

**WOMEN'S HEALTH AND PAEDIATRICS DIVISION
Maternity Services**

Abbey Birth Centre

Operational Policy and Clinical Guideline

Amendments			
Date	Page(s)	Comments	Approved by
13/05/2014	12	Exclusion criteria – current pregnancy Reduced fetal movements	Supervisors of Midwives
30/06/2014	11-12	Updated Inclusion & Exclusion Criteria	Supervisors of Midwives
07/07/2014	11-12	Updated Inclusion & Exclusion Criteria	Supervisors of Midwives
18/09/2014	6-7/45 3-4 12,17,19	Addition of Home Birth Management and flow chart Addition of communication with Maternity bleep Holder overnight Updated Inclusion & Exclusion Criteria Updated management of abnormal observations,EBL	Supervisors of Midwives

Compiled by: Alex Bell – Midwife Team Leader - Abbey Birth Centre and Supervisors of Midwives (SOMs)

In Consultation with: Maternity Services Multidisciplinary Team

Ratified by: Associate Director of Maternity Services and Supervisors of Midwives

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Impact Assessment Carried Out By: SOMs

Comments on this document to: Supervisors of Midwives

		First Ratified April 2014	Reviewed	Version 4	Page 1 of 50
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Philosophy of Abbey Birth Centre

Leading the way for normal birth the **Abbey Birth Centre** has been purpose built and aims to offer an individualised service in an environment that allows women and their families to experience birth in a supportive and safe place. Our Birth Centre midwives encompass those values all women should expect throughout their birth experience, that is, a passion for –

- Providing excellent and evidence based care throughout women's childbirth experience
- Prioritising the safety of women and their babies
- A deep understanding of the process of normal birth and how to support that process and meet the individual needs of women and their families using our service
- Delivering excellence, working in partnership with women to ensure their requirements are met with kindness, compassion, respect and understanding
- Providing high standards of care to women and their families

Service objectives of Abbey Birth Centre

- To provide midwifery led care for birth in a non-medicalised environment, that encourages women to labour and birth in a 'normal context'.
- To provide an alternative birth environment for women and their families where women can engage in their experience whilst supported by skilled staff who will facilitate normal birth
- To provide an autonomous birth experience and bespoke individualised care
- To facilitate alternative ways to promote normal birth and outcomes by employing the use of water, positioning and alternative therapies during labour
- To support midwives and other health professionals to practice in a 'normal' environment and breakdown barriers through excellent clinical leadership, training, education and development.
- To audit each birth initially in order to modify, develop and improve the service as and when necessary. (Audit Tool appendix 7)

Birth Centre Operational Policy

Service Description

A purpose-built Birth Centre (BC) providing 24-hour midwifery led care to women with low risk pregnancies, booked to deliver at the trust.

1. Communication

Five telephone points –one in reception, two in the midwives office and assessment room and one in the corridor

- IT provision – three PC's –1 in reception, 2 in the office

		First Ratified April 2014	Reviewed	Version 4	Page 2 of 50
--	--	------------------------------	----------	-----------	--------------

- Phone numbers –
 1. Telephone Triage – 01932 723761
 2. Office - 01932 723882
 3. Team Leader/ Office – 01932 723891
 4. Corridor – 01932 726643
 5. Consulting Room - 6642
- Call bells in every room – one by the bed, one for the pool in the pool rooms
- Emergency call bells in each bathroom and birthing room by the door - In the event of an emergency to gain support or assistance
- The BC will have a member of staff to answer the phone 24hours a day
- A midwife will be available 24hours a day to talk to women who are booked to have their babies at the BC, and who telephone for advice. Any woman not booked to have her baby at the BC will be directed to Labour Ward Triage (please refer to exclusion criteria – section 8.4)
- The midwife receiving the phone call will use the Telephone Triage Assessment Tool see appendix 1 (TTAT) to Triage all women who contact the BC.
- There will be a weekly multidisciplinary Birth Centre meeting

1.1 Communication from Birth Centre – Maternity bleep holder overnight

- Following handover on the night shift the Birth Centre Core midwife will contact the maternity bleep holder and let them know those staff members who are working in the Birth Centre overnight and the number of current and anticipated admissions, if known.

This is for information only; LW will not assume responsibility for the Birth Centre.

- This communication should happen at handover. The bleep holder/ team leader informed if the activity significantly increases/changes in the Birth Centre.
- If assistance is required from an MA, to support cleaning rooms; feeding; giving refreshments – this can be negotiated with the bleep holder at this time or should the need arise. The core midwife is expected to plan ahead and communicate with the bleep holder.
- Escalation guidance should be followed if appropriate

It is the Birth Centre core midwife’s responsibility to inform LW of the above information – the birth centre midwives are not required to give a clinical handover of the women in the birth centre

2. Patient Flow

Criteria

- All women assessed as ‘**low risk**’ at their booking appointment by their midwife will be booked to deliver in the BC provided they met the criteria or they choose not to and ‘**opt out**’
- Some women deemed low risk may choose not to use the birth centre and can ‘opt out’. This should be discussed and fully documented in the maternity notes

		First Ratified April 2014	Reviewed	Version 4	Page 3 of 50
--	--	------------------------------	----------	-----------	--------------

- Please refer to the Clinical Guidelines for the criteria (section 8.3/4); admission (Section 8/8.1) and transfer from the BC(section 12-14)
- Information regarding the BC and the 'opt out' process will be given to all low risk women at their first contact with the GP and/or Midwife booking appointment
- The final decision to deliver in the Birth Centre will be made with the community midwife at 34/36 weeks
- Should the women's suitability to have her baby in the BC change following 34/36 weeks, the change **in Lead professional must be recorded on the front of her notes**. These women should also be advised to contact Labour Ward Triage when labour commences
- Should a woman require advice regarding the BC please contact, the BC Team Leader and/ or the Supervisor of Midwives
- Information will be available for women throughout the antenatal period through the woman's community midwife, GP and on our Maternity website.

