

May 2021

Homebirth

Clinical guidance





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Introduction

As evidence relating to the benefits and safety of homebirth grows, this guidance provides practical advice for Victorian maternity and neonatal care providers to support, sustain and expand safe homebirth. While intended for midwifery, medical, nursing and allied health professionals, this guidance is also helpful for women and their families when considering if homebirth is suitable for them.

In Victoria there were 131 homebirths in 2000, increasing to 322 in 2018. There were 11 fewer public homebirths in 2019 compared to 2018.¹ However, the rate of homebirth in Victoria (0.5%) is low when compared to other countries like New Zealand (3.4%), the United Kingdom (2%) and Canada (2%).²

There are currently two publicly funded homebirth services offered in Victoria, but only a small number of births occur through these programs. Three quarters of all homebirths are under the care of privately practising midwives.

Key messages

- Homebirth is a safe option for some births.
- Homebirth provides more choice for women.
- Health services and private maternity providers are encouraged to consider homebirth services for women who are suitable.

Please note: This guidance consistently uses the terms ‘woman’, ‘she’, ‘mother’ and ‘maternity’. This is for clarity and is not intended to exclude pregnant people who do not identify as women.

Homebirth is a safe option for some births

The latest evidence, drawn from international and Australian studies, shows that offering homebirth as an option to women with low risk pregnancies is safe for the right woman, with the right providers, in an integrated system.^{3,4,5}

Maternity services should provide models of care that respond to the needs and preferences of their local communities. All childbearing women have a right to receive respectful care and protection of their autonomy and a right to self-determination.⁶

Robust leadership is also required within health services to ensure that these models are not only implemented but supported and maintained.

The evidence shows that women want continuity of carer – that is, the same people caring for a woman during pregnancy, as well as during and after the birth. There is also strong evidence to support this model. Clinical outcomes and satisfaction levels are better for women and their babies when care is provided by a known midwife, along with other clinicians such as obstetricians, neonatologists and general practitioners as clinically indicated.⁷

A strong relationship between a woman and the clinical team is central to providing a safe and high-quality homebirth. Homebirth is one way of providing an opportunity for continuity of care for women.

Homebirth provides choice for women

Women have the right to choose a planned place of birth suitable to them. Their rights and beliefs should be listened to and respected.⁴ A woman may choose homebirth for a number of reasons, for example:

- She may want to give birth in familiar surroundings where she feels more relaxed and comfortable.
- She may want more privacy, or the company of a support network including older children, friends, or extended family.
- Previously, she may have had a negative birth experience associated with her environment or processes.
- If now suitable for her, a homebirth may enable a greater sense of control and autonomy.

If you don't currently provide a homebirth service

Public and private maternity and neonatal services are encouraged to use this guidance to consider providing homebirth services and to develop continuity of care and carer models.

Maternity services and clinicians are responsible for ensuring all maternity care, including homebirth services, is evidence-based, safe and of high quality, and for ensuring:

- women are actively involved in decisions about their care
- the individual needs of the woman are met
- advice about assessment, management and guidance on escalation of care is consistent and practical.

Guidance for starting a public homebirth program is available in [Implementing a public home birth program: Guidance for Victorian public health services](#)

<<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/implementing-public-home-birth-program>>.

More information

Visit the [Better health channel](#) for further information about homebirth options in Victoria.

<<https://www.betterhealth.vic.gov.au/health/servicesandsupport/homebirth>>

Peer review and consultation process

This guideline was developed by an expert working group of clinicians and consumer representatives. Peer review and public consultation with consideration of all submissions considered prior to publication.

What the evidence shows

In comparing planned homebirth to planned hospital birth for women identified as suitable for homebirth at the onset of labour, the evidence shows that:

- the rates of unassisted vaginal birth are higher
- the rates of intrapartum caesarean section and instrumental birth are lower
- the rates of postpartum haemorrhage and severe perineal trauma are lower
- the rates of Apgar score <7 at five minutes and admission to the neonatal nursery are similar
- women having their first baby (nulliparous) do not experience higher rates of adverse perinatal and maternal outcomes
- the rates of intrapartum and postpartum transfer are higher for nulliparous women compared to multiparous women planning a homebirth²
- the rates of stillbirth and neonatal death are similar.

