Planning place of birth guideline (GL887)

Approval

<table>
<thead>
<tr>
<th>Approval Group</th>
<th>Job Title, Chair of Committee</th>
<th>Date</th>
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<tbody>
<tr>
<td>Maternity &amp; Children’s Services Clinical Governance Committee</td>
<td>Chair, Maternity Clinical Governance</td>
<td>8th May 2015</td>
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Change History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author, job title</th>
<th>Reason</th>
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<tbody>
<tr>
<td>1.0</td>
<td>March 2011</td>
<td>A Weavers (Consultant Midwife), P Street (Consultant Obstetrician), A Duffield (Rushey MLU manager) J Sangha (Matron for CMW &amp; MLU), L Rough (Matron for Hospital services), E Matthews (Midwife)</td>
<td>Trust requirement</td>
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<tr>
<td>2.0</td>
<td>May 2012</td>
<td>A Weavers (Consultant midwife)</td>
<td>Review due</td>
</tr>
<tr>
<td>3.0</td>
<td>May 2014</td>
<td>A Weavers (Consultant midwife)</td>
<td>Review due</td>
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<tr>
<td>4.0</td>
<td>April 2015</td>
<td>A Weavers (Consultant Midwife)</td>
<td>Updated NICE CG190, published December 2014.</td>
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<td>4.1</td>
<td>April 2016</td>
<td>A Weavers (Consultant Midwife)</td>
<td>Addition of criteria for women to deliver in MLU – top pg 3</td>
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Author: A Weavers
Job Title: Consultant Midwife
Policy Lead: Group Director Urgent Care
Location: Policy hub/ Clinical/ Maternity / Antenatal/ GL887

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Overview: All women have the right to receive personalised care that meets their needs as individuals. This should include having a real choice of where to give birth.

This guideline aims to provide information for doctors and midwives to facilitate women’s preferences for place of birth. The choices for women are home birth, co-located midwifery led unit (Rushey Birth Centre) or the Delivery Suite (DS). For some women living in this area, they may be able to access a freestanding MLU. This guideline is separate to: Consultant Referral Criteria - Indications for Referral for Opinion as to Management of Antenatal Care.

Healthy women with low risk pregnancies should be offered a choice of birth setting. Women in a MLU and women planning birth at home experience fewer interventions than those planning birth in an obstetric unit, they are more likely to experience normal birth.¹ This maternity service aims to positively recommend suitable women to consider birthing in a MLU or at home.

The guideline uses the RAG system to assist with risk assessment on admission to the unit.

For women in the below categories:

- Primiparous women should be recommended birth in an MLU and can be offered and supported in choosing home birth.
- Multiparous women should be recommended birth at home or in an MLU.
- Associated risks and benefits of place of birth, for mothers and their babies, should be discussed with women, using the findings from the Birthplace study (Appendix 1)

- 37-42 weeks gestation
- Spontaneous onset of labour
- Cephalic presentation
- Hb equal to or >85g/l
- BMI 30 kg/m² or below at booking
- No major medical complaints
- No history of significant obstetric complications likely to recur in this pregnancy (ie no history of PPH 1L blood loss or more, shoulder dystocia, previous CS)
- No signs or symptoms of significant pregnancy related complications (eg. pre eclampsia, confirmed IUGR by USS, cholestasis)
Birth on the MLU can also be offered for the following women:

- Multips with a history of uncomplicated normal birth/assisted vaginal birth with a booking BMI between 30 – 40 kg/m²
- All women following Induction of Labour who labour following one intervention (ie post Propess/prostaglandin or ARM) if they do not require continuous electronic fetal monitoring in labour and they meet the above criteria

Women with high risk pregnancies should be advised to give birth on the DS.

Written information is available to facilitate discussions – see leaflet: ‘Choosing where to have your baby’, which states the advantages and disadvantages of different options and if choosing MLU/Home birth, the likelihood of transfer in labour to the main Delivery Suite.

All women should have personalised discussions around their preferences during the antenatal period. As a minimum, these discussions should take place at the booking appointment and again at 34-36 weeks gestation which are then documented in the handheld records. A further discussion can take place in early labour and using the labour pathway, a clinical assessment will be carried out by a midwife. At this point, further discussion can take place around the woman’s choice for place of birth in light of clinical findings and her preferences.
It is recommended that those women with the following medical conditions give birth on the DS. These women are most likely under Consultant Care – see antenatal notes for further information.