3. Staffing

- The BC will be staffed with a core team of midwives and community midwives who will rotate in, according to the service needs.
- There will be a Team Leader working 0900-1700 Monday to Friday, who is supernumerary.
- All staff will work 11.5 hour shifts and are expected to rotate on to nights and days. The one hour break down
- Shift times are:
DAY - 7.30-20.00
NIGHT - 19.30-08.00
- There will be 2 midwives on each shift, supported by an administrator during the daytime.
- Any short falls in staffing for the core team will be covered by the core team – to be organised by the BC Team Leader.
- Maternity Assistants will be deployed to the BC as required to support the midwives.
- Any shortfalls in the community rotational team will be covered by the community team – to be organised by community Team Leaders
- There will be access to neonatologists and obstetricians in the event of an emergency – please refer emergency transfer guideline below, table 6, for specific guidance

3.1 Roles and Responsibilities

Team Leader – Midwife

- The Team Leader will assume operational and clinical responsibility 24 hours a day. She will be on duty and available to staff 9-5pm Monday to Friday for the BC.
- The BC Team Leader will foster and develop robust relationships with the Team Leaders in all clinical areas ensuring excellent communication which is key to women and their families receiving the safest care and optimising a positive childbirth experience
- The role of the Team Leader encompasses the support of both the women and staff who use the BC - in context to the clinical management of normality and will be the reference point for expert; evidence based clinical guidance and management of normal birth.

		First Ratified April 2014	Reviewed	Version 4	Page 4 of 50
--	--	------------------------------	----------	-----------	--------------

- She will lead by example and foster an environment where normality and team work will flourish, facilitating women to achieve the best possible birth and postnatal experience.
- The Team Leader will lead on Audit of BC outcomes and ensure clinical Effectiveness is reflected in the implementation of practice changes
- The Team Leader will promote a dynamic and innovative learning environment for midwifery practice ensuring midwives and students are able to develop and flourish.

Core Band 6 and community midwives will:

- Provide expert, high quality midwifery care and advice in the context to the Birth Centre and in line with Midwives Rules and The Code.
- promote a culture of normality in childbirth and identify deviations from the normal to ensure appropriate action is taken
- Support and foster the promotion of normality throughout the Maternity Service.
- Be competent and up to date in all clinical competencies, including; managing normal birth, water birth, obstetric emergencies, perineal suturing, adult IV cannulation and neonatal resuscitation
- Communicate effectively and promote a culture of team work and support.

Admissions and discharges

- All women will be admitted and discharged on patient centre
- All women will have a venous thrombo -embolism (VTE) assessment on admission and if they are in the BC for longer than 24hours
- On discharge the community midwives discharge summary sheet will be taken to the community office or phoned out to the relevant Trust
- On discharge the discharge summary for the woman will be completed on inpatient lists (IPL) and sent electronically to the GPs

3.2. Escalation and On Calls

Management on call

There will be a manager on call 24hours a day for advice specifically for the BC
The manager on call can be contacted to discuss **any** issue related to the BC, including:

- Sickness/ absence
- Clinical decision making
- Staffing
- Unexpected transfers
- Unexpected outcomes
- Interdepartmental communication

This list is not exhaustive - If in doubt do not hesitate to contact the on call manager.

Supervision on call

There will be a Supervisor of Midwives on call 24hours a day for the Maternity service and for the BC, who will be available for any staff member who requires support and/ or advice – refer to trigger list for calling a Supervisor at <http://trustnet/docdata/maternity/index4.htm> or

		First Ratified April 2014	Reviewed	Version 4	Page 5 of 50
--	--	------------------------------	----------	-----------	--------------

[see Appendix 2](#). The Supervisor of Midwives is also available to the woman and can be contacted in the usual way.

3.3. Activity/ Workload

It is expected that 1/6 women booked at ASPH will deliver at the BC initially. It is anticipated that activity will increase as the service is implemented. Staffing plans should be in place by 5pm each day.

Should activity in the BC reflect the need for another midwife, the 1st on call community midwife will be contacted to cover (See staffing section 3.2)

Should the 1st on call midwife be unavailable, e.g., she is at a homebirth, the manager on call will be contacted to discuss contingency e.g. transfer of BC woman to LW, transfer of homebirth woman to LW or re deployment of staff to either LW or BC from community.

3.4. Homebirth Management (see appendix 8 for flow chart)

- Women booked for homebirth will phone the ABC triage from 37/40 to alert them that they are in labour.
- The ABC midwife will take a verbal history of labour to date
- The woman's details will be retrieved from the homebirth folder and her contact and address details checked to ensure that they are accurate
- Between the hours of 0830-1700 the allocated community team leader will be contacted to manage the home birth
- Between the hours of 1700-0830 the ABC midwife will contact the on call community midwife's work mobile (pertinent team midwife first if on call)
- The community midwife on call is responsible for contacting the 2nd midwife on call for the homebirth and keeping LW informed of events/ progress and when she has returned home safely (see lone worker guideline)
- The ABC midwife will contact the maternity bleep holder to inform them of the homebirth
- If considered no longer suitable for homebirth following the verbal risk assessment eg meconium stained liquor, reduced fetal movements - woman must be informed and advised to come in to the labour ward.

If birth is imminent – send the community midwife without equipment and instruct the woman to call 999 for paramedic assistance and inform the maternity bleep holder

4. Clinical Support Services

4.1. Infection Control

- See Waterbirth guideline for cleaning of the birth pools
- The taps for the birthing pools will be run through every shift and recorded in the Birth Pool Cleaning log

		First Ratified April 2014	Reviewed	Version 4	Page 6 of 50
--	--	------------------------------	----------	-----------	--------------

- The showerheads will be locked away and are not to be used by the women or when the pool is not in use.
- The shower heads will not be submerged in the pool **at any time and are strictly for use to clean the pool following** a delivery
- The shower heads will be run through every shift and recorded in the Pool cleaning log
- The linen will be dispensed in to labelled **blue** linen bags, collected from the BC, laundered and returned by Synergy. A completed Synergy linen slip with the number items will be completed for each bag of linen returned to Synergy.
- All staff will use universal precautions; Personal Protective Equipment (PPE) and Aseptic Non touch Technique (ANTT) as appropriate throughout their clinical practice.

