Worcestershire Acute Hospitals NHS Trust

Meadow Birth Centre Guideline

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Key Documents Owner/Lead:	Dr Hillman	Consultant Obstetrician
Approved by:	Maternity Governance Meeting	
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Key Amendments

Date	Amendments	Approved by

Introduction
This guideline applies to all maternity staff that provides care to women in the Meadow Birth Centre (MBC). The purpose of this guideline is to provide a clinical governance framework using national intrapartum standards to support midwives in their practice and to enhance the care of women, babies and their families.

The MBC is a specifically designed facility where midwives as the lead professionals 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 MBC environment.

Philosophy
The MBC will provide a warm welcoming relaxed and supportive environment for women and their families. The environment will support birth as a natural physiological process that will be supported by the expertise of the midwife as the lead professional for normal birth. Midwives will work in partnership with women and their families to empower their choices, ensuring a safe and positive birth experience.

Responsibility of the midwife
Midwives are responsible for the care of the woman and baby during labour, birth and the immediate postnatal period. Where there is a deviation from the norm, the midwife will seek advice from the appropriate health professional (NMC 2012).

Assessment during pregnancy
All women that follow a midwifery led pathway for their pregnancy will need to have a full risk assessment and completion of the MBC inclusion criteria checklist at 36 weeks gestation (Appendix 1) to confirm that the MBC is the appropriate birth place. Certain criteria outlined in WAHT-OBS-027 will exclude women from birthing in the birth centre. At 36 weeks the final risk assessment to determine place of birth should be recorded on the front page of the Pregnancy notes and the entry dated. The community midwife should ensure that the women are aware of who to telephone when they are in labour. If the woman is suitable to birth on the MBC, a MBC sticker should be placed on the front of the pregnancy notes (Appendix 2) and the woman informed of the triage process in accordance with **Triage Guideline. If any concerns noted the woman may need to attend Maternity Triage not MBC.**

NB If a woman had haemoglobin (Hb) of below 105 g/L at 28/40 it should have been re- checked at 36/40. If the Hb >95g/l she is suitable to birth on MBC.
If the Hb was not repeated at 36 weeks gestation blood should be taken on admission for full blood count, the result will determine the appropriate place of birth.

Early labour
Women and their families should be made welcome onto the MBC. On arrival a member of the MBC team will introduce themselves, explain the roles and responsibilities of other members of the team who may be involved with care and ensure language needs are met. (NICE 2014).

The assigned midwife will confirm the MBC inclusion criteria checklist has been completed and that the woman is suitable to birth in the MBC. The woman will then be shown into the birth room or Maternity Triage for assessment.

On admission the woman's details should be entered onto Oasis.

Following personal introductions the midwife should then undertake a full assessment again confirming the woman's suitability to birth in the MBC. See care in labour guideline. The full assessment should include:

- A full review of pregnancy records, both handheld, hospital records, Athena and eZ notes
- Listening to the woman and taking a full history, observing her demeanour/behaviour WHAT-OBS-115 (Modified Burvill Score) Appendix 3
- Enquire about contractions, fetal movements, wellbeing and vaginal loss
- Palpate her abdomen and measuring the symphysis-fundal height if not measured during the previous 2 weeks
- Auscultating fetal heart with Pinnard stethoscope/hand-held doppler
- Measure her temperature, pulse and blood pressure
- Offering vaginal examination as appropriate

Labour
All women in labour should be treated with respect, feel in control and encouraged to express their personal needs and preferences be involved in what is happening to them and allowed adequate time so that discussions do not feel rushed (NICE 2014). Effective continuous positive support is key to this. Care should be provided by the midwife together with the woman and her birth partner reviewing the birth plan and providing care accordingly. The midwife should ensure the woman's birth partner is encouraged to be actively participating in the care. It is known that the birthing environment is crucial to enable women to relax and thus stimulating their natural oxytocin. Rooms should therefore, with the woman's agreement, be softly lit with music of their choice. Women should be encouraged to bring in music on their mobile device as we provide Bluetooth speakers

Established labour is confirmed with the presence of regular painful contractions, and progressive cervical dilation (NICE 2014). Once labour is established a partogram should be commenced and fully completed until the birth of the baby. All observations should be documented on the partogram and in addition, entries in the notes if there are any significant events, management plans, discussion with women and informed consent for procedures. Drugs should be documented on the prescription chart.

