to help prevent this happening, including advice on pelvic floor exercises.
- Anal incontinence -Anal incontinence (involuntary farting or leaking poo) can happen after birth, particularly if there's been a 3rd or 4th degree tear. Because there's a higher risk of these tears happening with an assisted birth, anal incontinence is more likely.

The risks to your baby include:

- a mark on your baby's head (chignon) being made by the ventouse cup – this usually disappears within 48 hours
- a bruise on your baby's head (cephalohaematoma) – this happens to around 1 to 12 of all 100 babies during a ventouse assisted birth – the bruise is usually nothing to worry about and should disappear with time
- marks from forceps on your baby's face – these usually disappear within 48 hours
- small cuts on your baby's face or scalp – these affect 1 in 10 babies born using assisted birth and heal quickly
- yellowing of your baby's skin and eyes – this is known as jaundice, and should pass in a few days

You may sometimes need a small tube that drains your bladder (a catheter) for up to 24 hours. You're more likely to need this if you've had an epidural as you may not have fully regained sensation in your bladder and therefore do not know when it's full.

CAESAREAN - A caesarean section, or C-section, is an operation to birth your baby abdominally via a cut in your tummy and uterus. The cut is usually made across your tummy, just below your bikini line.

A caesarean is a major operation that carries a number of risks, so it's usually only done if it is deemed the safest option for you and your baby.
Around 1 in 4 pregnant women in the UK has a caesarean birth.
A caesarean may be recommended as a planned (elective) procedure or unplanned if there are complication in labour or done in an emergency if it's thought a vaginal birth is too risky.
Planned caesareans are usually done from the 39th week of pregnancy. If there's time to plan the procedure, your midwife or obstetrician will discuss the benefits and risks of a caesarean compared with a vaginal birth.

A caesarean may be carried out because:

- your baby is in the breech position (bottom or feet first) and your doctor or midwife has been unable to turn them by applying gentle pressure to your tummy, or you'd prefer they did not try this.
- you have a low-lying placenta (placenta praevia)
- you have pregnancy-related high blood pressure (pre-eclampsia)
- you have certain infections, such as a first genital herpes infection occurring late in pregnancy or untreated HIV
- your baby is not getting enough oxygen and nutrients – sometimes this may mean the baby needs to be born immediately
- your labour is not progressing or there's excessive vaginal bleeding
- you or your baby are not very well during labour and a caesarean section is a safer option for you

Most caesareans are carried out under spinal or epidural anaesthetic. This mean you'll be awake, but the lower part of your body is numbed so you will not feel any pain.
Recovering from a caesarean usually takes longer than recovering from a vaginal birth. The average stay in hospital after a caesarean is around 3 or 4 days, compared with an average of 1 or 2 days for a vaginal birth. This may be shorted dependant on the hospital you give birth at. You may experience some discomfort in your tummy for the first few days. You should be offered painkillers to help with this.

It is advisable to avoid some activities, such as driving, until you have had your postnatal

check-up with the doctor at 6 weeks.
The wound in your tummy will eventually form a scar. This may be obvious at first, but it should fade with time and will often be hidden in your pubic hair.
A caesarean is generally a very safe procedure, but like any type of surgery it carries a certain amount of risk. It's important to be aware of the possible complications, particularly if you're considering having a caesarean for non-medical reasons.
Possible complications include:

- Infection of the wound or uterine lining
- blood clots
- excessive bleeding
- damage to nearby areas, such as the bladder or the tubes that connect the kidneys and bladder
- temporary breathing difficulties in your baby
- accidentally cutting your baby when your womb is opened

If you have a baby by caesarean, it does not necessarily mean that any babies you have in the future will also have to be born this way. Most women who have had a caesarean section can safely have a vaginal birth for their next baby, known as vaginal birth after caesarean (VBAC). Some women may be advised to have another caesarean if they have another baby, this depends on whether a caesarean is still the safest option for them and their baby.

