| **Midwifery Led Care** | | Barnsley Hospital NHS<br>NHS Foundation Trust | |
|---|---|---|---|
| Author: | Guideline group | Reference number: | |
| Issue Number | 2 | Authorisation date:<br>Reviewed:<br>Next review date: | 06/04<br>07/08<br>07/11 |

**Philosophy for Midwifery led care**

The philosophy for the midwives at Barnsley is that the woman and her family will be the focus and centre of our care.
They will be treated as individuals whose beliefs and views will be respected at all times. They are equal partners in the planning and delivery of their care and they will be given information, allowing them to make informed choices of the options available
This care will be research and evidence based, acknowledging pregnancy and childbirth are a normal yet unique experience for the woman and her family.

**Midwifery led care**
Pregnancy is a normal physiological process, whilst it is recognized that some women are more at risk of developing complications during pregnancy. Women will be selected for midwifery led care only if they meet the agreed criteria. Women should receive clear, unbiased advice and be able to choose where they would like their baby to be born (DOH 1993 p25 DOH 2007)

At present there is no evidence to support women who are in good health and who do not have complicated medical or obstetric history not being offered a home birth booking. GP care or midwifery led care (MIDIRS 1997 DOH 2004) Only the midwife is trained to practice normal midwifery, and can conduct and supervise the antenatal care of healthy women. (NMC, 2004) Rules and Standards

The BHNFT Trust Board has acknowledged the autonomous role of the midwife and the importance of offering choices of care to women. The Trust Board has endorsed the introduction of Midwifery Led Care for low risk women.

The Corporate Management Team of the Women's Service, including the Clinical Director and the Head of Midwifery has supported the implementation of Midwifery Led Care in September 2003.

This booklet provides a resource for midwives supporting women who choose Midwifery Led Care. The booklet provides the midwives with clear pathways and lines of responsibility. It also provides evidence based guidelines for use with low risk women. (RCM 2005).

With this model of care, the midwife who is expert in normal pregnancy, childbirth and postnatal care can now be the lead professional, maintaining

good liaison and referral links to medical colleagues and referring women when there are any deviations from normal. (RCM June 2002)

They are there to guide and support midwives providing care for women who are fit and well with no underlying pre-existing medical conditions. This model of care acknowledges the type of care that midwives have always provided, but in the past women could only book under a doctor either a GP or a consultant. Now women can book with a midwife for her antenatal care, intrapartum care and postnatal care.

**Objectives**

**Midwives**

- All midwives will have the opportunity to participate in Midwifery Led Care
- All midwives will have guidelines to support the practice of Midwifery Led Care
- Midwifery Led Care will be reviewed on a regular basis
- Midwives will ensure that they keep their own GPs informed of the progress of Midwifery Led Care
- Midwives will ensure that the woman's GP is notified of booking

**Woman and families**

- Women will have sufficient information to allow them to understand the concept of midwifery led care. See choice of place of birth leaflet. Care will be community focused
- Women, if they choose, will have an option to see a consultant obstetrician
- Women will feel sufficiently empowered and confident to enable them to be active participants in making choices and decision making. (DOH 2006)

We would like to acknowledge the RCM who compiled this document and allowed for its use in other midwifery units.
We would also like to acknowledge the help and support of all those midwives, doctors and users of the service who showed interest, discussed ideas and shared resources during the process of putting this document together.

This section is for midwives to refer to when caring for women who are low risk and booked for Midwifery Led Care, they are not meant to be prescriptive or used as procedures.
The full copy of these guidelines with references is available to all midwives and is kept in the central labour ward office and the Trust's internet site

**Associated guidelines**

| | |
|---|---|
| Guideline for booking a woman for Midwifery Led Care | BHNFT guidelines |
| Antenatal Care Pathway | |

| | |
|---|---|
| Handover of care guideline (transfer of care from Midwife to consultant) | BHNFT Labour Ward handbook |
| Admission and triage guideline | |
| Pre labour rupture of membranes at term | BHNFT labour ward handbook |
| Normal labour guideline | BHNFT LWH |
| Waterbirth guideline | BHNFT LWH |
| Early transfer home guideline | BHNFT postnatal guideline |
| Postnatal guidelines | BHNFT postnatal guidelines |

**Inclusion criteria for low risk midwifery led care pathway**

Giving birth is generally very safe both for mother and baby. In booking women for midwifery led care it is essential to assess their previous medical and obstetric history, physical and mental well being.

