Trust Guideline for the Midwife-Led Birthing Unit (MLBU)
Operational Guideline

An Operational Guideline

For use in:	Maternity Services.
By:	Midwives
For:	Midwives working on the MLBU
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Name of document authors:	Rosie Goodsell (review/update by Tracey Miller)
Job title of document authors:	Practice Development Midwife (MLBU Team Leader)
Name of document author's Line Manager:	Lucy Weavers (Carmel Sayer)
Job title of author's Line Manager:	Head of Midwifery (Delivery Suite Manager)
Supported by:	Beth Gibson – Obstetric Consultant and lead for Maternity Guidelines
Assessed and approved by the:	Maternity Guidelines Committee If approved by committee or Governance Lead Chair's Action; tick here ☑
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If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why?	No deviation

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Version and Document Control:

Version Number	Date of Update	Change Description	Author
5	25/09/2020	Amended to align with Anaemia Guidelines Trustdocs Id: 16043. Hb is now over 95. Originally it was 90.	Rosie Goodsell (reviewed and updated by Tracey Miller).
6	26/11/2021	MLBU admission criteria. Risk section added.	Tracey Miller

This is a Controlled Document

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Background

The Midwife Led Birthing Unit (MLBU) is a co-located birthing suite with a separate entrance, situated within Blakeney ward.

Women admitted to the MLBU will be under the sole care of midwives who will provide midwife led care to low risk women in a comfortable 'home from home' environment. Should the need for medical intervention become necessary, then transfer to delivery suite will be required. Midwifery staff will adhere to the Trust Guideline for the Management of: Intrapartum Care in All Settings ***Trustdocs Id: 850*** and Management of Women Requesting Immersion in Water for Active Labour and/or Birth ***Trustdocs Id: 804***

Objectives

- To ensure appropriate women can access midwife led intrapartum care.
- To provide midwife with guidance on appropriate transfer and emergency management to ensure safety.

Rationale

Evidence suggests that birthing units that are situated away from the delivery suite are successful in achieving more normal births, have better breastfeeding rates, less medical interventions with no statistical differences in perinatal mortality rates and higher incidences of maternal satisfaction (Hodnett et al 2006).

Being sited separately from delivery suite allows the units to evolve with a distinct philosophy which is fundamental to its success (Walsh 2007).

A large national study considering place of birth for low risk women (Birthplace 2011) concluded that women who planned their birth in a midwifery unit had significantly fewer interventions, including substantially fewer intra-partum caesarean sections and more normal births than women who planned birth in an obstetric unit.

Philosophy of care

Midwives will provide care and support to women through the physiological process of labour and birth. Their care is instrumental in promoting normal birth by creating an environment in which the woman has the freedom to express herself physically and emotionally.

One-to-one support from midwives will empower women to have the confidence to progress through their labour and birth naturally without medical intervention. Physiological labour progresses along a continuum. Midwives will be alert to deviations and recognise and act upon any deterioration in the wellbeing of the woman and her unborn baby. Midwives practice will be guided by the best evidence available.

The booking process and ongoing advice

Throughout pregnancy place of birth will be discussed with the community midwife. Between 34-36 weeks the community midwife will confirm the place of birth and the care pathway with the woman, although this may change following risk assessment or the woman's choice.

For labour advice after 37 weeks gestation, women should contact the MLBU wherever possible on 01603 288260. Prior to 37 weeks of pregnancy women should contact their community midwife or McCleod Maternity Assessment Unit (MMAU) for advice.

Risk Assessment on admission

On admission, the midwife will listen to the woman's history, review her clinical records and undertake a physical examination. Her clinical history, lifestyle and psycho-emotional wellbeing should be part of this review. The midwife will complete the labour risk assessment (Appendix 1A) and document it in the maternal hand-held records which provide documented evidence that the woman is suitable to be cared for in the MLBU or transfer to delivery suite.

The midwife will need to assess maternal and fetal wellbeing to determine the plan of care. Individual requirements should be considered to ensure advice is appropriate and understandable taking into account any translation requirements and/or sensory/cognitive impairment.

If the woman is identified as high risk, as per the risk assessment tool, she will need to transfer to delivery suite where an individual plan of care will be made with an obstetrician.

Criteria for admission to MLBU

- Between 37+0 and 42+0 weeks gestation.
- Age: if > 40 at booking, in spontaneous labour before planned induction of labour (IOL), as agreed with consultant obstetrician.
- Para 0-5 (excluding miscarriages and terminations).
- Singleton pregnancy.
- BMI < 40 on admission in labour and good mobility – the admitting midwife needs to calculate and assess this on admission.
- Cephalic presentation.

