Birth Centre Guideline

Summary statement: How does the document support patient care?	By providing guidance for maternity staff; both when supporting women/people in choice of place of birth and when to transfer to the Central Labour Suite from the Birth Centre.
Staff/stakeholders involved in development:	Senior midwives, Obstetric Consultants and Joint Obstetric Guidelines Group, Supervisors of Midwives
Division:	Women and Children's
Department:	Maternity
Responsible Person:	Chief of Service
Author:	Community Matron
For use by:	Midwifery and Obstetric medical staff
Purpose:	To provide guidance for maternity staff when supporting women in their place of birth and caring for women/people on the Birth Centre.
This document supports:	NICE (2007/ updated February 2017)
Key related documents:	**UH Sussex (SRH & WH) Maternity Guidelines:** Antenatal Care and Patient Information, Risk Assessment in Labour, Homebirth, Care of Women in Labour
Approved by:	Joint Obstetric Guideline Group
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If you require this document in another format such as Braille, large print, audio or another language please contact the Trusts Communications Team

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Version	Date	Author	Status	Comment
1.0	October 2014	B. Corney	Archive	New Trust maternity guideline
2.0	August 2017	G. Addison	Archived	Triannual update
3.0	July 2020	S. Harris, G. Addison	Archived	3 yearly review – 5.2 updated, addition of appendix A
4.0	July 2023	K. Henton Community Team Leader	LIVE	3 yearly review

Contents

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1.0 Aim

The aim of this guideline is to provide guidance for midwifery and obstetric staff when offering birth options to women/people with regard to using the Birth Centre. The guideline also covers when transfer to the Central Labour Suite (CLS - SRH) / Delivery suite (WH) is indicated.

2.0 Scope

- Midwives
- Obstetricians.

3.0 Responsibilities

Midwives and Obstetricians are expected:

- To access, read, understand and follow this guidance.
- To use their professional judgement in the application of this guideline.

Management are expected:

- To ensure the guideline is reviewed as required in line with the Trust and National recommendations.
- To ensure the guideline is accessible to all relevant staff.

4.0 Abbreviations used in this guideline

CLS - Central Labour Suite	**FHR -** Fetal Heart Rate
SRH - St Richard's Hospital	**APH -** Antepartum Haemorrhage
WH - Worthing Hospital	**PPH -** Post Partum Haemorrhage
NIPE - Newborn Infant Physical Examination screen	**NNBS -** National Newborn Bloodspot Screening
MIS - Maternity Information System	

5.0 Introduction/Philosophy

Midwifery-led care is committed to the rights of women to have good information and be involved in decisions about their care. It is important that guidelines are not prescriptive but encouraged discussion and information sharing by doing so with the women/people in our care we can establish their needs help them to make informed choice and offer true woman/person centred care. The challenge for midwives is to practice through listening to the women/people in their care with patience and empathy.

The aim of the Birth Centre is to provide a relaxed, friendly and safe environment in which women/people experiencing low risk pregnancy can be facilitated to have the birth of their choice as a normal and natural process.

6.0 Criteria for Admission

6.1 Women/people at low risk of complications

The normal criteria for admission to the birth centre are the same as those used for women/people opting to have a home birth. These are lower risk women/people with the following:

- 37 – 42 weeks
- Singleton
- Cephalic presentation.

6.2 Women/people with significant risk factors

We recognise the physiological importance of birth environment for women/people and also their right to make an informed decision on place of birth based on their own ability and autonomy to balance the risks against the benefits. Where a woman/person has risk factors for birth, the alongside birth centre may still be an option for them provided they understand the potential benefits, risks and alternatives. The woman/person, midwife and/or obstetrician can make a plan with agreed thresholds for transfer to the Central Labour Suite. Each woman's/person's individual choice to birth on the birth centre should be respected – the criteria within this document are for guidance only. Agreed plans of care must be documented onto maternity information system (MIS). It is the senior midwives responsibility to ensure all staff involved in the care, are advised of the plan.

Please see Appendix 1 for a list of medical conditions and complications recommended by NICE (CG190) as indicating increased risk suggesting planned birth at an obstetric unit. Please be aware, this list is not exhaustive - any concerns should be discussed with a senior midwife or the on-call consultant obstetrician.

7.0 Indications for transfer to Central Labour Suite

The following are indications where transfer should be considered. Transfer should take place in discussion with the Co-ordinator and with the woman or person.

7.1 Obstetric and neonatal indicators

- Any risk factors recorded in the woman or person's notes that indicate the need for obstetric led care.
- Delay in the first or second stage of labour.
- Any vaginal blood loss other than a show.

- Rupture of membranes more than 24 hours before the onset of established labour
- Pain reported by the woman or person that differs from the pain normally associated with contractions.
- Maternal/birthing parent request for epidural in labour.
- Fetal heart rate below 110 or above 160 beats per minute.
- A deceleration in fetal heart rate heard on intermittent auscultation.
- Need for continuous electronic fetal heart rate monitoring due to non-reassuring fetal heart rate.
- Inability to locate or monitor fetal heart rate.
- Any meconium stained liquor (taking into consideration stage of labour and imminence of birth).
- Retained placenta
- Third / fourth degree tear or other complicated perineal trauma.
- Any abnormal presentation, including cord presentation.
- Suspected anhydramnios or polyhydramnios.
- Requests from the woman/person for cardiotocography (after risks, benefits and limitations have been discussed).
- Obstetric emergency
- Suspected chorioamnionitis
- Need for continuous electronic fetal heart rate monitoring due to hyperstimulation (more than 4:10).

