

Trust Guideline for the Midwife Led Birthing Unit (MLBU)

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V4.0	Nov 2017	MLBU Team Leader	Update admission criteria
V4.1	Mar 2019	MLBU Team Leader	Amended to bring into line with induction of labour and meconium guidelines
V4.2	Jul 2019	MLBU Team Leader	Change to the BMI cut off for the midwife led birth unit
V4.3	Nov 2019	MLBU Team Leader	Amended to align with Anaemia guideline Trustdocs 16043
V5	Nov 2020	MLBU Team Leader	Amended to align with Anaemia Guidelines Trustdocs Id: 16043. Hb is now over 95. Originally it was 90.
V6	Jul 2021	MLBU Team Leader	MLBU admission criteria. Risk section added.
V7	March 2024	MLBU Team Leader	Guidance transferred to new

Author: Tracey Miller Team Leader MLBU

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			template. Update re BMI and parity.
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Previous Titles for this Document:

Previous Title/Amalgamated Titles	Date Revised
None	Not applicable

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

The following were consulted during the development of this document:

Obstetric team

Senior Midwifery Leadership team

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

This document is a standard operating procedure applicable to Norfolk and Norwich University Hospitals NHS Foundation Trust; please refer to local Trust's procedural documents for further guidance, as noted in Section 5.

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1. Introduction

1.1. Rationale

Evidence suggests that birthing units 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.

1.2. Objective

The objective of the Trust Guideline for the Midwife Led Birthing Unit (MLBU) is to:

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

1.3. Scope

The scope of this document is relevant for labouring and birthing people, midwives, and obstetricians when on the MLBU.

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
DS	Delivery Suite
MLBU	Midwife Led Birthing Unit
E3	Euroking - NNUH maternity records programme
BMI	Body mass index
IOL	Induction of labour
ARM	Artificial rupture of membranes
MCA	Maternity Care Assistant
PPE	Personalised Protective Equipment
EIA	Equality Impact Assessment

2. Responsibilities

It is the responsibility of the Team Leader, MLBU, to review and update this document.

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3. Policy Principles and processes to be followed.

3.1 Background

The MLBU is a co-located birthing suite with a separate entrance, situated within Blakeney ward.

Women admitted to the MLBU will be under the 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 stabilisation of the evolving condition and 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 vs 12 and Management of Women Requesting Immersion in Water for Active Labour and/or Birth: Trustdocs ID: 804

3.2 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.

3.3 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.

3.4 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 Intrapartum and fetal monitoring risk assessment Trustdocs 17215

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and document it in the maternal hand-held records which provide documented evidence that the woman is suitable to be cared for on the MLBU or be recommended transfer to DS.

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 considering any translation requirements and/or sensory/cognitive impairment.

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

3.5 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 - 3 (excluding miscarriages and terminations).
- Singleton pregnancy.
- BMI < 35 at booking.
 - In addition, intrapartum care on delivery suite is recommended if BMI is ≥40 on admission in labour even if booking BMI was <35.
- Cephalic presentation.
- If membranes have ruptured, liquor must be clear or lightly blood stained.
- 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 DS will be advised.

Women who are otherwise low risk, have no risk factors for intrapartum fetal compromise and choose to labour/birth on the MLBU, following IOL meet admission criteria and are suitable for intermittent auscultation (NICE 2007) if:

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

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The process should be as follows:

- 1 x case at a time
- Clear communication prior to transfer between DS, Cley Obstetrics (CLEO) and MLBU coordinators
- If ARM indicated: MLBU midwife to go to CLEO, take over care, undertake CTG, ARM, CTG on CLEO or DS, 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 they should be informed that we would not recommend delaying starting it beyond four hours after ARM due to the increased risk of infection (and associated morbidity including higher chance of admission to the neonatal unit) with membranes ruptured longer than 24 hours.

3.6 Reasons for transfer following risk assessment:

- Malpresentation/unstable lie.
- Fetal heart rate abnormalities heard on auscultation in first or second stage.
- Intrapartum haemorrhage.
- Meconium-stained liquor.
- Cord prolapse/cord presentation.
- The woman requests an epidural.
- The woman requests to be transferred.
- Hypertension in labour BP $\geq 150/100$ on 2 or more occasions (recorded 15 minutes apart) or if the woman is symptomatic of pre-eclampsia (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.

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- Postpartum haemorrhage of 500 – 1000mL if woman clinically unstable or > 1000mL.
- Maternal collapse.
- Any deviation from the norm which concerns the midwife.

3.7 Transferring women from the MLBU to DS

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 DS so that the urgency of the situation is clearly understood. The senior midwife on the MLBU and the DS 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.

3.8 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 DS co-ordinator who will send senior assistance and organise a room on delivery suite for an obstetric emergency.

3.9 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 relevant obstetric/midwifery guidelines.

In the case of:

- **Post-Partum haemorrhage (PPH)** - 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

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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 DS 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

4. Training & Competencies

All clinical maternity staff to attend annual Practical Obstetric Multi-Professional Training (PROMPT) training as part of the trust mandatory training requirement.

5. Related Documents

Intrapartum Care in all settings: Trustdocs Id: 850 v12	https://webapps.nnuh.nhs.uk/TrustDocs/Doc.aspx?id=850
Waterbirth management: Trustdocs Id: 804	https://webapps.nnuh.nhs.uk/TrustDocs/Doc.aspx?id=804
Maternity care requested outside of guidance – A clinical guidance	https://webapps.nnuh.nhs.uk/TrustDocs/Doc.aspx?id=20414
Intrapartum and Fetal monitoring risk assessment tool	https://webapps.nnuh.nhs.uk/TrustDocs/Doc.aspx?id=17215
All maternity/obstetric guidelines pertaining to management of obstetric emergencies.	

6. References

Birthplace (2011) <http://www.bmj.com/content/343/bmj.d7400>

Hodnett, E.D. (2006) Continuity of caregivers for care during pregnancy and childbirth (Cochrane Review). In: *The Cochrane Library*, Issue 2. Chichester: John Wiley and Sons LTd.

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7. Audit of the process/policy principles/service to be delivered.

This guideline is an overview of intrapartum care on MLBU. Multiple aspects of intrapartum care are audited and detail of these audits are available.

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
Recordkeeping including completion of risk assessment, use of SBAR, use of I-CARE	Audit	Appropriate appointed midwife by MLBU team leader	Maternity Clinical Governance	Annual
Prolonged second stage	Datix Reporting trigger	Maternity Risk and Governance	Maternity Risk and Governance	Case by case

The audit results are to be discussed at maternity governance meetings to review the results and recommendations for further action. Maternity Governance will ensure that the actions and recommendations are suitable and sufficient.

8. Appendices

There are no appendices.

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9. Equality Impact Assessment (EIA)

Type of function or policy	Existing
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Division	3 W&C	Department	MLBU
Name of person completing form	Tracey Miller	Date	27/02/2024

Equality Area	Potential Negative Impact	Impact Positive Impact	Which groups are affected	Full Impact Assessment Required YES/NO
Race	no	no		no
Pregnancy & Maternity	no	no		no
Disability	no	no		no
Religion and beliefs	no	no		no
Sex	no	no		no
Gender reassignment	no	no		no
Sexual Orientation	no	no		no
Age	no	no		no
Marriage & Civil Partnership	no	no		no
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?				

<ul style="list-style-type: none"> • A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty • Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service • The policy or function/service is assessed to be of high significance
IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED
The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.