4.2. Pharmacy Services

- There will be a limited drug list for the BC appendix - 8
- There will be no regular top up process for the Birth Centre. The core team midwives will be relied upon to maintain agreed stock levels of all drugs, including emergency drugs.
- There will be a pharmacy stock list which will be checked every shift by a midwife
- Stock levels, have been agreed with pharmacy and staff should maintain levels and liaise directly with pharmacy to replenish these.
- The weekly drug audit will completed by the core team midwives and will be entered on to the trust team drive/ ward information. The audit will be scanned and entered onto the ward named Abbey Birth Centre.

4.2.1. Emergency drugs

There will be a store of emergency drugs kept in the treatment room at all times and will consist of the following:

- A box for managing Post-Partum Haemorrhage kept in the fridge
- A box for managing anaphylaxis kept in the locked drug cupboard
- A box for managing neonatal resuscitation – as requested by the neonatal team – kept in the locked drug cupboard

4.3. Laboratory Services

- Any urgent samples taken in the BC will be taken to the pod on Joan Booker Ward for transport to the lab ASAP.
- Results will be available on SPS/win path
- Hard copies will need to be filed as available in the woman's notes.
- Anti D is to be collected from the blood bank by the porter (this will be ordered on PAS/ patient centre).

4.4. Sterile Services

- The BC will have 8 delivery packs and 8 perineal suturing packs as stock
- The used packs will be stored in a designated container in the sluice and collected by Sterile Services daily.
- The container with the dirty packs will be taken to the door by a member of staff
- The packs will be bar coded to ensure they they come back to the BC specifically

5. Manual Handling

- Please refer to the Trust's Manual Handling guidelines and the safe systems for use of the birthing pool in the Water birth Guideline

		First Ratified April 2014	Reviewed	Version 4	Page 7 of 50
--	--	------------------------------	----------	-----------	--------------

6. Healthcare Records

- The outside covers for the woman will be collected from antenatal reception for all women attending the BC.
- The key will be kept in the BC office.
- The notes are to be tracked by the midwife to the BC on PAS/Patient Centre

7. Non Clinical Support Services

7.1. IT

- There will be 3 PC's available in the BC – one in reception, 2 in the office
- There will be wireless access in the BC
- There are telephone points in reception, the office, consultation room and the corridor; one will be for a cordless phone.
- There are data points in all the birth rooms for the users to plug in I pods, mobile phones and to listen to music
- There are televisions in all four birth rooms
- The staff will have access to Patient Centre/ PAS, Inpatients Lists(IPL) and Evolution to complete their records; including – admit, discharges, transfer and birth notification
- There will be a printer/ photocopier available for the staff to print the necessary paperwork and attach it to the woman's main notes and her hand held notes, which she will take with her upon discharge
- The midwives will be doing the discharge letters and Venous Thromboembolism (VTE) assessments on IPL and manually on the drug charts.

7.2. Security

- Where possible the midwife will personally greet the family at the main reception door
- There are security cameras 24/7 at the entrance and in the corridor of the BC
- Access to the BC from the outside will be open to women booked for the BC and the public between 08.00 and 17.00 into the main reception area
- Access into the BC from the main reception area will be by proximity swipe card only – women booked for the BC and the public will press the intercom to gain attention from the staff to enter
- Access to the BC from the outside between 17.00 and 08.00 will be via intercom – the staff will let the women and the public in via the BC main reception upon the intercom buzzing
- There are security doors which are locked 24/7 and can be accessed via proximity swipe card only and will be closed to the public.
- There is a list of staff who will be issued proximity cards for access via these doors –the list is on the T drive under maternity/birth centre.
- Any member of staff visiting the BC is expected to make their presence known to the midwife in charge of the BC – including at night.

7.3. Transfer equipment

- Generally women will be encouraged to walk if they need to be transferred
- There is a foldable wheelchair for transfer of those women to Labour Ward or the post natal ward who are unable to walk but are well, i.e. those women who require pain relief in labour or a who have presented in labour at the BC in error

		First Ratified April 2014	Reviewed	Version 4	Page 8 of 50
--	--	------------------------------	----------	-----------	--------------

- There is a trolley for transferring women who are unwell or who need alternative management from the BC to Labour Ward/ post natal ward
- This trolley will be stored in the BC cupboard and is not to be removed under any circumstances – except in the event of emergency transfer and is to be cleaned and returned asap following its use
- Should a woman need rescuing from the pool, the equipment will be kept on the emergency trolley in the cupboard. This equipment consists of: 2 large patient specific slide sheets; one Silvea rescue net; a bundle of linen and towels; two flotation devices (woggles)
- There is a resusitaire for transfer of those babies who require specialist management, resuscitation or care on NICU, Labour Ward or the post natal ward following delivery
- This resusitaire will be stored in the Equipment cupboard between rooms 1&2 in the BC and is not to be removed under any circumstances – except in the event described above and must be returned and cleaned asap following its use

7.4. Portering and Waste Management Service

- The bins will be taken to the link corridor where the porter will collect them when collecting from the Antenatal Clinic.
- The portering service will be as per the Abbey Wing Porter

7.5. Catering

- The BC will be supplied with cold snacks and drinks from the catering department – including fruit bowls; isotonic drinks
- Staff will share the same kitchen and sitting area with the women and their families and are expected to provide their own meals.
- There is a fridge and microwave and a hot tap in the kitchen
- The fridge will have a thermometer and the temperature will be recorded as per Trust Guidelines
- There is a water cooler in the reception area
- If a hot meal is required, one can be obtained from Joan Booker Ward
- The order form for the Birth Centre catering needs will be filled in as required and sent to the catering department in good time so there is a selection available at all times
- Special diets can be ordered on IPL each day

7.6. Domestic Service

- There will be a dedicated cleaner for the Birth Centre, 5 hours a day
- There is a dedicated cupboard for the cleaner to store their equipment
- The cleaner will have their own trolley