7.2 Observations of the woman/person

- Pulse over 120 beats/minute on 2 occasions 30 minutes apart.
- A single reading of either raised diastolic blood pressure of 110 mmHg or more or raised systolic blood pressure of 160 mmHg or more.
- Either raised diastolic blood pressure of 90 mmHg or more or raised systolic blood pressure of 140 mmHg or more on 2 consecutive readings taken 30 minutes apart.
- A reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (90 mmHg or more) or raised systolic blood pressure (140 mmHg or more).
- Temperature of 38°C or above on a single reading, or 37.5°C or above on 2 consecutive readings 1 hour apart.
- Maternal/birthing parent pyrexia (38^{o}C once or 37.5^{o}C on 2 occasions).
- Either raised diastolic (> 90mm Hg) or raised systolic (> 140mm Hg) on two consecutive readings taken 30 minutes apart.
- Post-birth the woman/person has been unable to void urine in the 6 hours prior and their bladder is palpable.

If any of the factors above are observed but birth is imminent, assess whether birth in the current location is preferable to transferring the woman/person to an obstetric unit and discuss this with the coordinating midwife and woman/person.

Communication between CLS co-ordinator and birth centre staff will take place before shift handovers and as needed during shifts and prior to any transfers.

8.0 Process for immediate care and emergency transfer

The midwife will provide immediate emergency care where required prior to transfer and make immediate assessment regarding the need for any emergency calls and safe time to transfer to the CLS if needed. In the event of an obstetric / medical / neonatal emergency the emergency bell must be pulled, which will alert and summon CLS staff. This must be followed by dialling '2222' and requesting the appropriate emergency team.

This will include the following clinical situations:

- Cord presentation / prolapse
- Fetal distress / bradycardia
- Maternal collapse or seizure
- APH / PPH
- Shoulder Dystocia
- Advanced neonatal resuscitation
- Cardiac arrest.

9.0 Postnatal Transfer

If low risk following birth, the woman/person can choose to go home from the Birth Centre or transfer to the postnatal ward.

It is important to remember communication of discharge and plan for visit, newborn infant physical examination screen (NIPE) and checking if Anti-D required if rhesus negative.

Complete checks, paperwork (including NBBS stickers) and discharge on MIS and PAS.

A baby temperature should be taken prior to discharge and documented on MIS.

Ensure community team aware of discharge and that discharge address and telephone number is checked.

Ensure the patient has the telephone numbers of the maternity unit and their community team before discharge.

10.0 Monitoring

Auditable standards can be found in the NICE intrapartum care Quality Standards (QS105).

References

National Institute for Health and Clinical Excellence (NICE) (2007) Intrapartum Care: Care of healthy women and their babies during childbirth (Updated February 2017).

National Collaborating Centre for Woman's and Children's Health. RCOG Press: London
National Institute for Clinical Excellence

Appendix 1: Medical conditions and complications indicating increased risk suggesting planned birth at an obstetric unit (NICE CG190)

Medical conditions:

- BMI <18 or > 35
- Diabetes
- Epilepsy
- Hypertension
- Haematological conditions
- Previous cerebrovascular injuries
- Anaemia- Hb less than 90 g/l
- Asthma- requiring an increase in medication during pregnancy
- Cystic Fibrosis
- Cardiac disease – requiring antibiotics in labour
- History of thrombosis / clotting disorders
- Hepatitis B / C with abnormal liver function tests
- Hyperthyroidism
- HIV
- Active tuberculosis
- Current active Chicken pox, Rubella, Genital herpes
- Toxoplasmosis - requiring treatment
- Systemic lupus erythematosus
- Scleroderma
- Renal issues – abnormal renal function, disease requiring specialist supervision
- Myasthenia gravis (neuromuscular disorder)
- Liver disease with current abnormal liver function tests
- Atypical antibodies which carry a risk of haemolytic disease of the newborn
- Psychiatric disorder requiring current inpatient care or where indicated by Consultant psychiatrist or Consultant obstetrician

Current Pregnancy Complications:

- Multiple birth
- Grand multiparity
- Maternal age of 35 years or older
- Placenta praevia
- Pre-eclampsia or pregnancy induced hypertension
- Preterm labour or preterm rupture of membranes
- Placental abruption
- Confirmed intrauterine death
- Alcohol and substance misuse
- Gestational diabetes
- Malpresentation ***/*** any abnormal presentation, including cord presentation
- Transverse or oblique lie
- High (4/5–5/5 palpable) or free floating head in a nulliparous woman

- Recurrent antepartum haemorrhage
- Haemolytic Strep B positive – individual assessment on staffing levels and availability of staff competent to administer IV antibiotics aiming to avoid unnecessary transfers
- Induction of labour

Previous Obstetric Complications:

- Unexplained still birth / intrauterine death or previous death related to intrapartum difficulty
- Previous baby with neonatal encephalopathy
- Placental abruption with adverse outcome
- Eclampsia
- Uterine rupture
- Primary postpartum haemorrhage (requiring additional treatment or blood transfusion)
- Caesarean section
- Confirmed shoulder dystocia
- Pre-eclampsia requiring preterm birth
- Retained placenta requiring manual removal in theatre

Fetal Complications:

- Suspected fetal growth restriction or macrosomia
- Antenatal abnormal fetal heart rate (FHR) or Doppler studies
- Ultrasound diagnosis of anhydramnios, oligohydramnios or polyhydramnios
- Reduced fetal movements in the last 24 hours reported by the woman or person
- Any meconium
- Identified major anomalies confirmed by ultrasound/screening

Previous gynaecological history:

- Myomectomy
- Hysterotomy
- Existing uterine abnormalities