Midwifery Led Unit (MLU) Guidelines

Related National Guidance	Intrapartum care for healthy women and babies NICE guidance (CG190) Published 03 December 2014 last Updated 21 February 2017	
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Purpose	To provide guidance to staff attending women who wish to use the Lucina Birthing Unit (MLU) for labour, birth, and the postnatal period.	
Primary Specialty	Obstetrics	
Related Specialties	Midwifery Neonatal	
Specialty Clinical Guideline Lead	Louisa Talbott Womens and Childrens Risk Manager Louisa.talbott@uhcw.nhs.uk	
Authors	**Lead Author:**	Louise Dean Matron for Intrapartum Services Louise.dean@uhcw.nhs.uk
	Reviewer(s):	Louise Clarke Consultant Midwife Louise.clarke@uhcw.nhs.uk
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Rationale

This Guideline follows the recommendations in NICE CG190

Dissemination and related guidance

On notification of upload to E. Library (Document Management System), email cascade to circulation lists.

Dissemination via newsletter

Training

- Low risk midwifery care - at induction and regularly according to individual needs
- Labour and birth in water - at induction and regularly according to individual needs

- Fetal surveillance – at induction and then annually according to maternity TNA
- Management of obstetric emergencies - at induction and then annually according to maternity TNA
- The sick pregnant woman and use of MEOWS - at induction and then annually according to maternity TNA
- Care of the healthy newborn infant- at induction and then annually according to maternity TNA
- Breast feeding - at induction and then annually according to maternity TNA
- Emergency transfer scenarios will be rehearsed as part of mandatory update training
- Multi professional skills drills will be completed unannounced as part of obstetric emergency training

Patient Information

None.

Audit & Monitoring

Audit title	**Audit Lead**	**Monitoring method and frequency**	**Committee responsible**
Low risk criteria assessed on admission	Lucina Birth Unit Manager	2 Yearly Documentation Audit	Obstetrics and Gynaecology Audit meeting
All women are supported by a midwife when in established labour	Lucina Birth Unit Manager	2 Yearly Documentation Audit	Obstetrics and Gynaecology Audit meeting
All women follow the Coping in Labour Pathway	Lucina Birth Unit Manager	2 Yearly Documentation Audit	Obstetrics and Gynaecology Audit meeting
All women who deviate from the norm are Transferred at appropriate times	Lucina Birth Unit Manager	2 Yearly Documentation Audit	Obstetrics and Gynaecology Audit meeting
All babies requiring neonatal resuscitation have support of the neonatal team	Lucina Birth Unit Manager	2 Yearly Documentation Audit	Obstetrics and Gynaecology Audit meeting

Changes from previous version

Date	**Updated information**
October 2022	All pages have had changes

Contents

Definitions

MLU	Midwifery Led Unit
UHCW	University of Coventry and Warwickshire NHS Trust
SBAR	Situation – Background – Assessment – Recommendation
NNU	Neonatal Unit

Introduction

The maternity service at University Hospitals of Coventry and Warwickshire NHS Trust (UHCW) offers a Midwifery Led Birthing Unit which is a specifically designated facility. Within the unit the midwives are the lead professionals who care for low-risk women and their babies during labour, birth and the immediate postnatal period. These guidelines have been developed to provide guidance on midwifery practice within the Midwifery Led Birthing Unit environment.

Scope

This guideline applies to all maternity staff that provides care for women in The

Lucina Birth Centre, Midwifery Led Unit (MLU). The purpose of this guideline is to provide a sound clinical governance framework using national intrapartum standards to support midwives in their practice and to enhance the care of women, babies and their families.

Roles and Responsibilities

Role of Delivery suite co-ordinator

- To support use of the Lucina Birthing Unit for labour, birth and the postnatal period.
- Ensure the midwife assigned to the Lucina Birthing Unit is adequately trained. It is the responsibility of the Delivery Suite co-ordinator to ensure that a second Midwife is available for the birth.
- Receive regular updates on progress of labour.