### Medical conditions indicating increased risk suggesting planned birth on DS

#### 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 <100,000
- Von Willebrand’s disease
- Bleeding disorder in the woman or unborn baby
- Atypical antibodies which carry a risk of haemolytic disease of the newborn

#### Infective Risk factors:
- 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

#### Endocrine:
- Hyperthyroidism
- Diabetes

#### Renal:
- Abnormal renal function
- Renal disease requiring supervision by a renal specialist

#### Neurological:
- Epilepsy
- Myasthenia gravis
- Previous cerebrovascular accident
- Multiple Sclerosis

#### Gastrointestinal:
- Liver disease associated with current abnormal liver function tests

#### Psychiatric:
- Psychiatric disorder requiring current inpatient care
Furthermore it is recommended that those women with the following pregnancy/obstetric history give birth on DS. Majority of these women are most likely already under Consultant Care – see antenatal notes for further information.

<table>
<thead>
<tr>
<th>Pregnancy / obstetric factors indicating increased risk suggesting planned birth at an obstetric unit</th>
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<tbody>
<tr>
<td><strong>Previous complications:</strong></td>
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<tr>
<td>- Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty</td>
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<tr>
<td>- Previous baby with neonatal encephalopathy</td>
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<td>- Pre-eclampsia requiring preterm birth</td>
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<tr>
<td>- Placental abruption</td>
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<td>- Eclampsia</td>
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<td>- Uterine rupture</td>
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<tr>
<td>- Primary postpartum haemorrhage (PPH) requiring treatment and/or blood transfusion or blood loss equal to or &gt;1000mls</td>
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<td>- Manual removal of placenta if the following applies: more than once, placenta accreta or associated with major PPH (women with a history of one previous MROP without the above complications can be offered choice of MLU)</td>
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<td>- Caesarean section</td>
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<td>- Previous uterine surgery</td>
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<td>- Shoulder dystocia</td>
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<td>- History of baby weighing &gt;4.5kg</td>
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<table>
<thead>
<tr>
<th>Current pregnancy:</th>
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<tr>
<td>- Multiple birth</td>
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<tr>
<td>- Placenta praevia</td>
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<td>- Pre-eclampsia or pregnancy-induced hypertension</td>
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<tr>
<td>- Preterm labour or preterm prelabour rupture of membranes</td>
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<tr>
<td>- Placental abruption</td>
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<tr>
<td>- Anaemia – haemoglobin &lt;85 g/l at onset of labour</td>
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<td>- Confirmed intrauterine death</td>
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<td>- Induction of labour</td>
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<tr>
<td>- Substance misuse</td>
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<tr>
<td>- Alcohol dependency requiring assessment or treatment</td>
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<tr>
<td>- Onset of gestational diabetes</td>
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<tr>
<td>- Malpresentation – breech or transverse lie</td>
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<td>- High (4/5-5/5) or free head in a nulliparous woman. Free or ballotable head in a multiparous woman.</td>
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<td>- Body mass index at booking of &gt; 35 kg/m2</td>
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<td>- Recurrent antepartum haemorrhage</td>
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<td>- Refusal to have blood products – Jehovahs witness</td>
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<tr>
<td>- No antenatal care</td>
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<tr>
<td>- Anaesthetic Alert – see anaesthetic plan for further advice</td>
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<tr>
<th>Fetal indications:</th>
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<tr>
<td>- Small for gestational age in this pregnancy (&lt; fifth centile or reduced growth velocity on ultrasound)</td>
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<td>- Abnormal fetal heart rate (FHR)/Doppler studies</td>
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<tr>
<td>- Ultrasound diagnosis of oligo/polyhydramnios</td>
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<tr>
<td>- Large for gestational age (&gt;97th centile on USS)</td>
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<tr>
<th>Previous gynaecological history:</th>
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<tbody>
<tr>
<td>- Myomectomy</td>
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<td>- Hysterotomy</td>
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Women with the following history should have an individual assessment when planning place of birth (for some women, there may be antenatal records to support this assessment prior to labour - if they have been referred for an obstetric opinion, they may already be under MW led care see Consultant Referral Criteria - Indications for Referral for Opinion as to Management of Antenatal Care link on pg 2). For women who do not meet the criteria for 'obstetric opinion in the antenatal period' and yet have any of the following may be suitable for the Birth Centre/home and therefore MW led care if all other clinical parameters are within normal limits. This assessment can be carried out by the triage midwife, Community Midwife or GP. Advice can be sought at any time from on call obstetric registrar.

