Document Control

Title **Low Risk Care of Women in Labour at Home or Midwife Led Setting Guideline**			
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CONTENTS

1.

1.1. The purpose of this document is to detail the process of Low risk Care for a woman at home or in an alongside unit/ room. The aim of this guideline is to provide documented resources to support excellence in clinical practice and is supported by evidence from National Institute of Health and Care Excellence (NICE) documents and is used in conjunction with existing supporting local guidelines.

1.2. The policy applies to all Trust staff that are likely to come into contact with women in low risk labour.

1.3. Implementation of this policy will ensure that midwives are able to support women in their place of choice of birth, whether this is at home or in an alongside unit after full discussion of the benefits and risks associated with each option. The women will have received an appropriate risk assessment and have a documented plan of care based on local and national guidance. This includes NICE recommendations and working in line with Better Births (NHSE, 2016). For a hospital birth, please refer to the Intrapartum Care of Healthy Women guideline.

2. Definitions

Normal Labour

2.1. Normal labour is defined as spontaneous labour commencing between 37 – 41+6 weeks gestation.

3. Responsibilities

Role of the Midwife

3.1. It is the responsibility of the midwife to ensure that women have sufficient information to make choices about her place of birth. Opinions from the obstetric team may be sought to aid decision making. All discussion and plans must be documented by the relevant clinician within the women hand held records.

3.2. All midwives

- Must give evidence based advice, taking into account the women's individual circumstance, about a suitable place of birth.
- Support a woman's choices ensuring advocacy for women within the maternity service.
- Complete a risk assessment form for women who choose to birth their baby at home
- Refer to the inclusion / exclusion criteria for women who are choosing to birth within the midwife led care room within the Lady well unit. If criteria apply the midwife must document and seek further advice from her line manager, lead midwife or obstetrician (if this is appropriate).
- Must ensure that all discussions and plans for a women place of birth is documented within her hand held records.

Role of Maternity Specialist Governance Group

3.3. The Maternity Specialist Governance Group (MSGG) is responsible for monitoring all governance activity within the service. The MSGG terms of reference identifies the full detail of the responsibilities of this group.

4. Introduction

4.1. The aim of this guideline is to provide documented resources to support excellence in clinical practice and is supported by evidence from National Institute of Health and Care Excellence (NICE) guidance, Better Births, (NHSE, 2016) and local guidelines.

4.2. This document will encompass care of the normal labouring woman who have chosen to labour at home or in the alongside birth setting and will refer to NICE recommendations for transfer to Obstetric care when indicated. Normal labour is defined as spontaneous labour commencing between 37 – 41+6 weeks gestation. This document will not cover pre-term labour, induction of labour, use of oxytocin in labour or assisted vaginal delivery or associated Obstetric care. Hyperlinks can be followed to access these on the Trust Maternity documents/guidelines via BOB.

5. Booking Appointment

5.1. Women and their partners should be informed of their choices of place of birth at their first antenatal booking appointment with their team midwife. Three options of Home, Midwife Led setting or Obstetric Led hospital labour ward should be offered, (NHSE, 2016).

5.2. All women should be given the NHS leaflet, "Your choice, where to have your baby" either;

https://assets.nhs.uk/prod/documents/NHSE-your-choice-where-to-have-baby-first-baby-sept2018.pdf ' for first time mums, or;

https://assets.nhs.uk/prod/documents/NHSE-your-choice-where-to-have-baby-baby-before-sept2018.pdf for women who have had a baby before.

It is important to discuss with the women their chances of outcomes, rates of transfer to a consultant led unit, according to place of birth, refer to Intrapartum care for healthy women and babies, NICE (2017).

5.3. Document a record of the discussion in the hand held notes.

6. Antenatal Care

Antenatal Care should be performed as per NICE recommendations, Antenatal Care for Uncomplicated Pregnancies, (NICE, 2019).

6.1. For those women eligible for Midwife Led Care, and choose to deliver at home, a Home Birth risk assessment should be completed around 36 weeks of pregnancy, in the woman's home. See Appendix A.

6.2. There should be a two-way discussion about the plan of care; any specific requests should be recorded. If a birth plan has been written, this should be read, discussed and clearly documented in the woman's hand held notes. If a mother does not wish to receive the care as suggested in these guidelines then this must be respected and the discussion recorded in her notes.

6.3. When a risk assessment is completed for a home birth, send a copy to labour ward, place a copy in the hand held notes, and leave the original with the woman.

