Standard Operational Procedure for Advice on Place of Birth and Risk Assessment of Women in Labour

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Table 1:

Women with any of the following history should have an individual assessment when planning place of birth. The conditions listed below are not reasons in themselves to recommend birth in an obstetric unit, but do indicate further consideration of birth setting is required. Discuss these risks and the additional care that can be provided in the obstetric unit to enable the woman to make an informed choice.

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 8.5-10.5 g/l at onset of labour – if symptomatic

Infective

- Hepatitis B/C with normal liver function tests

Immune

- Non-specific connective tissue disorders

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
- Crohns disease – if not on steroids
- Ulcerative colitis – if not on steroids

Previous gynaecological history

- Cone biopsy
- Fibroids (refer to USS results)

Previous complications

- Stillbirth / neonatal death with a known non recurrent cause
- History of previous baby more than 4.5kg
- Extensive vaginal, cervical, or 3rd or 4th degree perineal trauma – if have not required surgical correction
- Previous term baby with jaundice requiring exchange transfusion

Current pregnancy

- Antepartum bleeding of unknown origin (single episode after 24 weeks gestation) if placenta praevia / abruption excluded
- BMI at booking 30-35 kg/m^2
- Blood pressure of 140 mmHg systolic or 90mmhg diastolic on 2 occasions
- Clinical or ultrasound suspicion of macrosomia (if head not engaged)
- Para 4 or more if cephalic presentation
- Recreational drug use
- Under current outpatient psychiatric care
- Age over 35 at booking

Fetal indications

- Fetal abnormality

Table 2:

It is recommended that women with the following medical conditions give birth on the Delivery Suite. These women are most likely under Consultant Care – see antenatal notes for further information

Cardiovascular

- Confirmed cardiac disease
- Hypertensive disorders

Respiratory

- Asthma 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
- Von Willebrand's disease
- Bleeding disorder in the woman or unborn baby
- Atypical antibodies which carry a risk of haemolytical disease of the new born

Infective risk factors

- Risk factors associated with Group B Streptococcus whereby antibiotics in labour are 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
- 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 in patient care

Previous complications

- Unexplained stillbirth / neonatal death or previous death related to intrapartum difficulty
- Previous baby with neonatal encephalopathy
- Pre –eclampsia requiring preterm birth
- Placental abrupbtion
- Eclampsia
- Uterine rupture
- Primary postpartum haemorrhage (PPH) requiring treatment and/or blood transfusion
- Retained placenta requiring manual removal in theatre
- Caesarean section
- Shoulder dystocia

Current pregnancy

- Multiple birth
- Placenta praevia
- Pre – eclampsia or pregnancy induced hypertension
- Pre-term labour per preterm pre labour rupture of membranes
- Placental abruption
- Anaemia – haemoglobin <8.5 g/l 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
- High (4/5 – 5/5) or free head in a nulliparous woman. Free or ballotable head in a multiparous woman
- Body mass index at booking of >35 kg/m^2
- Recurrent antepartum haemorrhage
- Refusal to have blood products
- No antenatal care
- Anaesthetic alert

Previous gynaecological history

- Myomectomy
- Hysterotomy

Fetal indications

- Small for gestational age in this pregnancy (<5th centile or reduced growth velocity on ultrasound)
- Abnormal fetal heart rate (FHR) Doppler studies
- Ultrasound diagnosis of oligo / polyhydramnios
- Large for gestational age (AC >97th centile on USS)

1. Purpose/Background:

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.

The purpose of this guideline is to provide guidance for recommendations around place of birth and appropriate risk assessment of all women in labour.

2. Scope:

This document is for use by all obstetricians and midwives and it applies to all women cared for by the Maternity Services at St Mary's Hospital.

3. Responsibilities:

It is the responsibility of all Midwifery Nursing and medical staff to:

- Access read understand and apply this SOP
- Attend any mandatory training pertaining to the SOP

It is the responsibility of the department to:

- Ensure the SOP is reviewed as required in line with trust and national recommendations
- Ensure the SOP is accessible to all relevant staff

4. Procedure:

The choices for birth place on the Isle of Wight are:

- Home Birth
- St Marys Maternity Unit Delivery Suite- This incorporates three high risk rooms and two low risk rooms.

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 risk 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.

Women with any medical problem listed in **'Table 2'** on page 3 and 4 of this document should be classified as high risk. Women with any medical problem listed in **'Table 1'** on page 2 of this booklet should have an individual assessment when planning place of birth. The conditions listed are not reasons in themselves to recommend birth in an obstetric unit, but do indicate further consideration of birth setting is required. Discuss these risks and the additional care that can be provided in the obstetric unit to enable the woman to make an informed choice.