Table 1: Selected outcomes at the onset of labour, comparing planned homebirth of suitable women in Victoria, to planned hospital births. (2000–15)²

	Planned homebirth	Planned hospital birth
Unassisted vaginal birth	95% of births	70% of births
Epidural	3.2% of births	27.5% of births
Episiotomy	3% of births	21% of births
Instrumental birth	2.5% of births	17.5% of births
Caesarean birth	2.5% of births	12.5% of births
3rd/4th degree tear	1% of births	2% of births
Postpartum haemorrhage	9% of births	13% of births
Apgar <7 at 5 minutes	0.9% of births	1.2% of births
Stillbirth	0.62 per 1000 births	1.29 per 1000 births
Neonatal death	0.94 per 1000 births	0.37 per 1000 births
Perinatal (combined stillbirth and neonatal death) mortality	1.6 per 1000 births	1.7 per 1000 births

[Read a full summary and systematic review of the evidence.](#)

Assessing suitability for homebirth

Homebirth with a registered midwife is a safe choice for women who are deemed to be at low risk of complications during pregnancy, labour and birth and the postpartum period.

Individual assessment

Homebirth is a suitable option for women with all of the following:

- A low-risk pregnancy with no pre-existing or occurring medical conditions that may impact on the pregnancy, birth or postpartum period (maternal and fetal).
- Singleton pregnancy.
- At the onset of labour, baby is in the cephalic (head down) position.
- Term gestation (37+0 to 41+6 completed weeks' gestation).
- No previous caesarean section or uterine surgery.

Additional considerations

Women having their first birth have a higher rate of both intrapartum (34% vs 6%) and postpartum (8% vs 5%) transfer to hospital when compared to women who have had a baby before (multiparous).²

Indications for transfer include requests for further pain relief, progress less than expected, concern about maternal or fetal wellbeing, because the woman changes her mind, to assist in the completion of the third stage of labour and the need for perineal repair requiring resources not available in the home.

When to conduct an assessment

Assessing a woman's suitability for homebirth is an ongoing process. Suitability may change over the course of the pregnancy or during labour. Continuous risk assessment is important to assess ongoing suitability in line with the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral.⁹

Home environment assessment

Consideration and assessment of the suitability of the home environment should be undertaken. Providers should implement their own home visiting risk assessment process, according to local guidelines.

To ensure the safety of the mother, baby and the midwife, consider the following factors:

- Any possible risks such as dangerous animals, illicit drug use and domestic violence.
- If a birthing pool is used, access must be available from three sides (see [Water for labour and birth guidance](#)).
- Easy vehicle access, including parking, if required in an emergency.
- Access to clean running water and electricity.
- Reliable telecommunications – landline and/or mobile coverage.
- Suitable heating and lighting.

Who should care for women at home?

Discussing homebirth as an option

Health services and midwives have a responsibility to work in partnership with women to discuss birth choices. Her wishes should be listened to and respected.

Provide balanced, evidence-based, oral and written information for the woman, referring to current literature and statements from professional or government bodies about the risks and benefits of homebirth and whether it is the right option for her.

- [Better Health Channel](https://www.betterhealth.vic.gov.au/health/servicesandsupport/homebirth) <<https://www.betterhealth.vic.gov.au/health/servicesandsupport/homebirth>>
- ACM <<https://www.midwives.org.au/Web/News-media-releases/Articles/2019/03-March/Homebirthing-Statement.aspx?WebsiteKey=6a4b152d-a1fa-424a-a2ac-22524da4d52f>>
- [Royal Australian and New Zealand College of Obstetricians and Gynaecologists](https://ranzcoq.edu.au/wp-content/uploads/2022/05/Home-Births.pdf) <<https://ranzcoq.edu.au/wp-content/uploads/2022/05/Home-Births.pdf>>

Be clear on the services you can provide and communicate this clearly to women as early in pregnancy as possible.