6.4. For those women with additional risk factors where this decision presents a concern in facilitating a normal labour and birth, this should be discussed with a senior midwife and the woman's named consultant. An individualised plan of care can then be made accordingly.

6.5. If a woman wants to have her baby in the Midwife Led Setting room (within the Ladywell unit) please refer to inclusion/exclusion criteria as detailed in Appendix B.

7. In Labour

The initial assessment of labour will be carried out by telephone triage on labour ward:

7.1. A telephone triage SBAR form must be fully completed by a midwife for each woman who contacts the labour ward for advice.

7.2. Identify choice of place of birth. If requesting Home or Midwife Led room, reassess eligibility according to the current SBAR and pregnancy risk assessment. Consider a face to face assessment of labour at home or in Midwife Led setting, depending upon the woman's planned place of birth.

7.3. Give information about what the woman can expect in the latent first stage of labour and agree a plan of care with the woman, including, if appropriate, guidance about who she should contact next and when.

7.4. Any concerns regarding the clinical triage assessment must be escalated to the labour ward coordinator for support and advice.

7.5. The SBAR must be filed in the woman's main notes when no longer required

8. Care on attendance at home or on admission to Midwife Led setting

8.1. If attending birth in the home setting, equipment as in Appendix D must be taken to the home when attending for the initial assessment.

Initial Assessment of maternal and fetal wellbeing,

8.2. Baseline observations recorded to include:

- Maternal pulse, BP, temperature, respiratory rate and urinalysis.

- Abdominal palpation – to determine fundal height, fetal lie, presentation, position, engagement and frequency and duration of contractions.

- Auscultation of the fetal heart for a minimum of 1 minute immediately after a contraction and record it as a single rate – palpate the woman's pulse to differentiate between the two. Record accelerations or decelerations if heard.

- Dependent on above findings, vaginal examination should be offered.

8.3. Women identified with recognised vulnerabilities but remain eligible for either a home birth or Midwife Led setting, for example, mental health, housing, support concerns, should have a clear documented plan of care and treatment documented in the hospital notes.

8.4. If a woman develops any risk factors highlighted in Appendix C at any time throughout her labour, the midwife caring for her must refer her to the obstetric team on the labour ward for assessment and a plan of action made. In the event of imminent delivery assess and discuss whether birth in the current location is preferable.

9. First stage of labour

Latent Phase

On admission the correct diagnosis of the phase of labour is important.

9.1. The midwife must ensure that the woman is aware of the different stages of labour and that the latent phase may last for several hours. She should be offered advice and support to manage this stage, and empower the women to feel confident in returning

Active phase

9.2. When a woman is in the active phase of labour a partogram should be commenced. It is important that documentation is contemporaneous where possible

9.3. Breathing exercises, relaxation techniques, immersion in water, hypnobirthing and massage will support women in the latent stage of labour, support the woman in her choice. Do not offer or advise the use of hypnobirthing, aromatherapy, yoga or acupressure for pain relief unless you have been appropriately trained in these techniques.

9.4. Labouring in water is supported for healthy women with uncomplicated pregnancies and is recommended for pain relief.

9.5. Entonox (50:50 mix of oxygen and nitrous oxide) is available when supporting a woman at home or in a Midwife Led setting. It should be administered with clear instruction, refer to Analgesia and Anaesthesia in Maternity Guideline. Analgesia and Anaesthesia in Maternity Guideline

9.6. Within the Midwife Led Care setting, diamorphine or other opioids are available to administer, refer to Intrapartum Care including Fetal Monitoring Guideline for further information. Intrapartum Care Including Fetal Monitoring Guideline

9.7. Ongoing assessment of maternal and fetal wellbeing as per NICE guidance;

- Hourly maternal pulse
- 4 hourly Temperature and blood pressure
- Monitor uterine activity, document every 30 minutes
- Record frequency of emptying of maternal bladder
- Auscultation of fetal heart every 15 mins after a contraction for 1 min record as single rate
- Record accelerations or decelerations if heard.
- Vaginal examinations (VE) should be offered 4 hourly once in established labour (4 cm regular contractions), with abdominal palpation being recommended before each VE.
- Document any vaginal loss

9.8. Artificial Rupture of Membranes (ARM)

Membranes do not need to be artificially ruptured in an otherwise low risk labour. If this is to be considered, discuss with the labour ward co-ordinator first.