Role of the midwife

- To provide regular updates to the delivery suite co-ordinator to allow for situational awareness in the maternity unit.
- To provide information to all women during the antenatal period of the risks and benefits of giving birth in the Lucina Birth Unit.
- To monitor fetal and maternal wellbeing, document and escalate any deviations from the norm.
- Two staff members must be present within the MLU for the birth
- Ensure the resuscitaire is checked as appropriate.
- Maintain fresh ears in accordance to the fetal monitoring guidelines

Clinical guidance

Planning place of birth

All women during their pregnancy should receive information
regarding place of birth and that at UHCW there are three options:

Home Birth
Lucina Birth Centre (MLU)
Labour Ward

The information provided should be based on the woman's individual circumstances and risk factors. Both MLU and home birth are suitable for women who are under midwifery led care and therefore have no medical or obstetric risk factors. If women wish to give birth on the MLU but have pre-existing risk factors, then the woman should be referred to an obstetrician and consultant midwife for further discussion and a plan of care.

Initial assessment at the onset of labour**.**

The community midwifery team should ensure that all women are aware of who to telephone when they are in labour and provided with the Lucina Birth Unit and Triage telephone numbers.
Women will have their risk assessed for suitability regarding their place of birth at the onset of established labour. This may be done in triage area or the Midwifery Led unit and documented on the electronic records.
The primary aim of the risk assessment is to identify women who may have a developed a risk factor(s) which may affect their intended place of birth.
When performing an initial assessment of a woman in labour listen to her story and consider her preferences and her emotional and psychological needs.

Selection Criteria for MLU care

<u>Antenatal – Maternal Factors</u>
Gestation between 37+0 weeks and 41+6 weeks
Nulliparous or low risk obstetric history, up to and including Para 4.
Absence of maternal medical history that affects childbearing
No evidence of pre-eclampsia/pregnancy induced hypertension
Spontaneous onset of labour including SROM less than 24hours
BMI of between 18 and 35 at booking
Last known haemoglobin greater than 95g/l
Age 16 – 40 years, inclusive at booking

Antenatal – Fetal Factors

Singleton pregnancy

Cephalic presentation

Clinically well grown baby

Placenta outside of lower segment (if known)

Spontaneous rupture of membrane less than 24 hours

Reassuring vaginal loss (Mucous ‘show’ with the absence of fresh bleeding or significant meconium)

Normal fetal movements

The MLU can also accept certain women who are outside of the above criteria who do not require continuous electronic fetal heart rate monitoring (CEFM) in labour and have a well grown baby.

These women include those who have been offered induction of labour (IOL) for postdates who then establish in labour following one Propess/Prostin, providing labour is established by 40+14 and there are no other identified risk factors present.

For any women who are considered potentially suitable or if the woman questions the decision about their suitability, a consultant midwife or band 7 coordinator and the most senior obstetrician available on the obstetric unit should discuss and decide about suitable place of birth. Documentation of an agreed individualised plan will then be made in the electronic records.

Carry out an initial assessment to determine if midwifery-led care in any setting is suitable for the woman, irrespective of any previous plan.

The assessment should comprise the following:

Observations of the woman:

- Review the antenatal notes (including all antenatal screening results) and discuss these with the woman.
- Ask her about the length, strength and frequency of her contractions.
- Ask her about any pain she is experiencing and discuss her options for pain relief.
- Record her pulse, blood pressure and temperature, and carry out urinalysis.
- Record if she has had any vaginal loss.

- If there is uncertainty about whether the woman is in established labour, a vaginal examination may be helpful after a period of assessment but is not always necessary.
- Ask the woman about the baby's movements in the last 24 hours.
- Palpate the woman's abdomen to determine the fundal height, the baby's lie, presentation, and position, engagement of the presenting part, and frequency and duration of contractions.
- Auscultate the fetal heart rate for a minimum of 1 minute immediately after a contraction. Palpate the woman's pulse to differentiate between the heart rates of the woman and the baby.