7.7. Estates/ Maintenance

- Any equipment used in the BC will be PATS tested by Estates prior to use
- Any maintenance or repair issues in relation to the BC building, birth pools, plumbing, gases, heating etc. will be referred to estates

7.8. Fire

- Refer to The Abbey Birth Centre fire and evacuation procedure –Trust Guidelines see appendix 4

7.9. Linen

- There are double beds in each of the four birth rooms

		First Ratified April 2014	Reviewed	Version 4	Page 9 of 50
--	--	------------------------------	----------	-----------	--------------

- Each bed will be dressed with white double sheets, four pillows with white pillowcases, a pink blanket and a decorative counterpane, which **is to be removed once the bed is in use for infection control purposes.**
- There are 2 large towels and a bath mat in the bathroom
- Soiled/used linen will be dispensed in to labelled **blue** linen bags, collected from the BC, laundered and returned by Synergy. The Synergy Linen return form must be completed for each linen bag documenting the items held within the bag. A copy of the form will be obtained in a file in the BC office.

8. Equipment

Each room is equipped with the following:

- Double bed and mattress - stored behind cupboard and doors to be pulled down from the wall by a member of staff. **Under no circumstances is a woman to pull down or replace the bed herself.**
- Sphyg
- Stethoscope
- Pinnards
- Birth Stool
- Birthing Ball
- Large birth mat
- Large blue bean bag
- Sonicaid (mounted on individual stand)
- Thermometer
- Kneeling pad
- Steps for the pool
- Cot
- Changing station

There will be two oxygen cylinders stored in the equipment cupboard for use in an emergency situation.

The following equipment will be available for use in each of the rooms and will be stored in the consulting room and signed in and out of the equipment logbook before and after each use by the attending midwife.

The equipment will be checked daily:

- Ophthalmoscope for Midwives Examination of the Newborn (MEON)
- TV remotes
- Light remote control for each birth room
- Magnets for the birth pools
- Keys for the birth pool shower head cupboard

		First Ratified April 2014	Reviewed	Version 4	Page 10 of 50
--	--	------------------------------	----------	-----------	---------------

Clinical Guidelines

This guidance should be read in conjunction with the Ashford & St. Peter's Hospitals NHS Trust Maternity Guidelines <http://trustnet/docsdata/maternity/index4.htm>

1. Admission

1.1 Pre-Admission

All women will be risk assessed by their community midwife according to Guideline Inclusion/Exclusion Criteria **and** Booking for Place of Birth using the Pregnancy Risk Assessment Tool at booking and again at 34 weeks. If the woman remains Low Risk and under midwifery care, she will be given information about contacting the Birth Centre when she thinks labour has started. Her hospital and Pregnancy Hand-Held Records will be identified with a sticker as Low Risk on the front cover.

All women who have **ANY** concerns regarding herself or her baby will be encouraged to contact Labour Ward Triage which will be available 24 hours a day

1.2. Inclusion criteria for admission

- Singleton pregnancy
- Booking BMI ≤ 34 and greater than 18
- Age 18 – 42 years at booking
- Pregnancy of 37 - 42 weeks (by dating scan)
- No obstetric complications
- No medical complications

NB

- a. Women who are currently medicated for depression **OR**, who have a significant history of depression, irrespective of the cause, should have their suitability assessed on an individual basis, with input from supervision if appropriate. The woman's individual need for enhanced postnatal support and pathway must also be considered. And this should be clearly documented in the her notes at the time of the assessment
- b. Women taking medication for **hypothyroidism** and are well controlled, in the absence of any other risk factors, can come to the birth centre and should be under midwife care

1.3. Exclusion Criteria Previous Pregnancy

- Previous CS
- 3rd/4th degree tear
- Previous baby greater than 4.5kg
- History of placental abruption
- Previous Pre-eclampsia
- Previous stillbirth or neonatal death
- Previous PPH >1000mls – If due to trauma, requires discussion with SOM team, for consideration on an individual basis. If due to uterine atony with no other predisposing factors - for exclusion
- Previous shoulder dystocia
- Previous retained placenta – NICE advise that there is a 25% chance of reoccurrence and an increased risk of PPH.
- Previous puerperal psychosis

		First Ratified April 2014	Reviewed	Version 4	Page 11 of 50
--	--	------------------------------	----------	-----------	---------------

- Previous gynae history of hysterotomy, myomectomy
- Bicornate uterus

1.4. Exclusion Criteria - Current pregnancy

- SROM > 24 hours
- 2 episodes of reduced fetal movements after 34/40
- Severe asthma –any woman who is under medical care management for her asthma. E.g. medicated or have had a change/ increase in medication during current pregnancy; or hospital admission for a significant asthmatic episode.
- Hyperthyroidism
- Severe vulval varicosities to be assessed on an individual basis
- Any woman under Consultant Led Care after 36 weeks

If a woman no longer requires Consultant care, the notes must reflect that she has been transferred back to midwifery care. The woman requires to be seen and risk assessed against the BC admission criteria at 34-36/40 by her community midwife, at which point a sticker is placed on the notes

- Preterm labour – before 37/40
- Antepartum bleeding after 24 weeks
- Pre-eclampsia/gestational hypertension
- Fetal abnormality
- GBS positive
- BMI greater than 34 or less than 18 at booking
- Hb less than 10 gdl MCV <85fl at 34 weeks
- IUD
- Induction of labour
- Multiple birth
- Gestational diabetes
- Breech or transverse lie after 36/40 (current abnormal or unstable lie) – if successful ECV after 36/40 can come to Birth Centre
- Placental abruption
- Placenta praevia
- Preterm rupture of membranes before 37/40
- Late booker (greater than 20 weeks)- this does not include transfers from other units
- Concealed pregnancy(from 24 weeks gestation)
- Safeguarding issues
- Significant blood group antibodies – following advice from Consultant haematologist
- Clinically large baby with ultrasound measurements over **97th** centile
- Small gestational age with ultrasound measurements below **3rd** centile
- Polyhydramnios/oligohydramnios
- Grand Multigravida (Gravida 5 Para 4 or higher) – Requires discussion with SOM team, for consideration on an individual basis.
- Any fibroids identified on 12 week scan

		First Ratified April 2014	Reviewed	Version 4	Page 12 of 50
--	--	------------------------------	----------	-----------	---------------

If a woman booked for the BC is admitted to JB/LW for any reason after 34/40, her suitability to come to the BC is to be reassessed by a birth centre midwife before discharge. If she is to continue under consultant care following this admission, the BC sticker is to be crossed through and the change in Lead professional reflected on the front of the notes. The woman needs to be fully informed of the reasons for the change with documentation in the notes reflecting the discussion.