Midwives

Midwives providing homebirth services may be employed through a public health service or are privately practising midwives.⁸ They should have appropriate skills and equipment to manage maternal and neonatal emergencies. They should also:

- be registered with the Australian Health Practitioner Regulation Agency (AHPRA) to provide midwifery care
- comply with health service policies, procedures and guidelines at their place of employment
- practise in accordance with the ACM National Midwifery Guidelines for Consultation and Referral
- work within the standards, codes, policies and guidelines issued by the Nursing and Midwifery Board of Australia (NMBA):
 - [Registration standards](http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx) <<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>>
 - [Professional standards](http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx) <<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>>
 - [Safety and quality guidelines for privately practising midwives](https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/fact-sheet-safety-and-quality-guidelines-for-privately-practising-midwives.aspx) <<https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/fact-sheet-safety-and-quality-guidelines-for-privately-practising-midwives.aspx>>

Other health practitioners

Medical practitioners should:

- be registered with AHPRA to care for a woman in labour and birth
- have current competency and skills in maternal and neonatal emergency management and resuscitation
- have appropriate professional indemnity insurance to cover the episode of care to be able to provide homebirth services.

It is also acknowledged that general practitioners may play an integral part in the care of women through pregnancy and beyond. It is important that the relationship a woman has with her GP is preserved and continues throughout.

Planning for a homebirth

Health services and maternity care providers have a responsibility to provide safe, evidence-based and appropriate options of care. When planning for a homebirth, please consider ongoing suitability assessments, the possibility of transfer to hospital, and local service capability.

Pregnancy care guidance

Maternity services/providers should provide care to women based on a risk management approach that establishes when advice, referral, or transfer of women is required. This should align with the [Capability Framework for Victorian Maternity and Newborn Services](https://www.health.vic.gov.au/sites/default/files/2022-12/Capability-frameworks-for-Victorian-maternity-and-newborn-services.pdf) <https://www.health.vic.gov.au/sites/default/files/2022-12/Capability-frameworks-for-Victorian-maternity-and-newborn-services.pdf> which may include policies and guidelines/Capability-framework-for-Victorian-maternity-and-newborn-services> which may include transfer to a maternity service further away from the woman's home, or in the case of a public homebirth program, to a higher level maternity service.

Pregnancy care for women planning a homebirth should be provided in accordance with the [National Pregnancy Care Guidelines](https://beta.health.gov.au/resources/pregnancy-care-guidelines) <https://beta.health.gov.au/resources/pregnancy-care-guidelines>. Homebirth services/providers may also have their own minimum set of requirements for pregnancy care and tests before a woman is assessed as suitable for a homebirth based on specific policies and clinical guidelines.

Pregnancy care, tests and investigations should be individualised and provided in partnership with the woman to ensure shared decision making.

Ongoing assessments

There should be ongoing homebirth suitability assessments and documented plan for care as per the [ACM Consultation and referral guideline](https://www.midwives.org.au/Web/Web/About-ACM/Guiding-Documents.aspx?hkey=5f46e7ad-8ffa-4abb-ad31-e127157eceb2) <https://www.midwives.org.au/Web/Web/About-ACM/Guiding-Documents.aspx?hkey=5f46e7ad-8ffa-4abb-ad31-e127157eceb2> as well as adhering to local health service guidelines.

Hospital transfer and admission

Consider the possibility of transfer to hospital, either during pregnancy, labour or after the birth of the baby for enhanced pain relief, medical support if interventions are required, or if complications arise.

Homebirth providers should develop a management plan/guideline outlining their response to transfers and admissions. This should consider:

- how far the woman will be from her nearest hospital and the time it may take to arrive during peak and non-peak times. The parameters for this may vary according to local policies. Clinical decisions may require consideration of the time it may take to transfer to hospital in view of varied traffic conditions
- travel in private vehicle versus emergency service (ambulance) vehicles
- capacity and potential provision of emergency ambulance transport (private health, pension/concession card or ambulance subscription).