Frequency of observations in labour
See Care in Labour guideline

Progress in labour
Labour should progress spontaneously and without interference, the midwife should act in a supportive manner, offering explanations and encouragement.

The midwife should observe progress throughout labour as:

- Increasing strength and frequency in contractions
- Spontaneous rupture of membranes
- Increasing dilation of the cervix: Nulliparous 2cms in 4 hours and Parous 2 cm in 4 hours, being mindful of any slowing in the progress of labour for second or subsequent labours (NICE, 2014)
- Expiratory grunt
- Descent of fetal head
- Distension of Rhombus of Michaelis
- Purple line
- Anal pouting
- Perineal distension
- Vertex at introitus

Progress of the first stage can be assessed by cervical dilation and descent of the presenting part. These can be assessed by vaginal examination and abdominal palpation. These should be offered 4 hourly unless there is a more urgent need. The midwife should discuss with the woman if the vaginal examination is really necessary and whether it will add value to the decision making process. Midwives should ensure the woman's consent, privacy and dignity throughout the examination. The reason for the examination and what is involved should be explained and the midwife should convey her findings sensitively and honestly to the woman and her partner.

The second stage of labour should follow a period of transition, which may last up to an hour, particularly for Nulliparous women before signs of expulsion occur identifying the active second stage of labour.

Nulliparous women
Birth would be expected to take place within 3 hours of the active second stage.

A diagnosis of delay in the active second stage should be made when it has lasted 2 hours and the woman should be referred to a health professional trained to undertake an operative birth if birth is not imminent. This will mean transfer to the consultant delivery suite. However if on the MBC after 1 hour of active second stage the progress is poor or no signs of progress the MBC shift leader should be informed for advice. If after a further 30 mins there is no or little progress then the shift leader on the consultant delivery suite should be informed and a referral made by 2 hours of active second stage.(NICE 2014)

Multiparous women
Birth should be expected to take place within 2 hours of 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 the woman should be referred to a health professional trained to undertake an operative birth if birth is not imminent. This will mean transfer to the consultant delivery suite. However if on the MBC after 30mins of active second stage the progress is poor or no signs of progress, the MBC shift leader should be informed and consulted for advice. If after a further 15 mins there is no or little progress then the shift leader on the consultant delivery suite should be informed and a referral made by 1 hour of active second stage.

Delayed cord clamping
Delayed cord clamping will be routine practice in the MBC

See Umbilical Cord Clamping guideline

Third stage of labour

The option of management of the third stage of labour should be discussed with the woman as part of preparation for birth in order to facilitate informed choice. Physiological third stage will be supported and informed consent gained. **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 the woman's pulse and BP taken.

Physiological third stage

A Physiological third stage should be supported. Physiological management involves: no oxytocin and no early cord clamping, delivery of the placenta is by maternal effort. **Do not pull the cord or palpate the uterus.**

There is increased risk of bleeding if the cord snapped during physiological management. In that case, consider active management of third stage with syntometrine 1ml IM injection.

Change from physiological third stage to active management in the case of:

- Haemorrhage – Estimated Blood loss (EBL) >500mls
- Failure to deliver the placenta after 1 hour
- The woman's desire to artificially shorten the third stage

Active Management of the third stage

Active management includes: administration of oxytocin intramuscularly, cord clamping and cutting and delivery of the placenta controlled cord traction.

There should be two healthcare professionals to remain on meadow up to one hour following the delivery of the placenta

Care of the newborn

Wherever possible examination of the Newborn will be undertaken on MBC by a NIPE qualified midwife.