2. Telephone assessment

When a woman booked for the BC suspects she is in labour after 37/40, she will contact the Birth Centre; the midwife will commence **the Telephone Triage Assessment Tool (TTAT)** (appendix 1).

During the telephone call it is preferable to speak to the woman herself. The **TTAT** enables accurate history of the woman's situation to be documented and should be used in conjunction with Inclusion/Exclusion criteria for admission to the BC.

This approach will assist the midwife to give appropriate advice to those women expecting to be admitted to the Birth Centre.

The caller should be asked to identify:

- Themselves (or their relationship to woman) and their reason for calling
- Whether it is their first call or subsequent call/s in the preceding 24 hours
- The reason for calling
- Previous obstetric/medical history
- Current obstetric history and /or medical concerns
- History of vaginal bleeding/discharge
- History of fetal movements

All information taken and advice given should be fully documented on the TTAT form (appendix 1).

Using the information gained from the assessment, the midwife taking the call will advise accordingly and if appropriate, refer the woman to an alternative service e.g. Labour Ward triage or Labour Ward for assessment – **This will be documented on a TTAT form and filed in the woman's notes upon admission.** The BC midwife will inform the labour ward that the woman will be attending their Triage.

All women who telephone the Birth Centre should be invited to attend on their 3rd call in 24 hours.

3. Arrival at the Birth Centre - Admission assessment

The woman will be advised when to come into Birth Centre following completion of the TTAT and assessment of her individual needs. Most women benefit from being in their home environment during the early stages of labour.

On admission the woman will be welcomed to the Birth Centre and shown to her room. She will be orientated to the facilities and encouraged to familiarise herself with her surroundings.

A full history will be recorded in the Pregnancy Hand Held Records, ensuring that the Birth Centre Low Risk criterion has been met.

		First Ratified April 2014	Reviewed	Version 4	Page 13 of 50
--	--	------------------------------	----------	-----------	---------------

The woman must be 37-42 weeks gestation with an uncomplicated pregnancy.

A full examination and assessment should take place on admission, as per the Care in Labour Guideline-

NB A full set of observations must be completed and documented in the notes, including urinalysis before using the pool.

This initial assessment should be recorded in the hand held notes and include:

Table 1

Observation Examination	Rationale
Temperature	To identify pyrexia i.e. a temperature greater than 37.5c on two occasions or greater than 38c on one occasion
Pulse	To establish the difference between FHR and maternal HR To identify infection, haemorrhage
Respirations	To identify deviation from the norm (range 12-20 refer to MEOWS))
Blood Pressure	To identify altered BP/ hypertension/ pre-eclampsia and risk of haemorrhage
Urinalysis	To identify normal micturition, underlying bacteraemia, proteinuria and/ or infection and Ketoacidosis
Abdominal Palpation- Including measurement of fundus	To confirm that the fundus measures accurately for gestation, long lie, cephalic presentation, and position of the fetus and descent of presenting part.
Contractions	To confirm frequency, strength, length
Fetal heart auscultation (FHR)	To identify abnormal features and or fetal distress – refer to Care in Labour and Fetal Monitoring guidelines
VTE Assessment	To identify risk of VTE – refer to VTE Guideline
Diet/Fluid intake	To confirm that appetite is normal and no evidence of illness. H2 receptor antagonist drugs such as Ranitidine should not be used
Behaviour	To observe woman for normal features of labour and appropriately refer if any concerns are identified
If appropriate a vaginal examination (VE) can be considered in consultation with the woman	To assess: <ul style="list-style-type: none"> • Position of cervix • Consistency of cervix • Application of cervix to PP • Dilatation of cervix • Membranes present/absent • Fetal position • Position of PP in relation to ischeal spines maternal pelvis • Presence of caput/moulding • Presence of abnormal features - cord/placenta.

Please refer to the Modified Burville Score, appendix 6, to assist assessment of labour

		First Ratified April 2014	Reviewed	Version 4	Page 14 of 50
--	--	------------------------------	----------	-----------	---------------

4. Labour care in the Birth Centre

All women will receive one to one care during labour. Deviations from the norm will be acted upon in a timely manner based on current evidence and guidance. Women should not be left unattended when in established labour (see Care in Labour Guideline).

Informed consent must be obtained for **any** procedures; if a woman declines routine assessment or examination the implications of her choice must be identified through discussion, a risk assessment made and documented in the notes, along with the plan of care in this instance (refer to the Care in Labour Guideline re Communication).

If the woman's choice is felt to affect the midwives ability to deliver safe care - this should be discussed with woman and her partner in the first instance. The midwife should call the on call Supervisor of Midwives for advice and support.

All women will be offered intermittent fetal auscultation and will follow the Normal Labour Pathway – Appendix 4 and the Care in Labour Guideline.

All women in the Birth Centre will have the opportunity to use water for their labour and to deliver in the water pool should they wish to, provided a pool is available – please refer to and follow the Waterbirth guideline.

For assistance in supporting women, refer to Managing strategies for Low Risk Women in labour – Appendix 5, this includes:

- Behaviour
- Breathing
- Positions of comfort
- Birthing ball
- Hydrotherapy
- Aromatherapy blends – by an appropriately trained practitioner
- Entonox

If a woman has decided in her pregnancy to use regional anaesthesia to cope with labour, despite being Low Risk, she will not be booked for the Birth Centre. If a woman requires additional analgesia during labour the midwife should discuss transfer to Labour Ward for pethidine or an epidural regional block.