9.9. Spontaneous Rupture of Membranes

When membranes rupture spontaneously, the fetal heart should be auscultated. Observe and document vaginal loss regularly, especially in the presence of ruptured membranes.

The presence of significant meconium defined as dark green or black amniotic fluid that is thick or any meconium –stained amniotic fluid containing lumps of meconium should be transferred to an Obstetric Led care setting. The presence of thin meconium in itself in the absence of other accompanying risk factors does not necessitate transfer from a community setting, see Appendix B.

9.10. Uterine contractions should be assessed by abdominal palpation. This provides an assessment of frequency and duration. This should be recorded on the partogram.

9.11. If delay in the first stage is suspected take the following into account

- parity
- cervical dilatation and rate of change
- uterine contractions
- station and position of presenting part
- the woman's emotional state
- Offer the woman support, hydration, and appropriate and effective pain relief.

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

- Nulliparous: <2cm dilatation in 4 hours
- Parous : <2cm dilatation in 4 hours or a slowing in the progress of labour

9.12. For all women with confirmed delay in the established first stage of labour, the labour ward co-ordinator must be informed and transfer arranged to obstetric-led care for an obstetric review face to face assessment and a decision about management options.

10. Second Stage of Labour

10.1. Second stage of labour is defined as cervix has reached full dilatation on vaginal examination or the presenting part is visible. If the woman has no urge to push re-assess in 1 hour.

10.2. In the second stage of labour without complications, it is important that the woman should not be actively encouraged to push until the presenting part is visible or until the desire to push is overwhelming.

10.3. Continuous assessment of maternal and fetal wellbeing;

- Maternal temperature 4 hourly
- BP and maternal pulse hourly unless otherwise indicated
- Vaginal examination as clinically indicated
- Frequency of contractions, every 30 mins
- Record frequency of emptying the bladder

- Fetal Heart every 5 mins after a contraction for 1 min record as single rate (where possible). Record accelerations or decelerations if heard.

- Palpate the woman's pulse every 15 minutes to differentiate between the two heart rates

- Continue to monitor and record vaginal loss

10.4. The second stage may be divided into two phases: the descent/rotation phase and the pushing/active phase.

10.5. The mother should be free to choose her position for delivery within safe and reasonable limits. If the chosen position is not possible ensure that this is adequately explained and documented in the labour notes.

10.6. There is no evidence that sustained (Valsalva) pushing is physiologically more effective (Cochrane 2006).

10.7. The person conducting the delivery should be responsible for giving guidance to the mother. It is important to avoid more than one person talking at any one time.

10.8. Definition of delay and recommended duration of second stage.

Nulliparous: If after 1 hour of active second stage progress is inadequate,

Parous: If after 30 minutes progress is inadequate

If delay is suspected, then transfer to the hospital setting is advised for obstetric opinion and plan of management made. If this is from home, please refer to Clinical Guideline Maternal transfer by Ambulance and Appendix C**.**

11. Third Stage of Labour

The third stage commences with the complete delivery of the baby. It is important that options for management of the third stage have been discussed with the woman (where possible) in advance of its commencement.

11.1. Active Third stage:

- Routine use of uterotonic drugs
- Deferred clamping and cutting of the cord
- Controlled cord traction after signs of separation of the placenta

11.2. Physiological third stage:

- No routine use of Uterotonic drugs

- No clamping of the cord until pulsation has stopped
- Delivery of placenta by maternal effort
- If the baby requires resuscitation or the cord is very short it should be clamped and cut after which the clamp may be removed from the maternal end to drain.

11.3. Delivery of the placenta should be expected within 30 minutes or within 60 minutes of the birth with physiological management. In the event that it is retained, transfer to an Obstetric Led care setting. Refer to Appendix C for reasons to transfer to Consultant Led Setting.

11.4. Observations in the third stage;

- her general physical condition, as shown by her colour, respiration and her own report of how she feels
- vaginal blood loss.

12. Monitoring Compliance with and the Effectiveness of the Guideline

This guideline will be reviewed three yearly and compliance with it will be monitored with the audit programme.

Process for Implementation and Monitoring Compliance and Effectiveness

12.1. This guideline will be approved through the Maternity Specialist Governance group every 3 years.

12.2. There will be yearly audit of birth within the MLC setting to ensure compliance with this guideline.

12.3. This audit will be presented at the Audit and Case Review meeting

13. References

- Nice, (2019). Antenatal care or uncomplicated pregnancies. CG 62
- Nice, (2017). Intrapartum care for healthy women and babies CG, 190
- NHS England, (2016). Better Births. Improving outcomes of maternity services in England. A five year forward view for maternity care.