Privately practising midwives should understand the local maternity services with appropriate level of capability (according to the Capability framework) should escalation of care be required.

Health services are expected to liaise with Ambulance Victoria (AV) and facilitate hospital to hospital transfer for escalation of care when required.

Private homebirth providers, health services and women are strongly encouraged to work in partnership and develop mutually respectful relationships. These will support the processes required for seamless transfers, if required.

Familiarisation

Consider offering the woman:

- a familiarisation hospital visit in the 3rd trimester
- a home visit at 36 weeks' gestation (or prior to consideration of planning a homebirth if the decision is made after 36 weeks) to carry out a risk assessment of the home and for midwives to familiarise themselves with the intended place of birth.

Individual services/providers may offer or require a 'booking in appointment', and/or hospital doctor visit at 35–36 weeks' gestation as per local guidelines, as a prerequisite for homebirth. Advise the woman of this possibility in early pregnancy.

Helping women plan for a homebirth

- Make sure the woman has contact details of more than one midwife, in case the primary midwife is unavailable/uncontactable.
- Ensure the woman knows how to contact the local maternity service/hospital that would provide care should escalation be required.
- Ensure the woman is aware of and understands the reasons why transfer to hospital care for clinical advice/risk factors may be necessary.

Labour and birth care at home

Requirements and attendance for homebirth

Two AHPRA registered health practitioners are required at all homebirths:

- One must be a midwife.
- The second registered health practitioner must be educated to provide maternal and newborn care, with the required current knowledge and skill in maternity and neonatal emergency management and resuscitation.⁸

Intrapartum care

For guidance on care from onset of labour, to birth of the placenta, follow SCV's [Labour and birth guideline](https://www.bettersaferecare.vic.gov.au/resources/clinical-guidance/maternity-e-handbook/care-during-labour-and-birth) <<https://www.bettersaferecare.vic.gov.au/resources/clinical-guidance/maternity-e-handbook/care-during-labour-and-birth>>

Recognition of clinical deterioration of the woman/baby and appropriate escalation and transportation is required, including discussion of management with the receiving hospital and arranging transportation by AV as appropriate.

Homebirth providers must also be aware of:

- prescription and supply/storage of medication (see **Appendix 1**)
- safe storage, handling and transport of oxygen and nitrous oxide cylinders
- [water for labour and birth guidance](#).

Care following birth

For guidance on care of the woman and newborn after birth, see SCV's [Labour and birth guideline](https://www.bettersaferecare.vic.gov.au/resources/clinical-guidance/maternity-e-handbook/care-during-labour-and-birth) <<https://www.bettersaferecare.vic.gov.au/resources/clinical-guidance/maternity-e-handbook/care-during-labour-and-birth>>

Recognition and stabilisation of the unwell woman or newborn at home and facilitation of appropriate transfer is required, including discussion of management with the receiving hospital and arranging transportation by AV.

Follow up

Offer newborn bloodspot screening and ensure transport of the specimen to the Victorian Clinical Genetic Services (VCGS).

Help organise Victorian Infant Hearing Screening (VIHSP) tests.

Ensure the documentation including Notice of Birth, Victorian Perinatal Data, discharge notification to Maternal Child Health Nurse Service and other birth information is completed and submitted as required (see **Appendix 2**).