Maternal and fetal wellbeing: managing abnormal features

Recognising, recording and acting on deviations from the normal

Progress in labour must be documented in the Birth notes and the partogram commenced when the woman is in established labour. Deviations from the expected progress should be acted upon immediately. See table below. If, after assessing the situation, there is need for medical opinion, the midwife should explain any concerns to the woman and her partner and take immediate action to transfer to Delivery Suite.

In the event of the woman or baby requiring immediate lifesaving attention, an emergency call will be triggered (2222) stating "obstetric or neonatal emergency Meadow Birth Centre room …"

TABLE 1 – Managing abnormal features

Abnormality	Observation	Action
Fetal Heart	Any fetal heart rate abnormality suspected e.g. a deceleration, bradycardia or tachycardia	• Listen in after the next contraction. If fetal heart abnormality persists perform vaginal examination and if birth is not imminent, summon help within the birth centre and arrange

		immediate transfer to delivery suite. Delivery suite to arrange review by Obstetrician. • If the baseline fetal heart rate bradycardia continues and there is no improvement summon help from within the birth centre team and arrange immediate transfer to delivery suite. Delivery suite is then to arrange review by Obstetrician. • If birth imminent, call two 2222 calls, one for 'obstetric emergency Meadow Birth Centre room name' and one for 'neonatal emergency Meadow Birth Centre" Room name' for appropriate staff to come to the Birth Centre.
Abnormal Maternal Observations (in labour)	Pyrexia >37.6 on 2 occasions and / or Tachycardia on 2 occasions and /or Proteinuria ≥+3	• Inform shift leader • Liaise with delivery suite coordinator and on call registrar • Transfer to delivery suite
Liquor	Presence of significant meconium	• If during the first stage of labour transfer to delivery suite • If during the second stage of labour, transfer to the delivery suite if time allows. If birth is imminent stay on the MBC and request neonatal assistance via bleep 2222 and have the resuscitaire ready in the birth room
Antepartum Haemorrhage	Any blood loss that is bright red, not mucousy and greater than 50 mls	• Assess amount • Summon help within the birth centre team • Take immediate resuscitative action if needed • If woman is in a collapsed state call for urgent obstetric assistance via 2222 'obstetric emergency Meadow Birth Centre room name'
Post-partum haemorrhage	Any blood loss that exceeds 500 mls during the management of the third stage of labour or following completion of third stage of labour	• Assess amount • Summon help within the birth centre team • Take immediate resuscitative action if needed • Transfer to delivery suite • If woman is in a collapsed state call for urgent obstetric assistance via 2222 'obstetric emergency Meadow Birth Centre room name'
Abdominal pain (not contractions)	Presence of abdominal pain not consistent with labour which may be constant or intermittent. (Uterine rupture can occur in women who	• Record a full set of maternal observations on a Worcestershire Observation Chart (WOW)

	have not had uterine surgery)	• Summon help within the birth centre team • Take immediate resuscitative action if needed • Transfer to delivery suite
Hyperstimulation	Hyperstimulation is unlikely to occur in spontaneous labour. Frequent contractions which exceed the normal for the first stage of labour e.g 5 in 10mins	• If hyperstimulation without fetal heart irregularities – observe for maternal distress and discuss with shift leader, consider liaison with delivery suite coordinator and obstetrician. • If hyperstimulation with fetal heart irregularities – contact delivery suite and transfer immediately. Delivery suite to arrange for obstetrician to review.
Hypertension	Abnormal BP reading range: • >30mmHg systolic and >15mmHg diastolic from booking blood pressure on 2 occasions 30mins apart • 140/90 on 2 occasions 30mins apart • 150/110 on one occasion • proteinuria + or more with Hypertension	• Contact delivery suite coordinator and arrange transfer to delivery suite ensuring that the shift leader is fully informed. Delivery suite to arrange for obstetrician to review. • Record observations on a WOW chart
Maternal collapse Seizures / Fits	During any stage of labour other than a simple faint without haemorrhage	• Summon help within the Birth Centre team • Call for urgent obstetric attendance 2222'obstetric emergency Meadow Birth Centre room name' • Refer to eclampsia guidance for appropriate management • Transfer to delivery suite
Undiagnosed Malpresentation	Fetal presentation during 1st or 2nd stage 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 delivery suite. Delivery suite to arrange for obstetrician to review
Cord presentation or prolapse	The palpation or observation of cord	• Take immediate action to prevent cord prolapse • If birth imminent call two 2222 calls, one for 'obstetric emergency Meadow Birth Centre room name' and one for 'neonatal emergency Meadow Birth Centre Room name' for appropriate staff to come to the Birth Centre. • If delivery is not imminent follow fill the bladder as prolapsed cord guideline • Birth Centre staff to manage