Additional consideration will include:

- Medical history
- Anaesthetic history, to include women who may decline blood products
- Obstetric History
- Factors from previous pregnancies
- Social / Lifestyle history (nutrition, exercise, smoking, alcohol, drug use)
- Details relating to current pregnancy

Symphysis fundal height measurement will not be taken routinely during the labour assessment. However, if the midwife is concerned following palpation, they may take a fundal height measurement and refer to medical staff if still concerned.
Following this risk assessment an appropriate place of birth will be agreed between the healthcare professional and woman.
During this assessment, if any deviation from normal is identified, that has not been assessed antenatally and a plan made, the midwife must refer to the medical team on call and the labour ward coordinator.
If a risk is identified that requires specialist management, for example safeguarding, the midwife will refer to the relevant specialist service as per the individual guidelines.

If risk factors are identified, please consider if an individual birth choices plan has been put in place by the consultant midwife.

On arrival the midwife should introduce herself and show the woman and her partner to the room explaining the facilities available including how to call the midwife if needed. There is a selection of equipment to promote progress in labour and reduce pain such as birth balls, stools, bean bags. Women should be encouraged to adapt the environment to meet her individual needs and to move and adopt whatever positions they find most comfortable throughout labour.

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. This should be done by the midwife together with the woman and her partner reviewing the birth plan and providing care accordingly. The midwife should ensure that the woman's partner or other labour support person is encouraged to be actively participating in the care.

Observations to be carried out during the Established First Stage of Labour
Observations to be carried out **as a minimum** by a midwife during the first stage of labour include:
MATERNAL

- 4 hourly temperature and blood pressure.
- Hourly pulse
- Half hourly documentation of frequency of contractions
- Frequency of emptying the bladder encourage voiding every 4 hours including measurement of fluid input & output
- Offer vaginal examination 4 hourly or where there are concerns about the woman's progress or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss)

If it is felt that that increased observations are required, this should be documented in the management plan in the intrapartum records.
All maternal observations and any deviations from normal must be documented in the labour records and escalated to the labour ward coordinator.

FETAL
For fetal observations please refer to trust Intrapartum Fetal Monitoring Guideline

Care during the 1st stage of labour

Mobilisation and position

Women should be encouraged and helped to move and adopt whatever position they find most comfortable throughout labour

Eating and drinking in labour

- Women may drink during established labour and be informed that isotonic drinks may be more beneficial than water.
- Women may eat a light diet in established labour unless they have risk factors that make a general anaesthetic more likely

Pain Relief During Labour (NICE 2007**)**

- Healthcare professionals should think about how their own values and beliefs inform their attitude to coping with pain in labour and ensure their care supports the woman's choice.
- If a woman chooses to use breathing and relaxation techniques in labour, support her in this choice.
- Offer the woman the opportunity to labour in water for pain relief (NICE, 2007).
- If a woman chooses to use massage techniques in labour that have been taught to birth companions, support her in this choice.
- Ensure that Entonox (a 50:50 mixture of oxygen and nitrous oxide) is available in all birth settings as it may reduce pain in labour but inform the woman that it may make her feel nauseous and light-headed.

- IM Opioid analgesia is available in all birth settings. Inform the woman that these will provide limited pain relief during labour and may have significant side effects for both her (drowsiness, nausea, and vomiting) and her baby (short-term respiratory depression and drowsiness which may last several days).
- If an IM opioid is used, also administer an antiemetic.
- Do not offer acupuncture, acupressure, or hypnosis, but do not prevent women who wish to use these techniques from doing so. (NICE 2014)
- Support the playing of music of the woman's choice in labour.
- Do not offer transcutaneous electrical nerve stimulation (TENS) to women in established labour but do not prevent women who wish to use these techniques from doing so, however they must supply their own TENS machine (NICE 2014)
- If the woman requests regional analgesia for pain relief such as an epidural, then she must be transferred to labour ward.