BREECH BIRTH- 3-4% of babies are breech at term, with around a third of those being undiagnosed at the start of their labour. For babies presenting in advanced labour as breech, vaginal breech birth is not contraindicated and there are no benefits to be had from an emergency caesarean section. However, home birth is not asvised for unplanned breech birth. If your midwife finds baby is breech when you are in labour at home, she will advise immediate transfer to hospital unless birth is imminent. National recommendations and most breech birth practitioners would recommend birth in a supportive hospital environment, so that additional facilities are quickly available. National guidelines recommend continuous electronic fetal heart monitoring (EFM). This cannot be offered at home.
During antenatal care, if breech presentation is detected from 36 weeks onwards, there should be a full discussion regarding birth choice, including: elective caesarean section, a medically managed vaginal birth or a physiological breech birth
Ultrasound scans (USS) – can provide helpful information for a woman choosing how to have her baby. In particular, position, attitude of the head, liquor volume, fetal growth and fetal Biometry.

3rd STAGE- AFTER THE BIRTH OF YOUR BABY:

PERINEUM- Sometimes a woman's perineum may tear as their baby is born, in some births an episiotomy may be suggested. Suturing of perineal trauma can assist in preventing infection, control bleeding and assist the wound to heal.
Types of tears:

- First Degree -Involving skin only
- Second Degree - Involves skin and perineal muscle.
- Third Degree and Fourth Degree: involve injury to the anal sphincter complex. It is essential they are prepared by an experienced doctor in a surgical environment.

Perineal Massage

Perineal massage is a way of preparing the tissue of the perineum, the area between the vagina and the anus, for the stretching which happens during childbirth.
There is some evidence that perineal massage helps the perineal tissues to stretch and therefore helps to reduce both tearing and episiotomies, as well as reducing the stinging sensation when the largest part of baby's head is being born -crowning.

Perineal massage is most effective if practised from around week 34 for between five and ten minutes at a time. This should NOT HURT so if it does stop and discuss with your Midwife.

How do you do it?
This is best performed in a warm, comfortable environment and privacy. Use a natural massage oil. Don't use any petroleum-based products for perineal massage. If doing the massage yourself you can use a mirror, at least for the first few times to familiarise yourself with the perineal area. A hand-held mirror can be more trouble than it's worth, a large mirror may be easiest.

1. Whoever is giving the massage should wash their hands and nails.

2. Sitting with your legs comfortably apart, massage a little oil into the outside of the perineum and on your fingers and thumbs.

3. Insert your thumbs about half a thumb length into your vaginal canal and apply pressure to the perineum (the area between the vagina and anus). If your partner is doing the massage, they should use their index fingers. Stretch the perineum until you feel a slight stinging/pulling sensation. When you feel that sensation hold the stretch for about a minute. Try to ensure your mouth and jaw are relaxed while you are doing the massage.

4. Circle your thumb to massage the oil into the tissues down to the base of the vagina, gently pulling the tissues forward and back then to the sides of the vagina, moving thumb in a 'u' shape. Again, you should stretch enough to feel a slight stinging/pulling sensation, without inflicting pain on yourself. Gently pull the tissues of the sides of the vagina downwards in imitation of how your baby's head will pull on the tissue during birth. Do this about half-way up the sides of the vagina.
DO NOT pull, rub, stretch or put pressure on the urethra at the top.

Remember that the massage should be gentle and not abrasive or vigorous. Initially you probably won't be able to stretch the tissues very far before the stinging sensation kicks in, but the point of the massage is that with repetition you'll be able to stretch more and more. A bath before-hand helps the blood vessels to expand, soften and relax ready for the massage, others may find the massage itself relaxing, particularly as they become more adept at it.

And don't forget….

To make the most of perineal massage, team it with your regular pelvic floor exercises to increase tone and control of your pelvic floor muscles. If you have good control of your pelvic floor muscles then consciously relax them as you perform the massage.

3rd STAGE

There are 2 options for birthing your placenta.

1- **Active management** - involves administration of a prophylactic uterotonic drug close to the time of birth, clamping and cutting of the umbilical cord and controlled cord traction to expedite the third stage.

This should be completed within 30 minutes of birth. If not completed within this timeframe, consider holistic approaches, empty bladder, sit on w.c. breastfeeding, document a plan of care and inform the local Unit and the on-call midwifery manager. An ambulance transfer is always indicated for retained placenta.