**Medical conditions:**
- Cardiovascular: Cardiac disease without intrapartum implications
- Haematological: atypical antibodies not putting the baby at risk of haemolytic disease
- Sickle-cell trait
- Thalassaemia trait
- Anaemia: haemoglobin 85–105 g/l at onset of labour – if symptomatic – to DS
- Infective Hepatitis B/C with normal liver function tests

**Endocrine:**
- Hypothyroidism

**Skeletal/neurological:**
- Spinal abnormalities – depends on anaesthetic assessment
- Previous fractured pelvis – depends on obstetric opinion

**Gastrointestinal:**
- Liver disease without current abnormal liver function
- Crohn’s disease – if not on steroids
- Ulcerative colitis – if not on steroids

**Previous complications:**
- Stillbirth/neonatal death with a known non-recurrent cause
- Extensive vaginal, cervical, or third- or fourth-degree perineal trauma – if have not required surgical correction
- Previous term baby with jaundice requiring exchange transfusion
- GBS infection ** IV antibiotics can be given on MLU – antibiotics will need prescribing by doctor

**Current pregnancy:**
- Antepartum bleeding of unknown origin (single episode after 24 weeks gestation) -if placenta praevia/abruption excluded
- Body mass index at booking of 30–35 kg/m2
- Blood pressure of 140 mmHg systolic or 90 mmHg diastolic on two occasions
- Clinical or ultrasound suspicion of macrosomia (if head not engaged to DS)
- Para 6 or more – if cephalic presentation
- Recreational drug use
- Under current outpatient psychiatric care
- Age over 40 at booking

**Fetal indications:**
- Fetal abnormality

**Previous gynaecological history:**
- Cone biopsy
- Fibroids – (refer to USS results)
**Indications for intrapartum transfer from MLU or home to DS**

The risks and benefits should be assessed when considering transfer to an obstetric unit, bearing in mind the likelihood of birth during the transfer:

- Indications for electronic fetal monitoring (EFM) including abnormalities of the fetal heart rate (FHR) on intermittent auscultation
- Delay in the first or second stages of labour (labour pathway)
- High (4/5-5/5 palpable) or free floating head in a primiparous woman. Free or ballotable head in a multiparous woman* (*No recommendation regarding high head in multiparous women in NICE guidance, local recommendation)
- Thick meconium-stained liquor [please see Meconium guideline GL887](#) or suspicion of oligohydramnios
- Maternal request for epidural pain relief

**Obstetric emergency:** APH, cord presentation/prolapse, PPH, maternal collapse
- Retained placenta
- Maternal pyrexia in labour (38.0 °C once or 37.5 °C or above on two occasions 2 hours apart)
- MOWS 2 or more
- Malpresentation or breech presentation diagnosed for the first time at the onset of labour
- Either raised diastolic blood pressure (over 90 mmHg) or raised systolic blood pressure (over 140 mmHg) on two consecutive readings taken 30 minutes apart
- Uncertainty about the presence of a fetal heartbeat
- Third- or fourth-degree tear or other complicated perineal trauma requiring suturing
- Neonatal: apgar score <7 at 5 mins or prolonged resuscitation required (home birth.)
- Urinary retention
- Maternal request

For those women in whom the professional recommendation is to give birth on the DS but who choose not to follow that advice, professional support and advice may be sought from the on call obstetric Registrar (discuss with on call Consultant Obstetrician), DS Coordinator, Consultant Midwife, or a Supervisor of Midwives
EARLY LABOUR ASSESSMENT in Rushey triage

Women suspecting they are in labour will be ‘triaged’ over the telephone using the standard triage proforma and invited for clinical assessment to the most appropriate area ie. Rushey triage or Delivery Suite (DS) ** - except those women who have booked for home birth.

For safety, women with any of the following history are excluded from Rushey Triage. They will be invited to attend the main Delivery Suite for early labour assessment. All other women can be invited to the Rushey triage for clinical assessment and then triaged to DS or Birth Centre when in established labour.

EXCLUSION CRITERIA for Rushey Triage (ie to be seen on DS)

- Preterm labour
- Multiple pregnancy
- Diabetes
- APH at time of telephone call
- Placenta praevia
- Known malpresentation
- Unbooked woman
- Substance Misuse
- Confirmed pre-eclampsia/PIH on treatment
- Booked for CS
- Vaginal Birth after Caesarean Section
- Professional discretion (for example woman in advanced labour with known risk factors for birth on DS)

Standards:
Home birth or birth in a midwife led unit can be recommended by the midwife or doctor to those women without medical/obstetric complications

100% women will be given an information leaflet about place of birth at booking appointment

A shared decision between the woman and the midwife/doctor for choice of place of birth will be made by the 34-36 week antenatal check up which is documented in the hand held notes.
References:


Author/s: Annette Weavers & Kate Nash in collaboration with Pamela Anderson Registered Midwife, Jaqui Fudge, Registered Midwife, Laura Wallbank Clinical Lead Midwife, Catherine Verrichia, Midwifery Sister, January 2011

Reviewed: May 2012 (A Weavers), May 2014 (Alison Duffield, Jean Sangha, Linda Rough, Emma Matthews, Pat Street and Annette Weavers), A Weavers & L Randall (March 2015

Review: May 2017