Strategy for assisting labour to progress normally include**:**

- One to one care
- Encourage mobility
- Hydration and nourishment
- Using positive encouragement
- Support the woman's choices/preferences
- VE to ensure that labour is progressing normally
- Observe for frequency of contractions. If they diminish in frequency, then VE is probably indicated to check that progress is being maintained both in the first and second stages of labour

Progress in the first stage of labour

If delay in the established first stage is suspected, assess all aspects of progress in labour when diagnosing delay, including:

- Cervical dilatation of less than 2cm in 4 hours in first labours.
- Cervical dilatation of less than 2cm in 4 hours or a slowing of progress for second or subsequent labours.
- Descent and position of the head.
- Changes in the strength, frequency and duration of contractions.
- If there is any doubt about progress, discuss with the labour ward coordinator.

If delay in the first stage of labour is confirmed transfer the woman to the labour ward.

For fetal observation refer to Trust Intrapartum Fetal Monitoring Guideline

Second stage of labour

Signs indicating possible transition from First to Second Stage of Labour
These signs may vary depending upon individual behaviour and analgesia:

- Increase/change in strength of contractions
- Strong urge to push
- Involuntary bearing down
- Mucous show
- Rectal pressure/bowels open
- Purple line visible
- Vulval bulging/gaping
- Anal dilatation

For many women, the physical demands and the psychological challenge of labour are increased in the 2nd stage. For this reason and combined with the increased vulnerability of the baby, the 2nd stage is associated with increased surveillance of the fetal condition and intensive support and encouragement for the labouring woman (NICE 2007).

MATERNAL

- Hourly blood pressure.
- Palpate the woman's pulse every 15 minutes to differentiate maternal from fetal heart rate (NICE 2014).
- 4 hourly temperatures (unless PROM see PROM guideline).
- VE should be offered hourly in the active second stage or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss).
- Half hourly documentation of the frequency of contractions.
- Frequently empty the bladder.

On-going consideration of the woman's emotional and psychological needs.

- Assessment of progress should include maternal behaviour, effectiveness of pushing and fetal wellbeing, considering fetal position and station at the onset of the second stage.

All maternal observations and any deviations from normal must be documented in the labour records.

FETAL

For fetal observations refer to Trust Intrapartum fetal Monitoring Guideline

Care during Second Stage of Labour

- Where possible women should be discouraged from lying in the supine or semi supine position. They should adopt any other position that they find comfortable.
- Women should be guided by their own urge to push.
- If pushing is ineffective or if requested by the woman, strategies such as change of position support and encouragement with pushing and bladder emptying should be used.
- Perineal massage should not be performed.

- Either the ‘hands on’ (guarding the perineum and flexing the head) or the ‘hands poised’ (with hands off the perineum and baby’s head but in readiness) technique can be used to facilitate spontaneous birth.

Nulliparous women

Birth would be expected to take place within 3 hours of the start of the active stage of labour.
A diagnosis of delay in the active second stage should be made when it has lasted 2 hours, and women should be referred to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.

In the LUCINA BIRTH CENTRE, if after 1 hour of active second stage the progress is poor or there are no signs of progress, inform the delivery suite coordinator for advice. If after a further 30 minutes, there is limited, or poor progress then transfer to the Labour Ward for an obstetrician review.

Multiparous women
Birth would be expected to take place within 2 hours of the start of the active second stage in most women. A diagnosis of delay in the active second stage should be made when it has lasted 1 hour, and women should be referred to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent

In the LUCINA BIRTH CENTRE, if after 30 minutes of active second stage there is no, or poor progress inform the labour ward coordinator. After a further 15 minutes of no or poor progress then transfer to Labour ward and Labour ward obstetrician review.