Labour should progress spontaneously and without interference; the midwife should act in a supportive manner, offering explanations and encouragement.

The midwife should observe the woman's progress throughout labour. Signs may include the following:

- Increasing strength and frequency of contractions
- Spontaneous rupture of membranes
- Increasing dilatation
- Primipara - 2cm in 4 hours

		First Ratified April 2014	Reviewed	Version 4	Page 15 of 50
--	--	------------------------------	----------	-----------	---------------

- Multipara - 4cm in 4 hours
- Expiratory grunting
- Descent of presenting part
- Distension of Rhombus of Michaelis
- 'Blue Line'
- Anal pouting
- Perineal distension
- Vertex at introitus
- Full dilatation of cervix

The second stage of labour should follow a period of 'Transition', which may last up to one hour, particularly in primiparous women, before active signs of expulsion occur. Once active pushing has commenced the second stage of labour should not exceed 2 hours in a Primip and 1 hour in multiparous women.

Progress will be documented in the woman's hand held notes and the Partogram completed. The maternity Evolution data base will also be completed.

Deviations from the norm will be acted upon immediately - see table 2 and actions below.

All women will follow the normal birth pathway (Appendix 4) – see guidance below:

Table 2

Observations/Examinations	Frequency	Rationale	Action
Temperature	4 hourly NB – if in the pool – hourly in 1st stage ½ hourly in the 2nd	To identify pyrexia >	• If >38 on one occasion or >37.5 on more than 2 occasions 30 minutes apart contact Labour Ward for transfer using the SBAR tool.
Pulse	1 hourly	To identify infection, haemorrhage and establish the difference between fetal heart rate	• If tachycardia is present >100 on two occasions and there is no obvious reason – re check after 30 minutes transfer to Labour Ward using the SBAR tool
Blood Pressure	4 hourly	To identify pre-eclampsia, gestational hypertension, haemorrhage	• If above 140/90 on 2 occasions 15 mins apart or a single resting reading 150/100 transfer to Labour Ward using SBAR tool
Urinalysis	4 hourly	To identify normal micturition, underlying bacteraemia, proteinuria and or infection and Ketoacidosis	• Obtain a clean specimen. In the absence of ruptured membranes or other symptoms, urinalysis and shows 1+ protein, transfer to Labour Ward using SBAR tool
Abdominal Palpation	Before every vaginal examination	To confirm that the fundus measures accurately for gestation, long lie, cephalic presentation, position of the fetus and descent of presenting part	• If fundus is +/- 3cm than dates suggest or suspected breech or mal presentation transfer to Labour Ward using SBAR tool
Contractions	On admission and at	To confirm frequency,	• If contractions are less than 3:10

		First Ratified April 2014	Reviewed	Version 4	Page 16 of 50
--	--	------------------------------	----------	-----------	---------------

	a minimum hourly during 1 st stage labour	strength, and length	ensure labour is established. <ul style="list-style-type: none"> If labour has progressed and contractions reduce in frequency length and strength– offer mobilisation and fluids/food.
Intermittent Fetal heart auscultation	<ul style="list-style-type: none"> On admission, Prior to vaginal examination, 1st stage- every 15 mins for 60 secs following a contraction 2nd stage -every 5 mins or after every contraction 	To identify abnormal Fetal heart rate features	<ul style="list-style-type: none"> If a FHR abnormality is detected using pinard or sonicaid in labour transfer to Labour Ward using SBAR tool.
Vaginal Examination	In the absence of other signs of progress in labour or as requested by woman or 4 hourly	To assess: <ul style="list-style-type: none"> Cervix position Consistency of cervix Application of cervix to PP Dilatation of cervix Membranes present/absent Fetal position Decent of the presenting part Presence of caput/moulding Presence of abnormal features - cord/placenta. 	<ul style="list-style-type: none"> Vaginal examinations are useful to determine malposition, failure to progress in labour and to identify any potential birth problems.
Diet/Fluid intake	On admission and throughout labour	To confirm that appetite is normal and no evidence of illness.	<ul style="list-style-type: none"> Women should be offered light diet and continue with fluids through 1st stage of labour as this helps to prevent acidosis and dehydration – refer to Care in Labour Guideline
Behaviour	On admission and throughout labour	To observe woman for normal features of labour and refer if any concerns are identified	<ul style="list-style-type: none"> Some women find labour more difficult to cope with; 1:1 support from the midwife will identify problems. Some cultures expect women to be very noisy during labour – the midwife should be aware and supportive of this. If however a woman is struggling to cope, the midwife should offer support

5. Transfer Procedure

There will be occasions where labouring women will require or request transfer to the Labour Ward. This may include:

- Request for further pain relief
- Slow progress in 1st or 2nd stage labour
- Meconium stained liquor
- Abnormal maternal/ fetal observations (can be urgent/ emergency – see section 12.1-14)

The midwife will discuss and document her findings with the woman and her birthing partner. Contact the labour Team Leader and give a brief history using SBAR principles including:

- Name and hospital number
- Transfer reason
- Stage of labour
- Treatment or investigations recommended.

The woman and her partner will be transferred on foot or chair with all documentation completed.

Report all transfers to labour ward from the Birth Centre via Datix.

All transfers will be discussed daily and peer reviewed, monthly data will be collated for governance purposes.

5.1 Transfer to the Labour Ward

Please see Management of an Obstetric Emergency in the Birth Centre – section 13, below

NB – The attending midwife is expected to manage urgent/emergency situations in the Birth Centre and the following will apply:

The attending midwife will use the emergency bell in the room to alert the 2nd midwife that immediate assistance is required

The attending midwife will lead the process and instruct the 2nd midwife to assist her with managing the situation as per the guideline and plan to transfer the woman/ baby to the appropriate place asap

Should an urgent transfer from the Birth Centre to the Labour Ward be required - this will be communicated using the Red priority phone Ex 2160 the labour ward will send one midwife to assist transfer.