14. Associated Documentation

- Guideline for labour and monitoring

- Maternal transfer
- Water birth guideline

Appendix A

Home Birth Planning Assessment Form

EDD: Gravida: Para:	Named Midwife: Team: GP:	Sticker: Phone number:

The issues below must be discussed with the woman and her birthing partner in the home environment around 36 weeks.

Blood Group **Last Hb**

36 week Assessment at Home	Yes	No	Risks or Potential risk Identified	Actions/Contingency Plans	Signature/Date
Home birth can be offered between 37 weeks & Term+12. After this individual planning with the obstetrician would need to be arranged.					
There will be one midwife present initially to access progress. Once labour established and progressing a second midwife will be called to attend. The Midwives will then work together in the same room with you and your partner ensuring safety and continuity.					
Confirm suitability for a home birth following a full review of her medical, surgical & obstetric					

history (refer to guidelines) Discuss with your Manager if any risks identified Development of an individualised care plan if necessary for diabetes, GBS, BMI>35. (if going against medical advice please speak with team leader and a separate letter will be sent following meeting with woman and partner)					
Contact details for when labour starts.					
Birthplan: Discussed and fully completed on Pg. 29 of Antenatal notes, or ensure personal plan is attached. Please note any specific aspects of care that wish to be declined and advice given.					
Environment					
Location: Parking issues Safety of surrounding area Easily accessible for midwife & ambulance staff: Stairs Lifts Pets Has area for delivery been discussed? (check access/space adequate) Discuss tokens for meters/mobile phone					

reception etc. Availability of heating? Hot water bottle to warm baby towels/clothes if no heating. **Useful tips.** Good lighting, (Torch), Waterproof sheeting. Old towels/blankets. Refreshments and snacks for everyone. **Hospital bag packed**. **Client:** Mobility issues Language spoken (state language) Is there a family member/friend available to care for other children? Hand hygiene/Toilet facilities. Social services involvement					
Routine monitoring in labour as per NICE guidance: Maternal observations as per guidelines • Pulse hourly • Resps hourly • BP 4 hourly • Temp 4 hourly • Bladder care 4 hourly • Abdo palpation 4 hourly • Fetal monitoring every 15 mins in 1st stage and every 5 mins in 2nd stage. To					

include when to monitor-after a contraction and why • VE's in labour • Management of 3rd stage-active –use of syntometrine/Syntocinon or physiological					
Pain relief in labour: • Use of TENS • Use of Entonox • Alternative therapies • Hypnobirthing - if using this method discuss how to get consent.					
Possible reasons for transfer by ambulance & distance from unit/time to transfer discussed? Maternal concerns: • Raised blood pressure • Persistent pyrexia • Prolonged SRM • Haemorrhage • Shoulder dystocia • Cord prolapse • Malpresentation/breech • Maternal complications • Slow/no progress • Retained placenta • Difficult suturing • Maternal request • Any case where there is an ongoing professional concern • Include discussion around transfer rates into					

Hospital- ***See Your Choice, Where to have your baby Leaflet.*** Fetal concerns: • Meconium (*significant meconium defined as dark green/black or any amniotic fluid containing lumps. The presence of thin mec in itself in the absence of the other risk factors does not necessitate transfer from the community setting).* • Fetal heart irregularities • Fetal complications, including if baby needs resus • Hypoglycaemia • Hypothermia/Hyperthermia • Unexpected abnormality					
Document discussion around how staffing for homebirth works: individually assessed based on service availability.					
If booked for a water birth discuss the following: **Discuss possible test run of filling and emptying pool prior to labour.** • Positioning of the pool • Not to get in until a midwife is present • Pool temperature • Maintaining pool temp • Keeping pool clean-responsibility • Performing VE's					

• Observations whilst in the pool & necessity to get out if unable to perform • Monitoring the FH • Whether the 2nd stage will be in the pool • Emergency situations					
What happens after the birth: • Skin to skin • Vitamin K • Need to pass urine • Lochia-what to expect • Routine PN care • Midwife visits • Hearing test • Newborn examination • If any concerns re self or baby in the postnatal period phone Bassett ward. 01272 322612 or Delivery suite 01272 322605.					
Midwife check points. Stickers/Intrapartum/postnatal notes arranged. Home birth details sent to delivery suite folder.					

Midwives Name……..

Date and time…….