2- **Physiological management** - requires no uterotonic drug administration, no cord clamping until the birth of the placenta and no cord traction, with the placenta being born by maternal effort. This should be completed within 60 minutes of birth. Consider holistic approaches as above.

Optimal or delayed cord clamping is recommended.

- Delayed cord clamping is the name typically given to a practice of waiting before clamping the baby's umbilical cord at birth. It is recommended by many international bodies including The World Health Organisation, ACOG, RCOG and NICE. There is a huge amount of research that recommends delayed cord clamping, for all babies and particularly preterm neonates. The timing of the delay in clamping and cutting the umbilical cord varies from 1 - 5 minutes, with longer times providing the most advantage to the newborn. Delayed cord clamping can also be called deferred cord clamping.

- Optimal cord clamping is the term used when the umbilical cord vessels are allowed to close naturally, until the cord stops pulsating and becomes white before it is clamped and cut. This often takes much longer than 5 minutes. Again there is no set time definition, some cords complete the blood transfer quickly, others continue to pulse for up to an hour. The hashtag #waitforwhite is often used to describe this process. Optimal cord clamping has the greatest advantages to the newborn. Optimal cord clamping allows all baby's circulating iron, oxygen and stem cell rich blood to move from the placenta to the baby. Baby makes a gentle cardio-pulmonary transition at birth and the mother baby unit is protected, enabling the benefits of skin to skin contact and initiation of breastfeeding if the woman chooses.

Skin to skin contact is also recommended.

REASONS TO TRANSFER TO OBSTETRIC LED CARE

The decision to transfer to obstetric led care is based on holistic assessment and clinical judgement. In some cases, it may be safer to remain at home or in the birth centre– particularly if birth is imminent.
However, the following check list is a guide to the decision-making process.
If any of the list below are present transfer to an obstetric led unit should be recommended.

Observations of the woman:

- pulse over 120 beats/minute on 2 occasions 30 minutes apart
- Raised blood pressure (diastolic blood pressure of 110 mmHg or more, or raised systolic blood pressure of 160 mmHg or more)
- 2+ of protein on urinalysis
- Temperature of above 38°C or below 36°C, not resolved by adjustment to environmental factors (e.g. cooling pool temp)
- Any vaginal blood loss other than a show, before or whilst in labour
- The presence of significant meconium
- Pain reported by the woman that differs from the pain normally associated with contractions
- Confirmed delay in the first or second stage of labour
- Request by the woman for additional pain relief using regional analgesia
- Third-degree or fourth-degree tear or other complicated perineal trauma that needs suturing.

Obstetric emergencies

These may occur at home or in a hospital setting. These are not normal pregnancy and birth events and require immediate action by the midwives. You will at this point need to listen to the midwives and follow their instructions quickly and calmly. **In all cases immediate transfer to an Obstetric Led Unit (Labour Ward) as quick as possible, will be required**. Your Midwives will give your partner an instruction card detailing what to do and say. Below, we have provided some additional information on how your midwife may handle these situations at home.

- Antepartum haemorrhage – Bleeding before birth

  Your midwife will try to find the cause and may insert a drip in your arm.

- Cord prolapse – When the cord comes out before the baby.

  Your midwife may ask you to adopt a hands and knees position with your head down. This is to take the pressure off baby's head. She may need to use her fingers to push baby's head off the cord.

- Postpartum haemorrhage – Bleeding after birth. There are several possible reasons for this. It is important to work out why you are bleeding and where the blood is coming from. Your midwife may advise an injection, a drip or a catheter to reduce the blood loss. Pads and sheets will be weighed afterwards to work out how much you have bled.

- Shoulder Dystocia – This is where the head of baby is born but the shoulders or body get stuck on the pelvis or sacrum. This is a problem as baby can't breath. Your midwife will turn you in a different positions and use her skills and training to help get baby out.
- Breech Presentation – This is when the bottom is coming first (this is only considered an emergency if this is unexpected and unplanned)
- Abnormal lie or presentation. This includes cord presentation or a high head that is not moving down.
- Maternal seizure or collapse.
- a need for Advanced neonatal resuscitation.
- Retained placenta. If the placenta is not delivered within 60 minutes your midwife will try a few techniques to help and if these don't work she may advise transfer to hospital as there is a risk of bleeding.
- Fetal heart rate below 110 or above 160 beats/minute baseline, or an abnormal pattern such as a deceleration in fetal heart rate heard on intermittent auscultation (may not indicate need for transfer if early deceleration as birth imminent) or Brady cardia (a prolonged deceleration which is slow to recover.