The occasions where labouring or postnatal women will require urgent transfer from the Birth Centre to the Labour Ward will be as per table below:

		First Ratified April 2014	Reviewed	Version 4	Page 18 of 50
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Table 3 Criteria for Transfer from BC to LW

Abnormality	Observation	Action
Abnormal Fetal Heart Rate (FHR)	Intermittent auscultation	<ul style="list-style-type: none"> • Change maternal position • If persists and birth imminent prepare for basic neonatal resuscitation • OR if not imminent – Contact LW team leader and transfer to Labour Ward
Abnormal Maternal Observations – see table 1 for normal observations	<p>Pyrexia >37.5 on two occasions 30 minutes apart or 38 on one occasion. Pulse >100 on 2 occasions 30 minutes apart Pulse 120 on one occasion</p> <p>Abnormal blood pressure reading range: 140/90 on 2 occasions 30 mins apart 150/100 on one occasion</p> <p>Urine – proteinuria +1</p>	<p>If above 140/90 on 2 occasions 15 mins apart or a single resting reading 150/100</p> <p>Ask for a clean specimen, if still shows 1+ transfer to LW as above</p> <p>For all of the above contact LW team leader and transfer to Labour Ward</p>
Liquor	Meconium stained liquor upon SROM	<ul style="list-style-type: none"> • ANY meconium-stained liquor - Contact LW team leader and transfer to Labour Ward • NB If meconium noted during 2nd stage of labour and the birth is imminent with no time to safely transfer – the midwife is expected to manage the situation and escalate as and when required.
Abdominal Pain (not contractions)	Presence of pain not consistent with labour which may be constant or intermittent. Uterine rupture can occur in women who have not had uterine surgery.	<ul style="list-style-type: none"> • Take Maternal and Fetal observations • Contact LW team leader and transfer to Labour Ward
Failure to Progress	Labour does not follow the normal pathway and expected progress	<ul style="list-style-type: none"> • Confirm vaginal dilatation, position and descent of presenting part, frequency and strength of contractions • If membranes are intact consider ARM with consent from the woman. • If no progress in two hours post ARM contact labour ward team leader and transfer woman to labour ward.
Retained Placenta	Failure to complete the 3 rd stage of labour within the normal guideline limit 30 minutes for active and 60 for physiological – refer to Care in Labour guideline	<ul style="list-style-type: none"> • Ensure active management of labour is initiated giving Syntometrine IM • Observe and document blood loss • Document maternal observations of pulse, blood pressure and respirations every 15 minutes • If placenta fails to deliver within 30 mins after active management contact labour ward

		team leader and transfer to Labour Ward
3 rd /4 th Degree Perineal Tear	Trauma sustained to the perineum during delivery	<ul style="list-style-type: none"> Identify the degree of trauma ask for assistance from Birth Centre staff if a second opinion Ensure initial haemostasis, apply pad Contact labour ward team leader and transfer to Labour Ward

All transfers from the Birth Centre will be discussed daily with the Birth Centre Team Leader, the attending midwife, if possible, and the Clinical Risk Midwife.

6. Management of an Obstetric Emergency in the Birth Centre and Urgent Transfer to Labour Ward

NB – The attending midwife is expected to manage urgent/emergency situations in the Birth Centre and the following will apply:

The attending midwife will use the emergency bell in the room to alert the 2nd midwife that immediate assistance is required

The attending midwife will lead the process and instruct the 2nd midwife to assist her with managing the situation as per the guidelines for specific obstetric and neonatal emergencies.

The plan should be to manage the emergency and to transfer the woman/ baby to the labour ward.

Should an urgent transfer from the Birth Centre to the Labour Ward be required - this will be communicated using the **Red priority phone Ex2160**. The labour ward team leader will send a midwife to assist the transfer.

In situations where transfer is not possible i.e. Sudden catastrophic collapse, no release of shoulder dystocia; poor neonatal condition following initial resuscitation priority call 2222 will be facilitated by the attending midwife and help requested. State obstetric/ neonatal emergency in the Birth Centre and state the room number.

Table 4 Management of Obstetric Emergencies in the Birth Centre

Emergency	Observation	Action
Fetal bradycardia – Greater than >3minutes	Intermittent auscultation	<p>Follow Care in Labour guideline</p> <ul style="list-style-type: none"> Change maternal position immediately to Left Lateral Check maternal pulse Call for help via emergency bell Perform VE to exclude cord prolapse Contact LW team leader using red priority ext. 2160; state emergency and request immediate assistance to transfer to labour ward- the team leader on labour ward will always send a midwife to assist the transfer
Antepartum Haemorrhage	Any blood loss that is bright red, not mucousy and greater than	Follow Guideline for Obstetric Haemorrhage

		First Ratified April 2014	Reviewed	Version 4	Page 20 of 50
--	--	------------------------------	----------	-----------	---------------

	50ml	<ul style="list-style-type: none"> • Call for help via emergency bell • Assess volume of vaginal blood loss • Contact LW team leader using red priority ext. 2160; state emergency and request immediate assistance to transfer to labour ward- the team leader on labour ward will always send a midwife to assist the transfer
Postpartum Haemorrhage (PPH)	Any blood loss that exceeds 500mls during the management of 3 rd stage or following completion of 3 rd stage. – The source must be identified and managed appropriately, ie trauma by suturing to stop the bleeding; If EBL .>1000ml,for transfer to the labour ward.	<p>Follow Guideline for Obstetric Haemorrhage</p> <ul style="list-style-type: none"> • Call for help via emergency bell • Assess volume of blood loss and maternal condition • Take immediate action to manage the initial haemorrhage as per Obstetric Haemorrhage Guidelines. • If bleeding is controlled and the woman is well it may be possible to transfer the woman to the Labour Ward. • Contact LW team leader using red priority ext. 2160; state emergency and request immediate assistance to transfer to labour ward- the team leader on labour ward will always send a midwife to assist the transfer
Maternal Collapse	During any stage of labour other than a simple faint without haemorrhage.	<p>Follow guideline for Collapse –Sudden Intrapartum/postpartum</p> <ul style="list-style-type: none"> • Call for help via emergency bell • Take immediate action to manage the initial collapse as per above - Collapse Guidelines. • If required Call 2222 state 'Obstetric priority' and 'Adult priority' in the BC, state the room number • Contact LW team leader using red priority ext. 2160; state emergency and request immediate assistance • Ensure access to the Birth Centre for the Obstetric team is facilitated • Once the woman is stable immediately transfer to Labour Ward
Eclamptic fit	During any stage of labour	<p>Follow guidance for management of Eclampsia in the Hypertension in Pregnancy Guideline</p> <ul style="list-style-type: none"> • Call for help via emergency bell • Call 2222 state 'Obstetric priority' in the Birth Centre, state the room number. • Contact LW team leader using red priority ext. 2160; state emergency and request immediate assistance