Delayed cord clamping

- Timely delay in clamping and cutting of cord is between 1 and 3 minutes
- Benefits for term babies include a better iron status during the first few months of life
- Delayed cord clamping does not interfere with the management of the third stage

Observation Examination	**Frequency**	**Rationale**
Temperature	• 4 hourly • Hourly temperature to ensure not pyrexial if in the pool.(NICE 2007)	• To identify pyrexia >37.5C
Pulse	• $^1/_2$ hourly	• To identify infection, haemodynamic compromise and establish the difference between fetal heart rate

Blood Pressure	• 4 hourly • 1 hourly 2nd stage	• To identify pre-eclampsia, haemo-dynamic compromise
Urinalysis	• 4 hourly	• To identify normal micturition, proteinuria and or signs of infection (nitrites) and ketoacidosis
Abdominal Palpation	• On admission and then before every vaginal examination	• To confirm that the fundus is appropriate for > 37 weeks gestation, long lie, cephalic presentation, and descent of presenting part.
Contractions	• On admission and at ½ hourly during 1st stage labour	• To confirm frequency, strength, tone and any changes
Fetal heart auscultation	• On admission • 15-minute intervals in 1st stage labour • At least 5-minute intervals or after each contraction 2nd stage	• To identify abnormal features and or suspected fetal distress
Vaginal Examination	• On admission • As requested by woman and in the absence of other signs of progress in labour	To assess: • Cervix position • Consistency of cervix • Application of cervix to presenting part • Dilatation of cervix • Membranes present/absent • Position of presenting part • Station of presenting part • Presence of caput/moulding • Presence of abnormal features such as cord/placenta.
Diet/Fluid intake	• On admission and throughout labour	• To confirm that appetite is normal and no evidence of illness.
Behaviour	• On admission and throughout labour	• To observe normal features of labour

General care, observations, and documentation during the third stage of labour

The options for management of the third stage of labour should be discussed with the woman as part of preparation for birth to facilitate informed choice.

The woman should not be left alone during the third stage of labour because of the risk of major haemorrhage. During the third stage the woman's general condition, respiration and colour should be observed. Assessment of vaginal blood loss should be continuous and if heavy, assistance should be called, and pulse and blood pressure taken.

Active management of the third stage Active management includes:

administration of oxytocin Intramuscularly, cord clamping and cutting and controlled cord traction.

Physiological management of the third stage should be supported if requested. Physiological management involves: no oxytocin/no early cord clamping; delivery by maternal effort. Do not pull the cord or palpate the uterus.
Change from physiological management to active management in the case of:

- haemorrhage
- failure to deliver the placenta within 1 hour
- the woman's desire to artificially shorten the third stage.

Postnatal care
Women who have birthed in Lucina wishing to be discharged home without admission to the postnatal ward or requiring further support should be discharged as soon as she feels well enough and all assessments of mother and baby are complete, this is usually within 12 hours of birth, if a longer period of admission is required then the woman should be transferred to the postnatal ward.

Maternal and Fetal wellbeing: managing abnormal features

Progress must be documented in the Maternity Records within the electronic records. Deviations from the norm should be acted upon immediately. The table below provides further guidance on actions required where the labour deviates from the norm.

The midwife will explain the concerns to the woman and her birth partner and take immediate action to transfer to the Labour Ward. **ALL women who are transferred to the labour ward need immediate review by an obstetrician and the labour ward co-ordinator.**

Maternal and Fetal wellbeing: managing abnormal features

Abnormality	Observation	Action

Fetal heart	Any fetal heart rate abnormality suspected, e.g. a deceleration on one occasion, bradycardia, tachycardia	Listen in after the next contraction. If persists and birth is not imminent, summon help within the birth centre team and arrange immediate transfer to the labour ward. Labour ward are to then arrange review by obstetrician. If the baseline fetal heart rate bradycardia continues to auscultate – if no improvement summon help within the birth centre team and arrange immediate transfer to the labour ward. Labour ward are to the arrange review by obstetrician. If birth imminent, call two 2222 calls, one for: "obstetric emergency Lucina Birth Centre, Room Number ," and one for "baby emergency Lucina Birth Centre Room Number "for appropriate personnel to come to the birth centre.