Other relatives……

People present at discussion:-

Mother's signature …….

Partner's signature …….

Doula ……..

Appendix B

Midwife Led Care Room (located within the obstetric unit)

(NICE, 2017)

Criteria for booking to be reviewed and decided from 36 weeks until labour

Inclusion

- Singleton pregnancy
- Cephalic presentation
- Uneventful pregnancy with expected growth
- Gestation – 37 +0 – 41+6
- Spontaneous onset of labour
- Spontaneous SROM- clear ; <24 hours
- BMI 18-35
- Para 4 or less
- Women who have agreement (documented) by their named Obstetrician to deliver in the MLC
- Choice

Exclusion

- Labour before 37+0 weeks gestation
- Labour after 42+0 weeks gestation
- Pregnancy complicated by underlying medical condition see PAGE 20/21
- Obstetric complication to include see PAGE 20/21
- Multiple pregnancy
- Grand Multip (Para 5 or above)
- VBAC
- Meconium stained Liquor
- BMI below 18 or above 36
- Continuous fetal monitoring in labour
- Epidural anaesthesia
- Induction of labour

If women enters the midwife care room and develops any of the exclusion criteria she must be transferred to an obstetric room and guidance sought by the labour Ward Coordinator / Obstetrician.

Factors indicating increased risk suggesting planned place of birth at an obstetric unit/room

Previous complications

- 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
- Primary postpartum haemorrhage requiring additional treatment or blood transfusion
- Retained placenta requiring manual removal in theatre
- Caesarean section
- Shoulder dystocia

Current pregnancy

- Multiple birth
- Placenta praevia
- Pre eclampsia or pregnancy induced hypertension
- Preterm labour or preterm prelabour rupture of membranes
- Placental abruption
- Anaemia – haemoglobin less than 85 g/litre at onset of labour
- BMI at booking of greater than 35 kg/m2
- Recurrent antepartum haemorrhage
- Induction of labour
- Substance misuse
- Alcohol dependency requiring assessment or treatment
- Onset of gestational diabetes
- Malpresentation – breech or transverse lie
- Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound)
- Abnormal fetal heart rate/Doppler
- Ultrasound diagnosis of oligo /polyhydramnios
- Confirmed intrauterine death

Previous gynaecological history

Myomectomy
Hysterotomy

Medical conditions indicating increased risk suggesting planned birth at an obstetric unit/room.

Cardiovascular	Confirmed cardiac disease Hypertensive disorders
Respiratory	Asthma requiring an increase in treatment or hospital treatment Cystic fibrosis
Haematological	Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major History of thromboembolic disorders Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100×10^9/litre Von Willebrand's disease Bleeding disorder in the woman or unborn baby Atypical antibodies which carry a risk of haemolytic disease of the newborn
Endocrine	Hyperthyroidism Diabetes
Infective	Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended Hepatitis B/C with abnormal liver function tests Carrier of/infected with HIV Toxoplasmosis – women receiving treatment Current active infection of chicken pox/rubella/genital herpes in the woman or baby Tuberculosis under treatment
Immune	Systemic lupus erythematosus Scleroderma
Renal	Abnormal renal function Renal disease requiring supervision by a renal specialist
Neurological	Epilepsy Myasthenia gravis Previous cerebrovascular accident
Gastrointestinal	Liver disease associated with current abnormal liver function tests
Psychiatric	Psychiatric disorder requiring current inpatient care

Appendix C

Indications for Maternal Transfer From a MLC Setting to an Obstetric Unit / Room

Please also see Maternal Transfer by Ambulance Maternal Transfer By Ambulance Guideline

Indications for Transfer

Antenatal

- Preterm Labour • Preterm rupture of membranes
- Severe hypertension in pregnancy
- Ante partum haemorrhage
- Medical conditions in Pregnancy; diabetes, amnionitis, heart disease.
- Multiple gestation with complications
- Intrauterine growth restriction with non-reassuring fetal monitoring.
- Trauma
- Fetal anomaly
- Inadequate progress in labour
- Malpresentation.
- Any other obstetric or neonatal emergency.