Supporting a woman's choice

Throughout the pregnancy, intrapartum and postpartum period, there may be times when a woman makes decisions that are contrary to the advice of her midwife and are inconsistent with best practice guidelines. When it is not possible to reach an agreement, the woman must continue to receive respectful and supportive maternity care within the parameters of her consent. When providing care to a woman who has declined professional advice, the responsibility of the midwife is to:

- make recommendations to the woman that are consistent with best practice guidelines and/or the guidelines set by their health service and document these discussions
- clearly describe their scope of practice and any limitations
- work within the boundaries of their scope of practice, the national professional standards and guidelines as outlined by the Nursing and Midwifery Board of Australia (NMBA) and the ACM
- follow the processes for transfer of care consistent with expectations and guidance of professional bodies (such as ACM), statewide guidance and receiving health services
- make a timely decision about withdrawing or continuing care – this will be dependent on the situation if issues arise during labour or in urgent circumstances, 'the midwife is obliged to attend the woman'.⁹ However, 'the midwife's continued care does not mean she or he endorses the woman's decision to choose a pathway of care that carries increased risk of harm to either the woman or her baby'⁹
- consult with another midwife or medical practitioner and document this consultation and the outcomes
- maintain documentation of the decision-making process, the care provided and the ongoing plan for care.

The ACM 'Record of understanding form' <https://www.midwives.org.au/sites/default/files/uploaded-content/field_f_content_file/record_of_understanding.docx> can be used to document when a woman chooses care against the advice of the ACM Consultation and Referral Guidelines or her midwife.

The woman and her caregivers should document:

- The care that is being declined
- Reasons for declining. (which should demonstrate the woman's understanding of the situation)
- An agreed care plan if appropriate.

For more details see:

- When a woman chooses care outside the ACM National Midwifery Guidelines for Consultation and Referral <https://www.midwives.org.au/Web/Web/About-ACM/Guiding-Documents.aspx?hkey=5f46e7ad-8ffa-4abb-ad31-e127157eceb2>
- Birth at home Midwifery Practice Standards 2016 <<https://www.midwives.org.au/resources/australian-college-midwives-birth-home-midwifery-practice-standards>>
- ACM Transfer from Planned Birth at Home guidelines 2016 <https://www.midwives.org.au/common/Uploaded%20files/New%20Doc/Planned-Birth-at-Home-Position-Statement-2019.pdf>
- Partnering with the woman who declines recommended maternity care <<https://www.health.qld.gov.au/consent/html/pwdrmc>>

Consultation, referral and transfer

Homebirth providers should offer care to women based on a risk management approach that establishes when advice, referral, or transfer of the woman is required. Ongoing risk assessment is vital to ensure that the woman gives birth in the safest place for her and her baby. It is important that the woman is aware that the referral and or transfer is for assessment and/or ongoing care.

Between 12 and 35 per cent of low-risk women planning a homebirth will transfer to hospital either before or during labour or in the postpartum period. The rates of transfer for women having their first baby are higher than for women having a subsequent baby.²

A transfer from home to hospital is not an adverse outcome, nor is it a failure of the woman or her midwives. It is acknowledged that a transfer may be disappointing for some women.

Transfers from home to hospital may occur for several reasons including:

- change in risk status of the woman or her unborn baby
- at the request of the woman (e.g. for enhanced pain relief or change of mind about planned place of birth)
- due to a postpartum haemorrhage or retained placenta
- for severe perineal tear repair
- neonatal care requirements
- change in environmental conditions. (such as bushfires, extreme weather conditions, no electricity or water, road conditions).

Transfer for ongoing care and assessment

Pregnancy care consultation should align with consultation and referral guidelines for escalation of care for women.

- Refer to [National Midwifery Guidelines for Consultation and Referral - 3rd Edition Issue 2 \(2021\)](https://www.midwives.org.au/Web/Web/About-ACM/Guiding-Documents.aspx?hkey=5f46e7ad-8ffa-4abb-ad31-e127157eceb2)
<https://www.midwives.org.au/Web/Web/About-ACM/Guiding-Documents.aspx?hkey=5f46e7ad-8ffa-4abb-ad31-e127157eceb2>

Providers should have documented escalation processes in place.

Transfer from planned homebirth to hospital (intrapartum/immediate postpartum)

Transport arrangements should be appropriate to the level of assessed risk and clinical factors either by ambulance assistance or the woman's private vehicle.