- If membranes have ruptured, liquor must be clear/non-significant meconium.
- Rupture of Membranes must be less than 24 hours at onset of labour.
- No epidural requested.
- No known or envisaged medical, obstetric, anaesthetic or neonatal complication.
- No previous significant obstetric history.
- No known history of HIV or Hep B.
- Hb over 95g/l.

Ongoing risk assessments are essential throughout labour. These must be formally recorded at each handover of care using the trust approved SBAR handover sticker. If at any time during labour a low risk woman deviates from the normal pathway, transfer to delivery suite will be necessary.

Women who are otherwise low risk, have no risk factors for intrapartum fetal compromise and choose to labour/birth on the Midwife Led Birthing Unit (MLBU) meet admission criteria and are suitable for intermittent auscultation (NICE xxxx) if:

- Primigravida: following 1 x propess, +/- artificial rupture of membranes (ARM)
- Mulitparous: following mechanical induction of labour (MIOL), 2 x prostin, +/-ARM

The process should be as follows:

- 1 x case at a time
- Clear communication prior to transfer between Delivery Suite, Cley Obstetrics and MLBU coordinators
- If ARM indicated: MLBU midwife to go to Cley Obstetrics, take over care, undertake CTG, ARM, CTG on Cley Obstetrics, transfer to MLBU
- After 4 hours, if not in active labour, for transfer to DS for augmentation
- Care to be handed over to DS midwife or MLBU midwife to remain with woman to ensure timely commencement of augmentation

Primigravida women to be advised that trust guidelines recommend starting oxytocin immediately following ARM when doing an ARM for induction, as local data showed the majority of primigravida women (93%) required oxytocin during an induction. However they may choose to delay. If they choose to delay starting oxytocin, then we they should be informed that we would not recommend delaying starting it beyond four hours after ARM due

to the increase risk of infection (and associated morbidity including higher chance of admission to the neonatal unit) with membranes ruptured longer than 24 hours.

Reasons for transfer following risk assessment:

- Malpresentation/unstable lie.
- Fetal heart rate abnormalities heard on auscultation in first or second stage.
- Intrapartum haemorrhage.
- Significant meconium stained liquor. Non-significant meconium stained liquor should not automatically preclude the woman from staying on the MLBU providing all other parameters are normal.
- Cord prolapse/cord presentation.
- The woman requests an epidural.
- The woman requests to be transferred.
- Hypertension in labour BP ≥150/100 on 2 or more occasions (recorded 15 minutes apart) or if the woman is symptomatic of PET.
- Maternal Pyrexia of 37.5°C or greater on two occasions, two hours apart or 38°C on one occasion.
- Failure to progress in the first stage of labour see Trust Guideline for the Management of: Intrapartum Care in All Settings Trustdocs Id: 850.
- Failure to progress in the second stage of labour (see guideline as above).
- Retained placenta.
- Suspected 3rd / 4th degree perineal tear.
- Postpartum haemorrhage of 500 – 1000mL if woman clinically unstable or > 1000mL.
- Maternal collapse.
- Any deviation from the norm which concerns the midwife.

Transferring women from the MLBU to the Delivery Suite

The speed of transfer will depend on the reason for transfer and the condition of the woman at the time. It is essential that the transferring midwife communicates clearly with the co-ordinator on delivery suite so that the urgency of the situation is clearly understood. The senior midwife on the MLBU and the delivery suite co-ordinator must decide the safest place of care. Clear communication regarding potential transfer is essential. Activity on delivery suite will be a consideration.

Mode of transfer should be appropriate to the situation - walk, trolley or wheelchair.

EMERGENCY MANAGEMENT

- **Pull the Emergency Buzzer** This will alert other staff on the MLBU and on Blakeney who will attend. The obstetric emergency trolley and drugs should be brought immediately to the location.

- The 2222 call must be made stating **'obstetric emergency' OR 'neonatal emergency'**, nature of emergency and the location. The call will alert the delivery suite co-ordinator who will send senior assistance and organise a room on delivery suite for an obstetric emergency.