Intrapartum

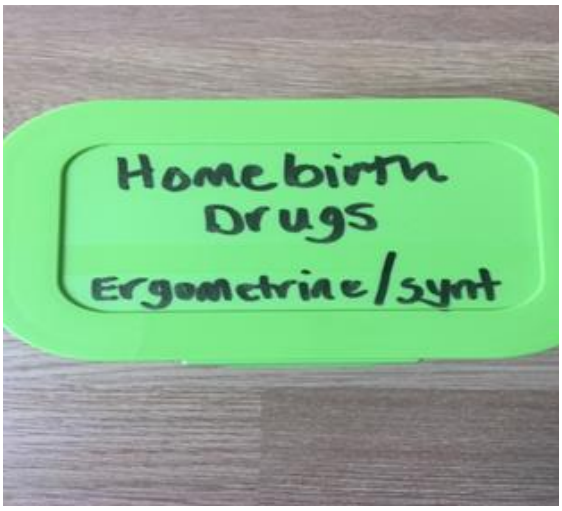
- Cord prolapse
- Failure to progress in labour
- Bleeding
- Malpresentation
- Analgesia
- Fetal compromise
- Maternal compromise

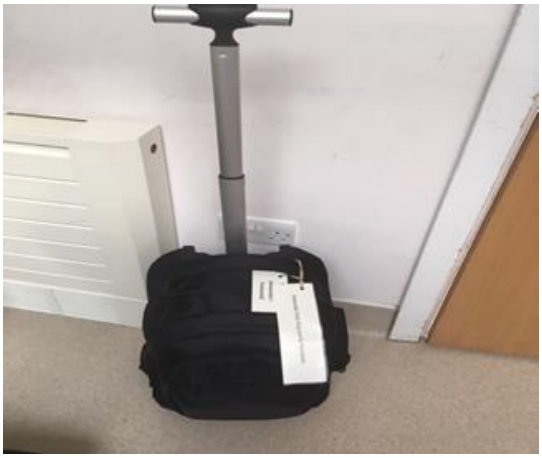
Postnatal

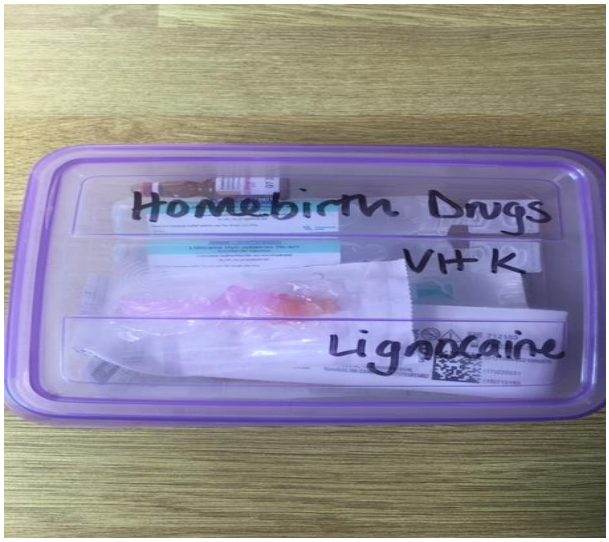
- Haemorrhage
- Suturing (if needs obstetric input)
- Retained Placenta
- Maternal or fetal compromise
- Birth asphyxia
- Infection
- Thromboembolic complications.

Appendix D

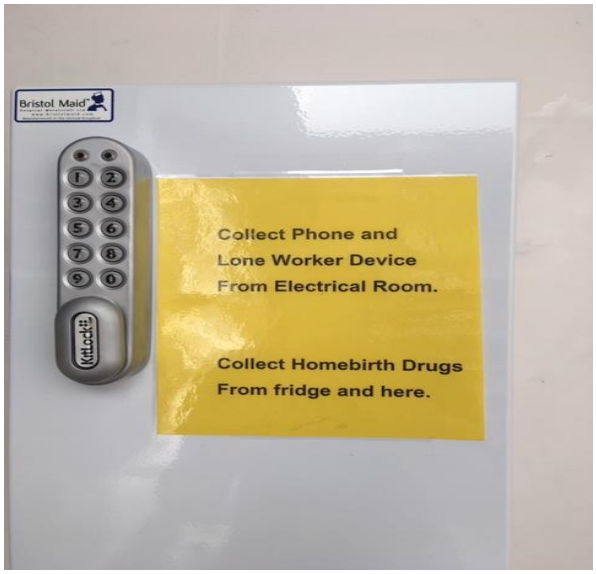
Midwifery Kit Needed for Home Births, Available on Central Delivery Suite






Homebirth Drugs
VIT K
Lignocaine


ENTONOX


Bristol Maid
Collect Phone and
Lone Worker Device
From Electrical Room.
Collect Homebirth Drugs
From fridge and here.