Use the safest mode of transport based on local guidelines. As per the ACM Transfer from Planned Birth at home guidelines it is important to note that if the woman consents to transfer, the midwife makes recommendations to the woman as below.

For the woman

In the event of an emergency or if birth is imminent, the midwife should recommend transfer in an ambulance and arranges this accordingly.

If the transfer is not urgent, the midwife can recommend that the woman and her support team travel in their private car, with the midwife following.

For the newborn

If the parents' consent to transferring their newborn, the midwife calls the ambulance for immediate transfer (a newborn must always be transferred by ambulance, regardless of urgency) and the midwife provides clinical care in the interim. If the parents decline transfer of their newborn, the midwife determines the urgency and acts in accordance with 'process of transfer for the newborn', ACM Transfer from planned Birth at home guidelines.¹⁰

Early request for transition of care via emergency ambulance is critical.

Ambulance dispatch is determined during the call taking process.

MICA (Mobile Intensive Care Ambulance) dispatch will be dependent on the information provided during call taking.

It is recommended that a handover form for transfer from place of birth is used or local documentation process.

Consultation/clinical handover

If clinical consultation or transfer from home to hospital is required, clear and concise communication in the ISBAR format is required between the attending midwife/midwives and the hospital plus/minus ambulance service.

Using both an oral and written handover is important to reduce the risk of error and insure the fidelity of the information. Where possible, providing oral handover in the presence of the woman is considered best practice.

ISBAR is a standard mnemonic created to improve safety in the transfer of critical information which stands for:

Identify

Situation

Background

Assessment

Recommendation or request.

More information on transfer communication

[ISBAR - a standard mnemonic to improve clinical communication](https://www.sahealth.sa.gov.au/wps/wcm/connect/8a8b26804896068a9cb8fc7675638bd8/15111.3-Clinical+Handover+Fact+Sheet+%28V1%29WebS.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-8a8b26804896068a9cb8fc7675638bd8-mMAoVdq)

<<https://www.sahealth.sa.gov.au/wps/wcm/connect/8a8b26804896068a9cb8fc7675638bd8/15111.3-Clinical+Handover+Fact+Sheet+%28V1%29WebS.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-8a8b26804896068a9cb8fc7675638bd8-mMAoVdq>>

Roles and expectations

In order to ensure the transfer of care is as seamless as possible, the woman's health and wellbeing must remain at the centre of all professional interactions.

'Upon transfer into hospital, the midwife works within their scope of practice and professional boundaries. Each midwife's scope and boundaries are different depending on their individual context and circumstances. It is the responsibility of the midwife to know and work within their own professional boundaries when entering the hospital with a woman.'⁸

Antenatal transfer

Public homebirth program

Refer to local guidelines.

Private midwifery care

- Midwife to contact appropriate person/area of referral service to notify of intent to change planned place of birth. This may or may not include escalation and referral to the medical team, depending on the clinical scenario.
- Midwife to provide written referral and copy of the woman's pregnancy record.
- Maternity service to formally acknowledge receipt of referral and arrange ongoing management of pregnancy care.
- Maternity service to provide a discharge summary to the midwife on completion of care.

Intrapartum and postpartum transfer

Public homebirth program

- Refer to local guideline.
- Midwife to notify midwife-in-charge of birth suite of impending transfer.
- Midwife continues clinical care on arrival.

Private midwifery care with admitting rights

- Midwife to contact midwife-in-charge of birth suite to notify of impending transfer.
- Midwife to provide timely oral handover using ISBAR to midwife-in-charge and/or medical team on duty.
- Midwife continues clinical care with consultation/escalation to the medical team as required.
- Maternity service to accept transfer.
- Maternity service to acknowledge and respect the relationship between the midwife and the woman.
- Maternity service to acknowledge and respect the significant change in the woman's birthing environment and support the woman to have a positive birthing experience.

Private midwifery care without hospital admitting rights

- Midwife should contact the midwife-in-charge of birth suite to inform of the impending transfer.
- Midwife to provide a timely verbal handover using ISBAR to the receiving midwife and the medical team on duty.