		immediate emergency by filling bladder with normal saline and calling 2222 'obstetric emergency Meadow Birth Centre en route to delivery suite'
Shoulder Dystocia	Shoulder Dystocia is defined as a delivery that requires additional obstetric manoeuvres to release the shoulders after gentle downward traction has failed to deliver the shoulders	• Call for help via emergency call bell. • Call two 2222 calls, one for 'obstetric emergency Meadow Birth Centre room name' and one for 'neonatal emergency Meadow Birth Centre Room name' for appropriate staff to come to the Birth Centre. • Follow the systematic emergency management of Shoulder Dystocia as per guideline
Failure to progress	Labour does not follow the normal pathway and expected progress	• Confirm vaginal examination, position and descent of presenting part, frequency and strength of contractions • Whether bladder is full • Do not wait beyond agreed times • Transfer to delivery suite if beyond agreed times or if approaching agreed time
Retained Placenta	Failure to complete the 3rd stage of labour due to adherent placenta in the absence of post-partum haemorrhage.	• Confirm state of bladder • For all women • Ensure active management of 3rd stage is initiated using Syntometrine IM • Observe and document blood loss and maternal observations • If placenta fails to deliver within 30mins after active management and 60mins after physiological management • transfer to delivery suite
3rd / 4th Degree Perineal Tear	Trauma sustained to the perineum during birth	• Correctly identify the degree of trauma • Ensure initial haemostasis, apply pad • Transfer to delivery suite

Transfer of lead professional and location

There are **three** categories of transfer:

Immediate ('Red')

Urgent ('Amber')

Non-urgent ('Green')

In **all** cases, the transfer relates to the transfer of care to lead professional in the Consultant led unit and necessitates the woman receiving an obstetric review on arrival to the Obstetric unit.

4)

'Red Transfer':

An obstetric or Neonatal Emergency requiring immediate response by the team; which will be requested to attend the Meadow Birth Centre via the '2222' emergency bleep system. Simultaneously, immediate additional support should be summoned using the emergency call bell.

- Do not leave the woman alone. Calmly explain to the woman and her partner what is happening
- Information is given to the second midwife who will contact delivery suite and inform delivery suite coordinator

Once the woman and/or baby has been stabilised, they will then be transferred to the Consultant Delivery Suite/Neonatal Unit for on-going care and management.

Complete datix for red transfer

'Amber Transfer'

Once a deviation from the normal has been identified the midwife will make arrangements for transfer to delivery suite for consultant led care to ensure the woman and her fetus receives timely assistance.

- Do not leave the woman alone. Call for assistance from another midwife using the emergency call bell
- Calmly explain to the woman and her partner what is happening
  Information is given to the second midwife who will contact delivery suite and inform delivery suite coordinator
- Transfer to delivery suite may take place via wheelchair or trolley depending on urgency and maternal condition
- Midwife to midwife/medical staff handover of care should be undertaken on arrival to delivery suite using SBAR in accordance with handover guideline
- The midwife will ensure that the woman and her birth partner are kept fully informed of what is happening
- The midwife will document in the birth notes the details of the transfer and care will subsequently be recorded on the K2 guardian system.
- Monthly data will be collated for governance processes
- Any serious untoward incidents will be reported on DATIX

'Green Transfer'

There will be occasions when labouring women will require or request a transfer to delivery suite for consultant led care. This may include the following which, depending on the situation, will have different time requirements for the transfer (see table 1 above):

- Personal request
- Slow progress in 1st stage
- Delayed progress in 2nd stage
- Suspected maternal infection in labour
- Offensive liquor
- Request for regional analgesia

The midwife will discuss her findings with the woman and her birth partner. The delivery suite coordinator should be contacted and transfer arranged.

