Bolton NHS
NHS Foundation Trust

Birth Suite Guideline

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Version	Type of Change	Date	Revisions from previous issues
3	3 yearly update	Dec 2021	Minor changes

Equality Impact

Bolton NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of healthcare Bolton NHS FT aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed to ensure fairness and consistency for all those covered by it regardless of their individuality. The results are shown in the Equality Impact Assessment (EIA).

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1. Purpose

1.1 The aim of the Birth suite is to provide one to one midwifery care in a home from home environment. Normality will be anticipated in line with the social model of childbirth (Walsh 2011).

1.2 Midwives, student midwives and other members of the Birth Suite team will provide holistic care for women and their families throughout labour and the early postnatal period.

1.3 If deviations from normal occur for mother or baby at any time during labour or after birth, the midwife will facilitate transfer to Consultant care.

1.4 Midwives will undertake the discharge procedures of mother and baby after birth. This will take place within a few hours of the birth providing both mother and baby are both in a stable condition.

2. Definitions

2.1 Midwives will be the lead professionals for those women who choose to give birth in the Birth Suite and who fall within the admission criteria. This document is a guideline for midwives working in the Birth Suite.

3. Content

3.1 Criteria for admission to the Birth Suite in labour

- Full term singleton pregnancy
- Up to and including 5th baby (individualised obstetric plan of care required if parity is more than 5)
- In spontaneous labour

- Cephalic presentation
- BMI less than 39.9 and satisfactory growth with no antenatal problems
- Hb more than 9g/dl
- May be Group B Streptococcus positive in current pregnancy requiring antibiotics in labour but must be asymptomatic, and not have any previous children affected by GBS
- Propess induction of labour for post-maturity equal to or >T+11 .
  x 1 propess only
  CTG normal on M2
  Contracting 3-4:10
  >4cm effaced cervix. Ie in active labour

3.2 Midwifery Care in labour

The midwife will facilitate birth by providing continuous support to the woman and her birth partner.

Intrapartum care will be offered in accordance with the Bolton guideline for management of normal labour and birth.

Where a deviation from normal becomes apparent in either the mother or the baby the midwife must call upon a qualified health professional who has the requisite skills and experience to assist her (NMC 2004).

3.3 Transfer of care from the Birth Suite

Giving birth at home or in the Birth Suite is an appropriate option for healthy women with normal pregnancies and labours. However if the woman requests alternative pain relief, ie epidural or if there are any deviations from the normal requiring obstetric/ paediatric consultation and involvement, then the woman should be transferred to Delivery Suite, or help should be requested on the Birth Suite.

3.4 Non Urgent Transfer

For example:

- If the woman requests an epidural
- Raised blood pressure, defined as:-
    - Diastolic blood pressure > 90mmhg twice, 30 mins apart
    - OR
    - Systolic blood pressure > 140mmhg twice, 30 mins apart
- Maternal pyrexia = or >38
- Delay in the first stage of labour without fetal compromise- defined as:

    - Primigravida- < 2cm dilatation in 4 hours
    - Multigravida- < 2cm dilatation in 4 hours

If delay in labour is suspected, consider amniotomy,if amniotomy is performed and liquor is clear, repeat vaginal examination in 2 hours, if progress is < 1cm diagnose delay in labour and transfer to obstetric care.

- Delay in the second stage of labour without fetal compromise- defined as:

    Primigravida > 2 hours in active second stage
    Multigravida > 1 hour in active second stage

Diagnose delay in second stage of labour and transfer to obstetric care.

3.5 Procedure for transfer

- The midwife coordinator and/or the obstetric middle grade on Delivery Suite should be informed of the reason
- The woman may be transferred on foot by chair or on the bed, whichever is most appropriate, accompanied by a midwife
- The transfer will be fully discussed with the woman and her partner.

3.6 Urgent or immediate transfer

For example (this list is not exhaustive)-

- Suspected abnormalities of the fetal heart rate, conduct a 30 minute CTG on CDS. If normal, discontinue and may come back to the Birth Suite.
- Intrapartum/ postpartum haemorrhage
- Cord prolapse
- Undiagnosed malpresentation.
- Insignificant meconium in women who are progressing well in established labour, at more than 40 weeks, in the absence of any other risk factors, may deliver on the Birth Suite,as recommended in the NICE 2014 Intrapartum Guidelines. The meconium should be assessed by a second midwife (fresh eyes) when making a management plan.
- If any meconium staining develops in previously clear liquor, transfer to obstetric care.
- Significant meconium liquor, defined as Grade 3 or particulate Meconium, must be transferred to Obstetric care.
- Maternal tachycardia up to 120 beats/per/minute is acceptable in a labouring woman with no other risk factors or symptoms, with a normal fetal heart rate. For maternal tachycardia above this rate, obstetric intervention is necessary.

3.7 Procedure for transfer

- The midwife coordinator and/or the obstetric middle grade on Delivery Suite will be informed of the reason for transfer.
- The woman may be transferred by chair or bed whichever is the most appropriate to facilitate swift and safe transfer.
- The transfer will be discussed fully with the woman and her birth partner.

3.8 Governance

Care and activity on the Birth Suite will be discussed and monitored at the Labour Care Forum.

4. Monitoring Compliance

Audit Standards

All women will be audited, this will include out of area women as well as women who receive all their care under Bolton NHS Foundation Trust

The maternity service aims for the gold standard of 100% against all the standards within this policy, however a benchmark of 75% will be deemed as acceptable in regards to benchmarking or progress.