ACTIONS FOR SPECIFIC EMERGENCIES:

Emergency measures must be initiated immediately by the midwives on the MLBU and transfer arranged urgently, as required. Guidance on emergency treatment can be found in the following obstetric/midwifery guidelines:

Management of Major Obstetric Haemorrhage Trustdocs Id: 852

Management of Shoulder Dystocia Trustdocs Id: 888

Management of Severe Pre-Eclampsia and Eclampsia Trustdocs Id: 887

In cases of

- **Post-Partum haemorrhage** - Initiate emergency treatment for excessive blood loss. If successful and the woman remains asymptomatic, provided estimated blood loss is less than 1000mLs, the woman may remain on the MLBU at the discretion of the midwife. If initial management is unsuccessful or the woman is showing signs of compromise prompt transfer should be initiated.
- **Eclampsia** - the priority will be the management of airway, breathing, circulation and stability then transfer to delivery suite as soon as possible for subsequent management.
- **Cord Prolapse/Presentation** - in cases of cord prolapse transfer should be arranged as soon as possible to delivery suite via the co-ordinator. Measures must be taken by MLBU midwives to relieve pressure from the umbilical cord prior to and during transfer.
- **Shoulder Dystocia** - the MLBU midwives must attempt the manoeuvres according to the shoulder dystocia guideline. An obstetrician and neonatologist will respond to the 2222 call.
- **Undiagnosed Breech** - If a breech is diagnosed in labour transfer to delivery suite should be arranged as soon as possible. If the midwife considers the birth is imminent, making transfer unsafe, the midwife should support physiological breech birth until assistance arrives; only using manoeuvres if required.
- **Neonatal Resuscitation** - If spontaneous breathing is not achieved with 5x inflation breaths the Emergency buzzer should be pulled and the 2222 call stating 'Neonatal Emergency' should be made.

THE DELIVERY SUITE CO-ORDINATOR WILL HAVE BEEN ALERTED OF AN EMERGENCY BY THE 2222 CALL HOWEVER IT IS ESSENTIAL THAT A FORMAL REQUEST FOR TRANSFER IS MADE WHERE APPROPRIATE

Transferring women from Delivery suite to MLBU

Women who arrive on the delivery suite who are suitable for midwife-led care may be transferred to the MLBU if they wish, subject to availability. There must be clear communication between the delivery suite midwife and the co-ordinating midwife on the MLBU.

Postnatal care

Women will be offered the choice of having an early transfer from the MLBU to community care or staying on Blakeney ward if desired or clinically indicated. The Newborn Infant Physical Examination (NIPE) will be performed on the MLBU prior to transfer home by a midwife, neonatologist or advanced neonatal nurse practitioner with the appropriate qualification. In exceptional circumstances this can be arranged in the community if there is a NIPE examiner available.

Clinical Audit Standards derived from guideline

The Maternity Service is committed to the philosophy of clinical audit, as part of its clinical governance programme. The standards contained in this clinical guideline will be subject to continuous audit, with multidisciplinary review of the audit results at one of the monthly departmental clinical governance meetings. The results will also be summarised and a list of recommendations formed into an action plan, with a commitment to re-audit within three years, resources permitting.

The Audit Criteria is as follows:

The number of women admitted to MLBU.

The number of women who give birth in the MLBU

Transfer rates and reasons

Labour outcomes

Pain management strategies

Health records

Source documents

Intrapartum Care in all Settings - Trustdocs Id: 850

Major Obstetric Haemorrhage Trustdocs Id: 852

Severe Pre-Eclampsia and Eclampsia Trustdocs Id: 887

Shoulder Dystocia Trustdocs Id: 888

Women Requesting Immersion in Water for Active Labour and/or Birth ***Trustdocs Id: 804***

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Appendix 1: Risk Assessment on Admission at Onset of Labour

Intrapartum and Fetal Monitoring Risk Assessment Tool

Complete within one hour of labour admission to MLBU or Delivery Suite or arrival of midwife at home.
(This tool may be used to hand over care in labour)

Name
Hospital Number

or add patient identifier label

E3 Alert checked
Tick once confirmed

Weight: *kg*
BMI:

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Intrapartum and Fetal Monitoring Risk Assessment Tool continued

Complete within one hour of labour admission to MLBU or Delivery Suite or arrival of midwife at home.
(This tool may be used to hand over care in labour)

Name
Hospital Number

or add patient identifier label

Circle all that apply

Anaesthetic Risk – **Alert Anaesthetic team on bleep 0011 if triggers a risk**			
Anaesthetic Alert	Yes	BMI 40 or above on admission	Yes
Severe Latex or relevant allergy	Yes	Spinal abnormality	Yes
Previous anaesthetic problems	Yes	Declines blood products	Yes
Poor venous access/needle phobia	Yes	Co-Morbidities (renal/cardiac/clotting)	Yes

Summary of any modifications to management of labour – if none, write “none”	
Detailed plan for high risk women or where to find details on E3 or COAC form:	
Midwifery co-ordinator aware of management plan if high risk:	

Name		Signature		Designation	
Date *dd/mm/yyyy*		Time *24 hours*			