Clinical Guideline

ST MICHAEL'S HOSPITAL CO-LOCATED MIDWIFE LED UNIT – ELIGIBILITY FOR LABOUR AND BIRTH

SETTING Division of Women's and Children's Services

FOR STAFF Staff within the service

PATIENTS All pregnant women

Guidance

It is essential that there is clear documentation of which professional is responsible for a woman's care at all times.

This resource for midwives can be used to help provide women with information when they are choosing their birth setting.

Explain to both multiparous and nulliparous women who are deemed low risk, that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth:

Advise low-risk multiparous women that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. (Birthplace in England collaborative group et al 2011)
Advise low-risk nulliparous women that planning to give birth in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby. [NICE 2017]

Explain to low-risk multiparous women that: planning birth at home or in a freestanding midwifery unit is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside midwifery unit, and these 3 settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit planning birth in an obstetric unit is associated with a higher rate of interventions, such as instrumental vaginal birth, caesarean section and episiotomy, compared with planning birth in other settings there are no differences in outcomes for the baby associated with planning birth in any setting. [NICE 2017]

Timing of Clinical Risk assessment for admission to the MLU

- Initial Booking appointment
- At each subsequent antenatal appointment
- Antenatal admissions; including DAU, ANC, CDS and MLU.
- At 36-week risk assessment
- On admission of and throughout labour

Risk assessment for appropriate place of birth

The risk assessment for appropriate place of birth is initially completed at the booking appointment, subsequently at each antenatal contact, at 36 weeks and at the start of and throughout labour.
In cases where there have been no risk factors identified, women can be given the option of delivering on the Midwife led unit or at home.
Any woman requiring consultant led care will be advised to deliver on the central delivery suite.

Process for referral back to midwife led care

It is possible that many women will be seen in the obstetric consultant clinic and may be eligible for referral back to midwife led care. In this care, the decision should be communicated with the woman and clearly documented in the handled notes along with any advice/triggers for referral back to consultant led care.

Admission Criteria for MLU

- Gestation 37+0 – 42+0
- Midwifery Led care at 36/40 risk assessment or low risk obstetric history
- Absence of maternal disease that affects pregnancy and labour
- Spontaneous onset of labour
- Group B Strep positive – with no allergy/sensitivity to Penicillin
- Up to and including 4th delivery
- Age ≤ 39 years at booking
- BMI >18 – 34.9 in primigravidas
- BMI >18 – 39.9 in multiparous women (with no other co-morbidity)
- If BMI <18 but USS confirms clinically well grown baby, may be eligible to deliver on the MLU.
- Singleton pregnancy
- Cephalic presentation
- Clinically well grown baby
- Placental site not low
- SROM <24hours – clear liquor. (Thin meconium on admission with established labour).
- Normal vaginal loss
- HB ≥100g/l
- Platelets ≥100

Please see Appendix 1 for more information on the inclusion and exclusion criteria for the MLU.

Care of Women on the MLU

Admissions in early labour

Women who attend the MLU in the latent phase of labour should have a full history, assessment of both maternal and fetal well-being on each admission and be offered a vaginal examination. Analgesia can be offered as per the Pain Relief in Labour Non Epidural guideline.
NB. Morphine Sulphate is a PGD and should only be administered once in the latent phase. Any further doses should be discussed with and prescribed by a doctor, who has seen the lady.
Women who are attending for the third admission in the latent stage of labour should have a medical review by a ST3 or above on CDS.

In labour

Please follow Labour Care guidelines care of low-risk women in labour on the MLU.
If you are concerned about the well-being of mother or fetus, inform the CDS co-ordinator using SBAR handover and MLU transfer form, and request transfer to CDS immediately.
Use either a wheelchair or the emergency transfer bed (located on DAU) to transfer patient – call for assistance if required.

NB. Note that the BMI inclusion for multiparous women, with no other contraindications is now 18 – 39.9. Please use own clinical and manual handling judgement when offering the pool for labour.

Assessment of spontaneous rupture of membranes

Low risk women whose membranes rupture prior to contractions should be assessed to offer and arrange induction of labour.
Women who call with SROM out of hours, who are low risk and have no concerns regarding fetal movements, report clear liquor or uterine activity may stay at home to await events – with the agreement that they are given and appointment to be seen first thing the next morning for assessment and to arrange IOL.
On admission: ensure maternal and fetal well-being; this includes a full set of maternal observations, abdominal palpation including SFH and auscultation of fetal heart. A speculum should be offered and performed and a HVS taken and sent – unless obvious liquor noted on sanitary pad.
When ROM is confirmed liaise with CDS band 7 to arrange IOL. This should be booked for 24hours post ROM.
Women should then be discharged home with Your Waters Have Broken leaflet, induction of labour leaflet and tempadots.