Abnormal Maternal Observations (in labour)	Pyrexia >37.6 occasions Pulse – tachycardia on 2 occasions Urine – proteinuria	Inform shift leader Liaise with labour ward coordinator and labour ward obstetrician Transfer to labour ward for obstetric review
	Presence of meconium	If during the first stage of labour - Transfer to the Labour Ward for obstetric review If during the second stage of labour, transfer to the labour ward if time allows. If birth is imminent stay on the LUCINA BIRTH CENTRE and request neonatal team assistance via bleep 2500 and ensure that the resuscitaire is moved into the birth room
Antepartum Haemorrhage	Any blood loss that is bright red, not mucusy and greater than 50ml	Assess amount Summon help within the birth centre team Take immediate resuscitation action Transfer to the Labour Ward for obstetric review. If woman is in a collapsed state call for urgent obstetric attendance (2222 "obstetric emergency Lucina Birth Centre Room Number...")
Postpartum Haemorrhage	Any blood loss that exceeds 500mls during the management of 3rd stage of labour or following completion of 3rd stage of labour	Assess amount Summon help within the birth centre team Take immediate resuscitation action Transfer to the Labour Ward for obstetric review If woman is in a collapsed state call for urgent obstetric attendance (2222 "obstetric emergency Lucina Birth Centre Room Number...")
Abdominal Pain (not contractions)	Presence of pain not consistent with labour which may be constant or intermittent. Uterine rupture can occur in women who have not had uterine surgery.	Record a full set of maternal observations Call for assistance Take immediate resuscitation action Transfer to the Labour Wardfor obstetric review.
Hyperstimulation	Frequent contractions which exceed the normal for the stage of labour: e.g., 5 in 10 during 1st stage of labour	If hyperstimulation without fetal heart irregularities – observe for maternal distress and discuss with shift leader, consider liaison with labour ward coordinator and labour ward obstetrician. If hyperstimulation with fetal heart irregularities – contact Labour ward coordinator and transfer to labour ward ensuring that the shift leader is fully informed. Labour ward are to then arrange review by obstetrician.

Hypertension	Abnormal blood pressure reading range: 140/90 on 2 occasions 30 minutes apart 150/110 on one occasion	Contact Labour ward coordinator and transfer to labour ward ensuring that the shift leader is fully informed. Labour ward are to then arrange review by obstetrician.
Maternal Collapse Epileptic Seizures Eclamptic fit	During any stage of labour other than simple faint without haemorrhage.	Summon help within the birth centre team Call for urgent obstetric attendance (2222 "obstetric emergency Lucina Birth Centre Room Number...") Refer to guidance for appropriate management Transfer to the Labour Wardfor obstetric review
Undiagnosed Malpresentation	Fetal presentation during 1st or 2nd stages of labour which may include breech, brow, face, shoulder or arm presentation	Summon help within the birth centre team and arrange immediate transfer to the labour ward. Labour ward are to then arrange review by obstetrician.
Cord presentation or prolapse	The palpation or observation of cord	Take immediate action to prevent cord further prolapsed If birth imminent, call two 2222 calls, one for: "obstetric emergency Lucina Birth Centre, Room Number," and one for "baby emergency Lucina Birth Centre Room Number" for appropriate personnel to come to the birth centre. If delivery is not imminent follow existing clinical guideline available on e-library Birth Centre staff to manage immediate emergency by inflating filling bladder with N/saline and calling "2222 obstetric emergency from Lucina Birth Centre ***en route to labour ward"***
Shoulder Dystocia	Shoulder dystocia is defined as a delivery that requires additional obstetric manoeuvres to release the shoulders after gentle downward traction has failed. (Resnick 1980).	Call for help Call two 2222 calls, one for : "obstetric emergency Lucina Birth Centre, Room Number ," and one for "baby emergency Lucina Birth Centre Room Number. "for appropriate personnel to come to the birth centre. Follow the Systematic Emergency Management of Shoulder Dystocia as per Shoulder Dystocia clinical guideline (CG 993)