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- Midwife to provide a summary of pregnancy and intrapartum care.
 - Midwife to formally hand clinical care of woman over to the receiving midwife.
 - Midwife to remain in a support capacity only.
 - Maternity service to accept transfer and handover of clinical care.
 - Maternity service to acknowledge and respect the relationship between the midwife and the woman.
 - Maternity service to acknowledge and respect the significant change in the woman's birthing environment and support the woman to have a positive birthing experience.
 - Reciprocal respect for the receiving maternity service to assume responsibility of care.
 - Maternity service to provide a discharge summary to midwife on completion of care.

Responsibility of paramedics

- Work with the midwife to ensure safe and effective care of the woman and/or her baby and efficient transfer.
- The paramedic will take the clinical lead and give direction for care if the presentation is not specifically related to the pregnancy or birth (for example cardiac arrest), with the homebirth midwives assisting.
- The paramedics will be considered the lead clinicians for advanced neonatal resuscitation requirements (for example intubation), within their scope of practice.

Useful tools

- [ACM Transfer from planned birth at home guidelines.](https://www.midwives.org.au/common/Uploaded%20files/New%20Doc/Planned-Birth-at-Home-Position-Statement-2019.pdf)
<https://www.midwives.org.au/common/Uploaded%20files/New%20Doc/Planned-Birth-at-Home-Position-Statement-2019.pdf>

Audit, reporting and performance improvement

All maternity services and care providers should have processes in place for:

- auditing clinical practice and outcomes
- providing feedback to clinicians on audit results
- addressing risks, if identified
- implementing change, if indicated.

Clinical outcome measures as per all maternity care and aligned with standard hospital birth including:

- adherence to standards of care
- 3rd and 4th degree tear rates
- caesarean section rates
- fetal growth restriction
- Apgar score less than 7 at five minutes
- breastfeeding rates
- PPH rates.

For all births in Victoria, whether at home or in hospital, data should be submitted to Victorian Perinatal Data Collection (VPDC). The VPDC collects and analyses detailed information on obstetric conditions, procedures and outcomes relating to every birth in Victoria.

Homebirth providers are encouraged to consider other audit measures such as:

- intrapartum/postpartum transfer from homebirth to hospital rates
- feedback from women and families regarding birthing services
- maternity care provider satisfaction.

Appendix 1

Medication considerations for homebirth equipment kit

Consideration should be given to medications required for management of pregnancy, labour, birth and post-natal and neonatal care, according to current guidelines.

Privately practising midwives

A privately practising midwife must be endorsed in order to prescribe medications for a woman and newborn under their care.

An endorsed midwife has met the requirements set out by the Nursing and Midwifery Board of Australia (NMBA) and is qualified to prescribe schedule 2, 3, 4 and 8 medicines and to provide associated services required for midwifery practice in accordance with relevant state and territory legislation. Authorisation for endorsed midwives to prescribe in Victoria is conferred through the Drugs, Poisons and Controlled Substances Amendment (Supply by Midwives) Act 2012.

Prescribing by endorsed midwives in Victoria is limited to prescribing medicines from the list of medicines approved by the Victorian Minister for Health. The list includes Schedule 2, 3, 4 and 8 medicines required for midwifery practice across pregnancy, labour, birth and postpartum and neonatal care. <<https://www2.health.vic.gov.au/public-health/drugs-and-poisons/scheduled-medicines>>

Midwives providing homebirth services through public hospitals

Endorsed midwives practising within organisations (including public hospitals) must also meet the internal organisational requirements for prescribers in addition to the requirements of the NMBA and those set out by the Victorian Government in the *Drugs, Poisons and Controlled Substances Amendment (Supply by Midwives) Act 2012*.

Registered midwives who are not endorsed to prescribe are authorised to possess Schedule 2, 3, 4 and 8 medicines necessary for administration to a woman and newborn under their care under the Drugs, Poisons and Controlled Substances Regulations 2017.