Generally healthy women having first, second, third or fourth babies at term with no identified complications, prior to, during or after labour are suitable for inclusion on the midwifery led care pathway.

Where a woman chooses the midwifery led care pathway but may have risk factors a midwife must inform her supervisor of midwives. If an obstetric opinion is sought either by the midwife or woman this should be obtained from a consultant obstetrician.

The following tables 1-4 indicate increased risk factors to be considered and discussed with women when advising on professional lead and choice of place of birth.

It is important that professional lead is clearly documented in casenotes and handheld notes and the woman clearly understands who is responsible for her care.

Table 1
Medical conditions indicating increased risk suggesting planned birth at an obstetric unit with consultant professional lead

| Disease area | Medical condition |
|---|---|
| Cardiovascular | Confirmed cardiac disease<br>Hypertensive disorders |
| Respiratory | Asthma requiring an increase in treatment or hospital treatment<br>Cystic fibrosis |
| Haematolgical | Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major history of thromboembolic disorders<br>Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100,000<br>Von Willebrand's disease<br>Bleeding disorder in the woman or unborn baby<br>Atypical antibodies which carry a risk of haemolytic disease of the newborn |
| Infective | Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended<br>Hepatitis B/C with abnormal liver function tests<br>Carrier of/infected with HIV<br>Toxoplasmosis – women receiving treatment<br>Current active infection of chicken pox/rubella/genital herpes in the woman or baby<br>Tuberculosis under treatment |
| Immune | Systemic lupus erythematosis<br>Scleroderma |
| Endocrine | Hyperthyroidism<br>Diabetes |
| Renal | Abnormal renal function<br>Renal disease requiring supervision by a renal specialist |
| Neurological | Epilepsy<br>Myasthenia gravis<br>Previous cerebrovascular accident |
| Gastrointestinal | Liver disease associated with current abnormal liver function tests |
| Psychiatric | Psychiatric disorder |

NICE Intrapartum Guidelines 2007

Table 2 Other factors indicating increased risk suggesting planned birth at an obstetric unit with consultant professional lead

| Factor | Additional information |
|---|---|
| Previous complications | Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty<br>Previous baby with neonatal encephalopathy<br>Pre-eclampsia requiring preterm birth<br>Placental abruption with adverse outcome<br>Eclampsia<br>Uterine rupture<br>Primary postpartum haemorrhage requiring additional treatment or blood transfusion<br>Retained placenta requiring manual removal in theatre<br>Caesarean section<br>Shoulder dystocia |
| Current pregnancy | Multiple birth<br>Placenta praevia<br>Pre-eclampsia or pregnancy induced hypertension<br>Preterm labour or preterm prelabour rupture of membranes<br>Placental abruption<br>Anaemia haemoglobin less than 8.5g/dl at onset of labour<br>Confirmed intrauterine death<br>Induction of labour<br>Substance misuse<br>Alcohol dependency requiring assessment or treatment<br>Onset of gestational diabetes<br>Malpresentation – breech or transverse lie<br>Body mass index at booking of greater than 35 $kg/m^2$ |
| Fetal indications | Recurrent antepartum haemorrhage<br>Age below 18 at the time of booking and more than 40<br>Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound)<br>Abnormal fetal heart rate (FHR) / Doppler studies<br>Ultrasound diagnosis of oligo-/polyhydramnious and fetal abnormality |
| Previous gynaecological history | Myomectomy<br>Hysterotomy |

NICE 2007

Table 3 Medical conditions indicating individual assessment when planning place of birth and professional lead

| **Disease area** | **Medical condition** |
|---|---|
| Cardiovascular | Cardiac disease without intrapartum implications |
| Haematological | Atypical antibodies not putting the baby at risk of haemolytic disease<br>Sickle cell trait<br>Thalassaemia trait<br>Anaemia – haemoglobin 8.5-10.5 g/gl at onset of labour |
| Infective | Hepatitis B/C with normal liver function tests |
| Immune | Non-specific connective tissue disorders |
| Endocrine | Unstable hypothyroidism such that a change in treatment is required |
| Skeletal/neurological | Spinal abnormalities<br>Previous fractured pelvis<br>Neurological deficits |
| Gastrointestinal | Liver disease without current abnormal liver function<br>Chrohn's disease<br>Ulcerative colitis |