The decision on whether the midwife from the MBC stays with the woman on delivery suite needs to be made at the time as this will be dependent on different factors:

- The staffing situation in MBC the Birth Centre
- The activity in MBC the Birth centre
- The experience the midwife has in providing high risk midwifery care.

Following all transfers, once the relevant care need has been met, it is important for the delivery suite staff to re-visit the woman's birth preferences/expectations and how these may be accommodated within the delivery suite.

Neonatal transfer or request for Neonatal Assistance
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 'neonatal emergency Meadow Birth Centre room name' call must be made.
In a sudden neonatal emergency:

- Midwife in attendance will call for help using the emergency call bell and provide immediate support and resuscitation
- 2222 neonatal emergency call
- Resuscitaire to be taken to the birth room
- Midwife will support the woman and her partner and keep them informed of what is happening
- Paired cord gasses to be obtained from the placenta and processed on delivery suite blood gas analyser
- If the baby is to be transferred to the neonatal unit (NNU) this will be facilitated using the resuscitaire. The midwife will ensure that any supporting information is available to NNU staff and maintain contact with the NNU on behalf of the woman
- Datix form to be completed
- Following routine postnatal care, if baby remains on NNU, mother to be transferred to maternity inpatient ward.

When a woman has been transferred to consultant led care it is important, wherever possible, that a MBC midwife provides the woman with opportunity to discuss and debrief regarding the transfer and birth experience prior to discharge. This is in addition to an Obstetric debrief if indicated.

Women who have an Individualised plan to birth on meadow

For women who have been reviewed and sit outside of criteria for meadow should have been given an individualised plan, this will show a full discussion with the woman and documented evidence to show the advanced plan where she fully understands the risks that sit with choosing a birth outside of criteria. The woman has a legal right to choose her birth preference with informed consent and be made fully aware of the decision making in-line with evidence based practice. See appendix 4 for individualised plan

Appendix 1 Assessment of Suitability for Meadow Birth Centre

Affix Patient Label here or record
NAME: . . . . . .
NHS NO:
HOSP NO:
D.O.B: D D / M M / Y Y Y Y

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NHS Trust

Meadow BIRTH CENTRE

Assessment Of Suitability For Meadow Birth Centre

In the Meadow Birth Centre at Worcestershire Royal Hospital, midwives offer care to all women who have had a healthy pregnancy, with no underlying medical conditions, who anticipate a normal birth and who do not require continuous fetal monitoring in labour.

It is widely accepted that for women who are suitable for midwife-led care, giving birth in a birth centre is safe and offers many advantages. In the Worcestershire Acute Hospitals Trust we offer an 'opt-out' service, meaning that all women who meet the suitability criteria will automatically be cared for in the Meadow Birth Centre, unless the woman chooses not to.

At approximately 36 weeks gestation the community midwife:

- Discusses with the woman and her family her suitability to birth her baby in Meadow Birth Centre, using the suitability criteria overleaf.
- Completes the criteria checklist and files it in the woman's handheld notes.
- **Reassesses suitability** at each subsequent antenatal visit – amend any changes on the checklist accordingly, including attendance at DAU, Triage or antenatal ward.

If the woman meets the criteria for Meadow Birth Centre and is not wishing otherwise please place an MBC sticker on the front of the notes and advise her to call either her community midwife or the Birth Centre when she thinks she is in labour – for non-labour related advice please call Maternity Triage.

Factors requiring individual assessment through the Meadow Birth Centre Options Clinic:

- Previous 3rd/4th degree tear or vaginal surgery if asymptomatic.
- Maternal antibodies which are of no clinical significance and will not lead to HDN – individual assessment.
- Medical condition that does not impact on the pregnancy or the woman's health.
- Maternal age > 40
- Women who do not meet the criteria but request to birth on Meadow Birth Centre.

Affix Patient Label here or record

NAME: . . . . . .