		First Ratified April 2014	Reviewed	Version 4	Page 21 of 50
--	--	------------------------------	----------	-----------	---------------

		<ul style="list-style-type: none"> • Ensure access to the Birth Centre for the Obstetric team is facilitated • Once stable immediately transfer the woman to Labour Ward
Undiagnosed Breech	During any stage of labour,	<ul style="list-style-type: none"> • If the presenting part is at the introitus and birth imminent request immediate obstetric attendance. • Call 2222 state 'Obstetric priority' in the Birth Centre, state the room number. • Contact LW team leader using red priority ext. 2160; state emergency and request immediate assistance • Ensure access to the Birth Centre for the Obstetric team is facilitated • If identified during labour – Contact labour ward team leader and transfer
Cord presentation or prolapse	The palpation or observation of cord presence in labour	<p>Follow Cord Prolapse/presentation guideline.</p> <ul style="list-style-type: none"> • Take immediate action to prevent further prolapse • Contact LW team leader using red priority ext. 2160; state emergency and request immediate assistance for transfer
Shoulder Dystocia	Slow descent of presenting part during 2 nd stage of labour and failure to restitute once head delivers	<p>Follow Shoulder Dystocia guideline.</p> <ul style="list-style-type: none"> • Call for help via emergency bell • Take immediate action to manage emergency as per shoulder dystocia guideline. • Contact LW team leader using red priority ext. 2160; state emergency and request immediate assistance

Any serious untoward incidents will be reported using risk governance processes, learning points and actions for change will be implemented following full root cause analysis process

7. Request for Neonatal Assistance

The midwife in attendance will provide immediate resuscitation in accordance with the *Neonatal resuscitation on the Labour Ward* guideline.

In principle it is expected that babies who are likely to be compromised at birth will have been transferred to Labour Ward prior to birth and those unexpectedly compromised at delivery and not responding to resuscitation by the midwife will require a 2222 'Neonatal Priority' call which will ensure the neonatal resuscitation team attend urgently.

7.1. Calling the Neonatal Team

- The attending midwife will undertake immediate resuscitation of the baby and request assistance from the 2nd Birth Centre midwife by using the emergency bell
- If required, the attending midwife will ask the 2nd midwife to bring the resuscitator into the room – **the baby is not to be taken out of the room**

		First Ratified April 2014	Reviewed	Version 4	Page 22 of 50
--	--	------------------------------	----------	-----------	---------------

- If required the attending midwife will instruct the 2nd midwife to call **2222** and state **‘Neonatal Priority in the Birth Centre’**, stating room number.
- Contact LW team leader using red priority **ext. 2160**; state emergency and request immediate assistance
- The attending midwife conducting immediate resuscitation will follow agreed Neonatal Advanced Life Support techniques until assistance arrives. (See **Neonatal resuscitation on Labour Ward Guideline**)
- Once in attendance, the neonatal team will assume responsibility for the baby and the transfer

7.2. Neonatal Transfer

- If the baby is to be transferred to NICU (Neonatal Intensive Care Unit) this will be facilitated by the attending neonatal team
- If the resusitaire is used for transferring the baby it must be returned immediately to the BC, cleaned and restocked
- The woman and her partner will be informed of all plans and this communication will be documented in the intrapartum section of the records.
- The mother will need to be transferred to JB ward when appropriate with handover using SBAR tool.
- Any baby requiring meconium observations or TPR (Temperature; pulse; respirations) for PROM (Prolonged Rupture of Membranes) will be transferred to Joan Booker ward with mother for neonatal review and completion of observations as per guidelines. Any baby causing concern e.g. grunting, cold baby should be transferred to Joan Booker Ward with the mother for neonatal review and observations. At night it may be appropriate to transfer to the Labour Ward
- Please include the NICU attending consultant neonatologist when transferring any baby of concern from the Birth Centre.

8. Midwives Examination of the Newborn (MEON)

- It is anticipated that women will stay in the Birth Centre with their babies between 6-24 hours
- All babies should have a MEON to include a pre (right hand) and post ductal (right or left foot) oxygen saturation ((O2 Sats) measurement*, as per trust guideline, and documented in the blue baby notes pg 6, prior to leaving the Birth Centre – if it is not possible for the baby to have a MEON prior to discharge, these babies must have their O2 Sats measured and recorded as above prior to discharge.

*The O2 Sats reading must be > 95% and the difference between the pre and post ductal reading no more than 3%. If the difference is greater than > 3% the O2 Sats should be repeated one hour later. If the difference remains >3% following the repeat, the baby needs to be transferred to JBW to be reviewed by a paediatrician ASAP

- Monday to Friday (daytime) the Team Leader for the Birth Centre is responsible for ensuring the MEON is undertaken prior to discharge OR a plan is in place for a MEON to take place in the home.

		First Ratified April 2014	Reviewed	Version 4	Page 23 of 50
--	--	------------------------------	----------	-----------	---------------

- At the weekend or at night if a woman wishes to go home and there is not a MEON trained midwife on shift, the core midwife is responsible for ensuring that there is a documented plan in place for the baby to have a MEON ASAP and to measure and record the baby's O2 Sats, as above, prior to discharge.
- All MEON's and plans for MEON's will be documented in the MEON Diary in the Consulting Room – ensuring confidentiality by documenting only the hospital number
- All women will be given their baby's red book at the MEON.

		First Ratified April 2014	Reviewed	Version 4	Page 24 of 50
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