NICE 2007

Table 4 – other factors indicating individual assessment when planning place of birth and professional lead

| **Factor** | **Additional information** |
|---|---|
| Previous complications | Stillbirth/neonatal death with a known non-recurrent cause<br>Pre-eclampsia developing at term<br>Placental abruption with good outcome<br>History of previous baby more than 4.5kg<br>Extensive vaginal, cervical or third or fourth degree perineal trauma<br>Previous term baby with jaundice requiring exchange transfusion |
| Current pregnancy | Antepartum bleeding of unknown origin (single episode after 24 weeks gestation)<br>Body mass index at booking of 30-34 kg/m2<br>Blood pressure of 140 mmHg systolic or 90 mmHg diastolic on two occasions<br>Clinical or ultrasound suspicion of macrosomia<br>Para 6 or more<br>Recreational drug use<br>Under current outpatient psychiatric care<br>Age over 40 at booking |
| Fetal indications | Fetal abnormality |
| Previous gynaecological history | Major gynaecological surgery<br>Cone biopsy or large loop excision of the transformation zone<br>Fibroids |

NICE 2007

**Indications for intrapartum transfer to consultant lead**

The following risks and benefits should be assessed when considering transfer to a consultant led obstetric unit, bearing in mind the likelihood of birth during the transfer:

- Indications for electronic fetal monitoring (EFM) including abnormalities of the fetal heart rate (FHR) on intermittent auscultation
- Delay in the first or second stages of labour
- Significant meconium stained liquor
- Maternal request for epidural pain relief
- Obstetric emergency – antepartum haemorrhage, cord presentation/prolapse, postpartpartum haemorrhage, maternal collapse or a need for advanced neonatal resuscitation
- Retained placenta
- Maternal pyrexia in labour (38c once or 37.5C on two occasions 2 hours apart)
- Malpresentation or breech presentation diagnosed for the first time at the onset of labour, taking into account imminence of birth
- Either raised diastolic blood pressure (over 90 mmHg) or raised systolic blood pressure (over 140 mmHg) on two consecutive readings taken 30 minutes apart
- Uncertainty about the presence of a fetal heartbeat
- Third or fourth degree tear or other complicated perineal trauma requiring suturing

Any transfer of care must be documented as per handover of care guideline

**Care throughout Labour**
Women should receive one to one midwifery care when in established labour and all care should be documented on the partogram.

**Communication**

All women in labour should be treated with respect and should be in control of and involved in what is happening to them, and the way in which care is given is key to this. To facilitate this, healthcare professionals and other care givers should establish a good rapport with the woman and her partner by treating the woman with kindness and respect at all times, maintaining her dignity. All health care professionals should be aware of their tone and demeanour, behaviour and actual words used.

- Greet the woman with a smile and a personal welcome. Establish her language needs, introduce yourself and explain your role in her care

- Maintain a calm and confident approach to reassure the woman that all is going well

- Knock and wait before entering her room

- Ask her how she is feeling

- If the woman has a written birth plan, read and discuss it with her

- Assess her knowledge of strategies for coping with pain and provide balanced information to find out which available approaches are acceptable to her
- Encourage the woman to adapt the environment to meet her individual needs

- Ask her permission before all procedures and observations

- Show the woman and her birth partner how to summon help; she may do so as often as she needs to. When leaving the room, let her know when you will return

- Involve the woman in any handover of care to another professional

The woman should be fully involved in planning her care and provided with the information with which to do this. The care and information provided should be appropriate to the woman, any additional needs and any cultural beliefs and practices.

**COPY OF THE GUIDELINES ATTACHED AS APPENDIX**

**Equality Impact Assessment statement**

Women's and Children's Services are committed to ensure that both current and potential service users and their families will not be discriminated against on the grounds of religion, gender, race, sexuality, age, disability, ethnic origin, social circumstance or background. The principles of tolerance, understanding and respect for others is central to what we believe and central to all care provided.

**References**

Department of Health 2004 Maternity Matters

NICE 2007 Intrapartum Care **www.ma.org.uk**

Department of Health 2004 NHS Framework (Maternity Standards11) DOH Publications London
NMC 2004 Rules and Standards