Failure to Progress	Labour does not follow the normal pathway and expected progress	Confirm vaginal dilatation, position and descent of presenting part, frequency and strength of contractions Do not wait beyond agreed times Transfer to labour ward if gone beyond or approaching agreed time for obstetric review and management plan.
Retained Placenta	Failure to complete the 3rd stage of labour from adherent placenta	Ensure active management of labour is initiated giving Oxytocin IM Observe & document blood loss and maternal observations If placenta fails to deliver within 30 minutes after active management or 1 hour after physiological 3rd stage transfer to labour ward for review by obstetrician
3rd/4th Degree Perineal Tear	Trauma sustained to the perineum during delivery	Correctly identify the degree of trauma Ensure initial haemostasis, apply pad Transfer to Labour Ward for obstetric review.

Urgent transfer procedure

Once an abnormality has been detected the midwife will take action to expedite transfer to ensure the woman and her fetus receives timely assistance reducing morbidity.

Do not leave the woman unattended. Call for assistance from another midwife using emergency call bell. (This emergency call bell is also activated on labour ward) labour ward staff are not required to attend and if needed this would be via the '2222' bleep system.

Information is given to the second midwife who will contact the Labour Ward and inform the labour ward coordinator.

Transfer may take place via wheelchair or gurney trolley depending on urgency

Handover of care should be completed upon arrival to the labour ward using the SBAR (Situation – Background – Assessment – Recommendation) in accordance to the Hand Over of Care on Site Clinical Guideline CG1795)

The midwife will ensure that the woman and her birth partner are communicated throughout and that all belongings are taken with the woman.

The midwife will document the transfer in the intrapartum records and will complete the transfer documentation in admissions book.

All transfers will be discussed daily during the early morning handover in the MLU and at the daily case review on the labour ward.

Monthly data will be collated for governance purposes

Any serious untoward incidents will be reported using risk governance processes, learning points and actions for change will be implemented following full root cause analysis process.

Non-urgent transfers

There will be occasions where laboring women will require request a transfer to Labour Ward. This may include:

Personal request
Slow progress in 1st stage labour
Suspected vaginal infection in labour
Offensive liquor
Request for regional analgesia

The midwife will discuss her findings with the woman and her birthing partner and document. The Labour ward coordinator will be contacted and given a brief history using the SBAR tool. The woman and her partner will be transferred on foot or chair with all documentation completed.

Monthly data will be collated for governance purposes.

<u>Neonatal transfers or request for neonatal assistance</u>

In the event of an abnormality during the birth, the midwife must alert the neonatal team as soon as possible. If emergency attendance is required “2222 baby emergency” call must be made

Please see Newborn Resuscitation/Life Support Clinical Guideline available on e library.

Midwife in attendance will call for help by means of the emergency bell and provide immediate support and or resuscitation.
‘2222’ baby emergency will be called.

Resuscitaire to be taken into birthing room
Midwife will support and inform parents of baby’s condition and document all actions taken
Paired cord gases to be obtained from the placenta and processed on the labour ward blood gas analyser
Placenta to be retained and sent to the laboratory in case of need for histological examination later and documented in the electronic records.

If the baby is to be transferred to the Neonatal Unit (NNU) this will be facilitated using the resuscitaire. The woman and her partner will be informed of all plans and any likely emergency procedures, and this will be documented in the intrapartum records. The midwife will ensure that any supporting information is available to NNU staff and maintain contact with NNU on behalf of the mother.
DATIX form completed

The resuscitaire must be returned immediately to the MLU cleaned, ready to be re-stocked and fit for purpose
Following routine immediate postnatal care, mother to be transferred to ward 25 unless requesting early discharge.