NHS NO:

HOSP NO:

D.O.B: D D / M M / Y Y Y Y

Criteria to be met on admission to Meadow Birth Centre	Criteria Met: √
Singleton pregnancy.	
Cephalic presentation.	
Gestation 37+0 – 42+0. Consider performing sweeps later provided no episodes of reduced fetal movements.	
Age 16 – 40yrs at term.	
Primiparous women booking BMI 18-35 Multiparous women with booking BMI up to 40: no co-morbidities; normal growth on scan – between 10th and 90th centile; good mobility (advised no hoist available to exit birthing pool in an emergency).	
Previous EBL ≤ 1000mls – not requiring blood transfusion.	
Placenta ≥ 3cm from internal os on scan.	
Stable hypothyroidism.	
Clinically well grown baby – 10th-90th centile on scan if concerns.	
Hb ≥ 95 g/L	
Platelets ≥ 100/L - following obstetric review to eliminate underlying autoimmune disorders.	
Spontaneous onset of labour on admission.	

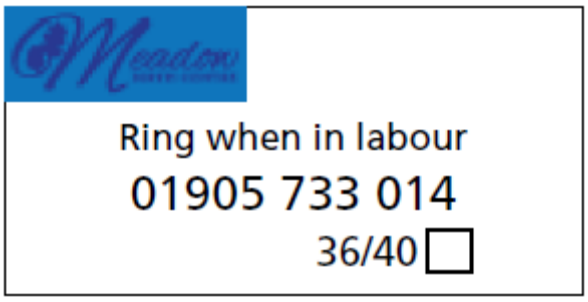
Completed by : _____ Signature: _____

Date: _____/_____/_____ Designation: _____

The following factors *do not* make a woman ineligible for Meadow Birth Centre:

- IVF or assisted conception: now term with no additional risk factors.
- Previous SGA baby: Provided ultrasound scan shows good growth velocity and growth ≥ 10th centile.
- **Previous** congenital abnormality.
- Previous large loop excision or other cervical treatment eg suture – now term.
- Women with safeguarding/social services input: if no impact on pregnancy or woman's health and clear plan in place. Criteria not met if any risks to staff, mother or baby identified.

Appendix 2



Appendix 3

Modified Burvill Score

To be completed at the discretion of the midwife for woman beyond 37/40 gestation where the diagnosis or exclusion of early labour is uncertain

	0	**1**	**2**
Themes	**Signs may indicate Early Labour**	**Signs may indicate Early Active Labour**	**Signs may indicate Active Labour**
Breathing	Exaggerated, pain like breathing	Deeper breathing, controlled, pronounced, like a sigh	Not shallow, cannot talk, focussed on breathing slow with contractions; grunting sounds, cries out with expiration
Conversation	Chatty, excitable, speaks quickly	Speaks less	Becomes quiet, conversation stops with each contraction, takes 20 seconds or more to resume talking; focus goes inward
Mood	Excitement/anxiety, happy, slightly agitated	Ceases to worry about external concerns	Withdraws, focus is on self
Energy	Wants to sort out practicalities	Becoming still. Inward focus on self	Still. Withdrawn into self
Movement & Posture	Grasps abdomen and bends forward with contractions	Less mobile. Stops for contractions and holds onto something/one	Stays in one position with or without contraction. Sways hips during contraction
Contractions without palpation	20 – 40 seconds	50 seconds or more – at least 4 minutes apart	50 seconds or more, 2-3 minutes apart

The Burvill score is not intended to replace clinical assessment but is to enhance the assessment process of labouring women. It is suggested that where the Burvill score is 5 or more 1:1 care and the partogram should be commenced

Appendix 4:

Individual Plan of Care

Name:		**Date of Birth:**
Address: **Telephone number:**		
EDD	**Parity**	**Gestation**
Previous Obstetric History:		
Significant Medical History:		
Social history:		
Medications:		
Current Pregnancy History:		
Agreed Plan to Birth in MBC:		
Completed By:	**Date Completed:**	
Any change in situation since agreed plan:		