Postnatal Early Discharge

Women who deliver on the MLU, who have had a normal vaginal delivery with no complications are expected to go home within 6 hours, unless they are clinically un-well or there is no other reason that they need to stay longer. They should then be transferred to the postnatal ward for routine postnatal care.
It is an expectation that multiparous women will go home from the MLU and this will be discussed in the community and at antenatal classes.
Ensure that women have passed urine as per the Bladder Care Guideline, prior to discharge home.

Ensure that you have referred to the Newborn Early Warning Trigger and Track chart to exclude any need for neonatal observations prior to discharge.

Ensure NIPE check is completed or arranged prior to discharge.
NB. Women who will have community midwifery care by NBT are not able to have a NIPE in the community. Make every effort to complete the NIPE prior to discharge or arrange an appointment in the NIPE clinic.

Confirm correct discharge address and telephone number and complete Medway Discharge summary contemporaneously and make sure they are discharged from Medway Live. (Please add all comments to the mother's comments section, including information regarding baby).

REFERENCES

Intrapartum care: Care of healthy women and their babies during childbirth (NICE 2017) http://www.nice.org.uk/guidance/cg190
Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study (Birthplace in England collaborative group et al 2011)

RELATED DOCUMENTS

Pain Relief in Labour Non Epidural
Labour Care
Bladder Care Guideline

AUTHORISING BODY

CDS Working Party

SAFETY

There are no known safety concerns.

QUERIES

Contact [redacted] and MLU Matron [redacted]

REVIEW

Review 1.3
Amendments agreed by CDS working party – advanced maternal age, BMI 40 and late booker

Appendix 1 - Admission and Exclusion criteria for the MLU

MLU admission criteria

- Gestation 37+0 » 42+0
- Midwife led care at 36/40 assessment and at onset of labour
- Absence if maternal disease that effects pregnancy and labour
- Spontaneous onset of labour
- Group B Streptococcus positive – with no allergy to Penicillin
- Up to including 4th delivery
- Age ≤ 39 years at booking
- BMI >18 - <35 in primigravida women
- BMI <18 - <40 in multiparous women with no other comorbidity
- Singleton pregnancy
- Cephalic presentation
- Clinically well grown baby
- Normal fetal movements
- Reduced fetal movements in last 24 hours with cCTG 'Criteria MET' or 'normal' standard CTG, obstetric review and FM present since.
- Placental site not low
- SROM <24 hours.
- Clear liquor (thin meconium on admission with established labour and no concerns regarding fetal well-being)
- Normal vaginal loss
- HB ≥100g/dl
- Platelets ≥100g/l

Relative contraindications requiring obstetric review

Factors requiring individual assessment by obstetrician during pregnancy

Current Pregnancy

- Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation)
- Clinical or ultrasound suspicion of macrosomic or small baby (AC >95th centile should have a consultant review).
- Age 40-42 years at booking
- Late booker

Past History

- Stillbirth/neonatal death with a known non-recurrent cause
- Pre-eclampsia developing at term
- Placental abruption with good outcome
- History of previous baby more than 4.5kg
- Extensive vaginal. Cervical or third/fourth degree perineal trauma
- Major gynaecological surgery
- Cone biopsy or large loop excision of the transformation zone
- Fibroids
- Women declining blood products
- Women who have a history of genital herpes

MLU exclusion criteria

Current Pregnancy

- Under consultant care at 36 weeks
- Hypertension
- Pre-eclampsia
- Antepartum haemorrhage
- Gestational diabetes
- Maternal condition
  - Diabetes
  - Cardiac disease
  - Hyperthyroidism
  - Vascular disease
  - Renal disease
- Age ≥43 years at booking

Previous History

- Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty
- Previous baby with neonatal encephalopathy
- Pre-eclampsia requiring preterm birth
- Placental abruption with adverse outcome
- Eclampsia
- Uterine Rupture
- PPH requiring additional treatment or blood transfusion
- Caesarean section
- Shoulder dystocia