In all emergency situations, your midwife will act promptly and firmly to safeguard you and baby. Her priority is your well-being. She may not have time to exlain things in great details, or ask permission gently. Her tone of voice may change and she will speak firmly and clearly. For this reason, in all cases of planned home birth, we advise a thorough discussion of these topics as part of your antenatal care.

BBA – BORN BEFORE ARRIVAL

Whilst an unplanned birth at home or a baby arriving before the midwives at a homebirth may seem frightening, the most important thing to remember is to try and stay calm. Focus on your breathing. Remember, women are made to have babies and your body knows what to do.

Call the emergency services. Phone the emergency number - **dial 999**.
Give your name, address and phone number.
Tell the operator how many weeks pregnant you/your partner is, and that your baby is coming quickly, so an ambulance can be sent.
If you can, let the operator know the length of your contractions and the intervals between them.
Put her on speakerphone so she can talk you or your birth partner through your baby's birth.

Call Us- Say "Babys coming" or "I've called an Ambulance" we will then drop everything and head to you.

Make sure you have someone with you. If you're on your own, call someone nearby who can come over as soon as possible. Anyone is better than no one. If you are in the pool or a bath please get out.

Make sure your door is unlocked. So that help can get in easily.

Put the heating on. Your baby will need to be kept warm once they are born, so it's important to make sure the room you give birth in is warm and cosy. Close any open windows and doors to prevent draughts.

Get ready. If possible, try to gather the items you'll need for the birth, such as:

- Large clean towels to dry and cover your baby.
- Blankets and hat to keep them warm.
- If you can: Bin liners or a large plastic tablecloth to protect your bed or carpet. Lay these down first and then cover with a sheet.
- A large bowl, or plastic bag without holes, to put the placenta in.

What if I feel the urge to push?

<u>If you are in a birthing pool or the bath, please get out.</u>

Lie on your left side, or get on all fours and bring your chest down to the floor. Your face should be near the floor, and your bottom in the air. This may ease the urge to push.

Try panting in three quick pants and a long blow. This may delay your baby's arrival for a few minutes if you're waiting for help to arrive.

If you still feel the urge to push, then go with it. It can be frightening to feel that your baby is coming in a way that you didn't plan, but your body was built for this, and help is on the way.

Bring your bottom nearer to the floor and put a folded towel or cushion beneath you to give your baby a soft landing. If there's someone with you, they can help to support your baby's body as they are being born.

Try to stay calm, and follow these instructions or ask your birth partner to.

When your baby's head is born, check if there's a loop of cord round his neck. If there is, gently slip your fingers under the cord and ease it over his head. Only do this if the cord is loose enough to do so without snapping. If the cord is too short or tight, leave it alone and don't pull on it. You can deal with it after your baby is born.

Don't pull your baby's head to help them come out. **Wait** for the body to be born with the next contraction.

Babies are slippery immediately after the birth so try to get a firm hold when handling your newborn. If the umbilical cord is short, be gentle when lifting baby to your chest.

It's really important that your baby stays attached to the cord and placenta until help arrives, don't be tempted to cut the cord.

Most babies have a good heart rate after the birth and breathe on their own within a minute or so. Healthy babies often have a dusky blue tinge to their skin at first, have good muscle tone, and cry within a few minutes of birth. If this describes your baby, move on to getting them dry and warm.

Use a clean, dry towel to dry baby off, once dried remove the wet towel.

The cord should be long enough to bring your baby up to lie on to mums' stomach or chest - skin-to-skin. Placing baby against Mums breast so they can nuzzle, whether you're planning to breastfeed or not, will help your body to produce the hormone that helps the placenta be born.

Keep Mum and Baby warm and the close to each other. Drape large, clean towels/blankets over Mum and baby and help keep both, calm and to regulate breathing, heart rate and temperature.

Wait for Help.