Where deficiencies in compliancy are noted during the monitoring of this guideline an action plan will be formulated to improve compliancy levels.

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ Group/committee for review of results	Responsible individual/ Group/ Committee for development of action plan	Responsible individual/ Group/ Committee for monitoring of action plan
	Audit of notes	**Manager**	**Monthly**	**Labour care forum and Womens Quality Forum**	**Manager**	**Labour care forum and Womens Quality Forum**

5. References

NMC (2012) *Midwives rules and standards 2012.* London: NMC. Available from: http://www.nmc-uk.org/Documents/NMC-Publications/Midwives%20Rules%20and%20Standards%20(Plain)%20FINAL.pdf (accessed 7 October 2013).

Walsh, D (2011) *Evidence and skills for normal labour and birth: a guide for midwives.* 2nd ed. London: Taylor & Francis.

NICE {CG190}. INTRAPARTUM CARE: Care of healthy women and their Babies during childbirth. http://www.nice.org.uk.guidelines/cg190/chapter/key-priorties-for-implementation.

6. Appendices

Appendix 1

Table 1 Medical conditions indicating increased risk suggesting planned birth at an obstetric unit

Disease area	Medical condition
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 100,000 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 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
Endocrine	Hyperthyroidism Diabetes
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

Table 2 Other factors indicating increased risk suggesting planned birth at an obstetric unit

Factor	Additional information
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 Fetal indications	Multiple birth Placenta praevia Pre-eclampsia or pregnancy-induced hypertension Preterm labour or preterm prelabour rupture of membranes Placental abruption Anaemia – haemoglobin less than 8.5 g/dl at onset of labour Confirmed intrauterine death Induction of labour Substance misuse Alcohol dependency requiring assessment or treatment Onset of gestational diabetes Malpresentation – breech or transverse lie Body mass index at booking of greater than 35 kg/m^2 Recurrent antepartum haemorrhage Women who would decline blood or blood products Women who have disclosed domestic violence of a physical nature . Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound) Abnormal fetal heart rate (FHR)/Doppler studies Ultrasound diagnosis of oligo-/polyhydramnios
Previous gynaecological history	Myomectomy Hysterotomy

Table 3 Medical conditions indicating individual assessment when planning place of birth

Disease area	Medical condition
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 8.5–10.5 g/dl at onset of labour
Infective	Hepatitis B/C with normal liver function tests
Immune	Non-specific connective tissue disorders
Endocrine	Unstable hypothyroidism such that a change in treatment is required
Skeletal/neurological	Spinal abnormalities Previous fractured pelvis Neurological deficits
Gastrointestinal	Liver disease without current abnormal liver function Crohn's disease Ulcerative colitis
Anaesthetic	Would require an individual plan of care by the obstetric anaesthetist.

Table 4 Other factors indicating individual assessment when planning place of birth

Factor	Additional information
Previous complications	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 4.5 kg Extensive vaginal, cervical, or third- or fourth-degree perineal trauma Previous term baby with jaundice requiring exchange transfusion
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation) Body mass index at booking of 30–34 kg/m^2 Blood pressure of 140 mmHg systolic or 90 mmHg diastolic on two occasions Clinical or ultrasound suspicion of macrosomia Para 6 or more Recreational drug use Under current outpatient psychiatric care Age over 40 at booking Bile Acids of 14 ugdl or more
Fetal indications	Fetal abnormality
Previous gynaecological history	Major gynaecological surgery Cone biopsy or large loop excision of the transformation zone Fibroids

(NICE, 2007)

Appendix 5

Lifestyle Considerations

- Prescribed medications
- Over the counter medications
- Complementary therapies
- Smoking
- Substance misuse

Depending on the known associated risks of the lifestyle considerations identified in the woman, birth in hospital may be the safest option. The risks and lifestyle considerations should be considered on an individual basis and with consideration of the woman's choice. An individualised management plan should be put in place, discussed with the woman and document in the woman's notes if any risks are identified. Appropriate referral should be undertaken as necessary and documented the woman's notes.

Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender (including gender reassignment)	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are there any valid exceptions, legal and/or justifiable?**	No	
4.	**Is the impact of the document/guidance likely to be negative?**	No	
5.	**If so, can the impact be avoided?**		
6.	**What alternative is there to achieving the document/guidance without the impact?**		
7.	**Can we reduce the impact by taking different action?**		

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Co-ordinator, together with any suggestions as to the action required to avoid/reduce this impact.

Document Development Checklist

Type of document	Birth Suite Guideline
Lead author:	Paula Rimmer
Is this new or does it replace an existing document?	Update
What is the rationale/ Primary purpose for the document [Motivation for developing the document]?	Admission Criteria
What evidence/standard is the document based on?	NICE Guidelines
Is this document being used anywhere else, locally or nationally?	No
Who will use the document?	Midwives/ Doctors at Bolton FT
Has a pilot run of the document taken place (optional)	Yes
Has an evaluation taken place? What are the results (optional)	
What is the implementation and dissemination plan? [How will this be shared?]	By email
How will the document be reviewed? [When, how and who will be responsible?]	At least 3 yearly
Are there any service implications? [How will any change to services be met? Resource implications?]	More women using the Birth Suite
Keywords [Include keywords for the document controller to include to assist searching for the policy on the Intranet]	Birth Suite
Staff/Stakeholders Consulted:	Yes
EIA:	Yes
Signed and dated By validator By ratifying officer	 …….B. Williams……11/12/2018……. …..04/11/2015….(no significant changes since last ratification)