If registered midwives who are not endorsed to prescribe medication are providing homebirth services through public hospitals, any medications required for management of pregnancy, labour, birth and post-natal and neonatal care must be prescribed and supplied by authorised persons under the Drugs, Poisons and Controlled Substances Regulations 2017. Medications should be prescribed on an appropriate prescription for supply and also on an administration order to be used during birth.

Medication storage considerations in the home

How medications are stored in the home in the preparation for homebirth must be considered.

- All medication must be stored out of reach of children.
- Medications must be stored in the container they were supplied in.
- Where a medication is specified as 'Protect from light', it must be stored in an opaque container.
- Medications must not be mixed in the same container. This can make identification of medication difficult during an emergency.

Medication that does not require refrigeration

- These should be stored in one designated location, in a cool (below 25°C), dry place away from direct sunlight.
- Avoid storing medication in the kitchen and bathroom as significant heat and moisture can be generated in these rooms.

Medication that requires refrigeration in a home refrigerator

These should be:

- transported to the home in an insulated container and placed in the home refrigerator as soon as possible, particularly in summer months
- placed in the middle shelves of the refrigerator towards the back of the fridge – medication placed too far towards the back may freeze and medication placed in the door is at risk of temperature fluctuations each time the door is opened
- stored in a separate container, avoiding direct contact with food.

Midwives attending homebirths where medications have been stored within the home should inspect those medications on arrival for the birth, to ensure that they are suitable for use in an emergency.

Appendix 2

Births, Deaths and Marriages

Privately practising midwives are required to [register as a new stakeholder](https://partners.rio.bdm.vic.gov.au/login) <https://partners.rio.bdm.vic.gov.au/login> Log on and complete, save and submit a birth notification.

Ensure parents know how to [complete their requirements online](https://www.bdm.vic.gov.au/baby) <https://www.bdm.vic.gov.au/baby>

[Download brochures](https://partners.rio.bdm.vic.gov.au/contact-us) <https://partners.rio.bdm.vic.gov.au/contact-us>

MCHN notification– Local council

Within 48 hours of the birth [complete a notice of birth](https://www.education.vic.gov.au/Documents/childhood/professionals/support/birthnoticeform.pdf) <https://www.education.vic.gov.au/Documents/childhood/professionals/support/birthnoticeform.pdf> and submit to the CEO (MCHN) of [the local council where the woman usually resides](http://www.education.vic.gov.au/findaservice/Home.aspx) <http://www.education.vic.gov.au/findaservice/Home.aspx>

Child Health Record (green book)

Provide a copy to parents. Copies are available from mch@edumail.vic.gov.au

Centrelink/Medicare

Where one or both parents are eligible for Centrelink/Medicare, provide parents with a [Parent pack](http://www.humanservices.gov.au/customer/information/order#a4) <http://www.humanservices.gov.au/customer/information/order#a4>

Victorian Infant Hearing Screening Program (VIHSP)

[Locate the local screening service](https://www.rch.org.au/vihsp/contact_us/) <https://www.rch.org.au/vihsp/contact_us/> and provide mother or father's name and contact number, baby name, date of birth, weight, sex and gestation.

Victorian Perinatal Data Collection

Register by emailing hdss.helpdesk@health.vic.gov.au

Submit data via the Health Collect Portal <https://www.healthcollect.vic.gov.au/>

Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM)

All adverse events including maternal deaths, stillbirths and neonatal deaths must be reported to [CCOPMM](https://www.bettersafecare.vic.gov.au/about-us/about-scv/councils/ccopmm/reporting-to-ccopmm) <https://www.bettersafecare.vic.gov.au/about-us/about-scv/councils/ccopmm/reporting-to-ccopmm>. Privately practising midwives are required to participate in this process, in conjunction with any health service involved in the care and/or individually.

Safer Care Victoria sentinel event program

In Victoria, public and private health services and all services under their governance structure are required to report sentinel events.

Consider local clinical governance processes – i.e. M&M/VHIMS.

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