Monitoring of outcomes and audit reporting

Data will be collected, collated, and reported monthly to the Obstetrics and Gynaecology QPS meeting regarding outcomes. Data will be sourced from:

LUCINA BIRTH CENTRE birth register
Transfer record
IT systems
Hospital records
DATIX reports

Appendices

Appendix 1: Exclusion criteria for birth in the LUCINA BIRTH CENTRE

Appendix 1

Exclusion criteria for birth in the LUCINA BIRTH CENTRE

Medical History:

Respiratory

- Asthma: severe attack requiring nebuliser/steroids in previous 12 months
- Cystic fibrosis

Haematological

- Sickle cell disease
- Previous P.E. or D.V.T.
- Von Willebrand's disease/other thrombotic disorders
- ITP (current pregnancy)

Gastro-intestinal

- Liver disease
- Crohn's Disease/ulcerative colitis – on medication
- Severe Hyperemesis

Immune

- Rheumatoid arthritis
- Systematic lupus erythematosus
- Connective tissue disease e.g., Ehlers Danlos and Marfan's syndromes

Neurological

- Epilepsy
- Neurological disease
- Myasthenia gravis

Endocrine

- Unstable Thyroid disease
- Diabetes, Type 1, Type 2, GDM on medication
- Other significant disorders e.g., Cushing's disease

Renal

- Renal disease/renal abnormality
- Recurrent UTI infections needing prophylactic antibiotics

Cardiovascular

- Known cardiac disease/congenital heart abnormality unless cardiologist happy
- Hypertensive disorders

Infective

- TB
- HIV
- Toxoplasmosis
- Chickenpox
- Genital herpes
- Hepatitis A, B and C

Psychiatric history:

- Previous puerperal psychosis
- Severe and enduring mental health problems
- History of substance and alcohol abuse (assess on individual basis)
- Child protection concerns, vulnerable adults. (Assess on individual basis)

Gynaecological history:

- Previous major gynecological i.e., Myomectomy, Hysterotomy.
- female genital mutilation (unless NVD has followed since treatment)
- Uterine/vaginal abnormality
- 3 or more previous consecutive, spontaneous miscarriages and no subsequent NVD

Obstetric history:

- Stillbirth/neonatal death
- Previous obstetric cholestasis
- Severe early onset pre-eclampsia
- Uterine rupture
- Previous C.S
- Primary PPH ≥ 500 ml
- Previous shoulder dystocia
- Previous baby of < 2.5 kg/>4.5 kg (< 10^{th} centile)
- Previous placental abruption
- Para 5 or more
- Pre-eclampsia

Current pregnancy:

- Less than 37/40
- Regular attendance to fetal wellbeing unit.
- More than 1 episode of reduced fetal movements after 37/40
- Rhesus disease
- Haemoglobin of less than 90g/L at term
- Age <16
- Age > 40
- APH /placental abruption PV bleed after 3^{rd} trimester
- Placenta praevia
- Unstable lie
- Multiple pregnancy
- Suspected or proven thrombo-embolism
- Hypertension >140/90
- Pre-eclampsia
- Gestational diabetes controlled with medication
- Obstetric cholestasis
- Current history of drug-alcohol abuse
- BMI of < 18 or > 35 at booking
- History of domestic violence with current partner
- Induction of labour, unless spontaneous labour following Propess/prostin
- Post maturity (41+6 days) unless in spontaneous labour.
- Prolonged rupture of membranes (greater than 24 hours)
- Suspected or confirmed fetal anomaly or SGA

References

National Institute for Health and Clinical Excellence. (NICE) **CG190 Intrapartum care of healthy women and their babies during childbirth.** 2014, Last updated February 2017. NICE: London. [online] available from https://www.nice.org.uk/guidance/cg190

National Institute for Health and Clinical Excellence. (NICE) **CG62 Antenatal care for uncomplicated pregnancies.** March 2008, Last updated January 2017. NICE: London. [online] available from https://www.nice.org.uk/guidance/cg62

NMC, 2015. The Code: Professional standards of practice and behaviour for nurses and midwives. https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

Resnick R. Management of shoulder dystocia girdle. Vol 23:559-64Clin Obstet Gynecol, 1980.

Sandwell and West Birmingham Hospitals NHS Trust. **Low Risk Inclusion/Exclusion Criteria and Booking for Place of Birth.** 2009. [online] available from http://www.rcmnormalbirth.org.uk/EasysiteWeb/getresource.axd?AssetID=140131&type=full&servicetype=Attachment