4.1 Home birth:

Women considered low risk and suitable for Midwife led care (See Antenatal risk assessment on page 5 of the Antenatal care record) should be informed that a homebirth is a safe option for the birth of their baby providing:

- The pregnancy is at term
- The mother is fit and healthy and has no underlying medical problems that may affect her labour
- Singleton pregnancy
- Cephalic presentation
- The baby is well grown and no problems have been detected antenatally.

If a woman chooses a homebirth further information regarding booking processes and paperwork can be found in the 'Standard Operational Procedure for Planned Home Birth, BBA and Transfer in via Ambulance'.

4.2 Hospital Birth:

Low Risk Hospital Birth

There are five labour rooms at St Mary's Hospital, two of which are considered low risk birthing environments, these include the pool room. These rooms are mostly suitable for women that are low risk according to the antenatal and labour risk assessments, and could have a home birth but have chosen to have their baby in a hospital setting.

High Risk hospital Birth

Women who are considered high risk according to the antenatal and labour risk assessments and any plan of care made throughout the pregnancy, should be advised to deliver on the Delivery Suite. This is due to the availability of continuous monitoring, and the obstetric team being on site. There are 3 labour rooms that support continuous monitoring and the higher levels of care often required by high risk women. Women requiring consultant led care should still be offered choice in their birth.

- They can be encouraged to remain mobile and use different positions
- Low lighting
- Noise kept to a minimum
- CTG turned down
- Encouraged to have alternative therapies i.e. hypnobirthing

4.3 Timing of risk assessment in labour:

The initial risk assessment occurs when a woman is first admitted to Delivery Suite for hospital births. For home births the initial risk assessment should occur when the community midwife arrives at the woman's home and labour is diagnosed. Risk assessment is ongoing throughout labour in all settings.

4.4 Initial Risk Assessment:

- The risk assessment process for women in labour is the same for women giving birth in the community or in the hospital setting.
- When the woman first presents in labour the initial risk assessment form should be completed on page 2 of the intrapartum notes (see Appendix A). This form lists the factors that should be considered including problems with previous pregnancies, lifestyle history and anaesthetic problems.
- E-care logic should be checked for any recent blood results.
- The midwife should also take note of the antenatal risk assessment and any individualised care plans that may have been made during pregnancy.
- Women identified as low risk should have midwifery led care and be offered a low risk birthing environment if they are in the hospital.

- If during the initial risk assessment for a home birth, the midwife discovers any problems not previously identified which classify the woman as high risk, it should be discussed with the woman and she should be advised to transfer to the maternity unit.
- Women identified as high risk will be under Consultant led care. The on call obstetric registrar must be contacted and informed of the woman's admission to Delivery Suite.
- The registrar should be asked to review the woman and document an individual management plan in the notes.
- The on call consultant obstetrician should be contacted if there are any concerns regarding the ongoing management plan.

4.5 Ongoing risk assessment:

- Women may continue to be classified as low risk if ongoing assessments in labour are normal, i.e. observations, FH monitoring and progress are within normal parameters.
- If new risks are identified for women under Midwifery led care that put them into a high risk category, they should be changed to Consultant led care.
- If they are in a low risk birthing room they should be moved to a high risk room to facilitate closer monitoring. If they are at home, they should be advised that transfer to the hospital is necessary and an ambulance transfer arranged (see Standard Operational Procedure for Planned Home Birth, BBA and Transfer in via Ambulance)
- The obstetric registrar must be informed and a plan of care should be documented in the maternal notes.
- If the woman declines transfer this should be discussed with the Delivery Suite lead and additional support put in place as necessary.

4.6 Women that choose to labour outside of national guidance:

Women that choose to birth outside of national guidance should be referred to the PMA and a consultant for discussion. A birth plan should be devised and agreed and signed by all parties. This should be disseminated to all staff. Where the woman

chooses to birth at home against advice, the community midwives should be supported by the clinical leads and senior midwives. An appropriate on call rota should be developed and shared to all staff highlighting the senior support available on each shift

5 Implementation/training/awareness:

- This is a review of a current document and it formalises current practice.
- Once ratified it will be available in all clinical areas within the Maternity Unit and on the intranet.
- All new, reviewed and ratified documents are notified to staff via the monthly maternity newsletter

6. Auditable Standards:

What aspects of compliance with the document will be monitored	What will be reviewed to evidence this	How and how often will this be done	Detail sample size (if applicable)	Who will coordinate findings	Which group or report will receive findings
Completion of Clinical risk assessment	Maternal Notes	Yearly	20 sets	Audit Midwife	Delivery suite Meeting
Documentation of individualised management plan	Maternal Notes	Yearly	20 sets	Audit Midwife	Delivery Suite Meeting
Documentation of referral when risk have been identified	Maternla Notes	Yearly	20 sets	Audit Midwife	Delivery Suite meeting

7. Related Documents:

Guidelines:

- Record Keeping
- Standard Operational Procedure for Continuous Electronic Fetal Monitoring in Labour
- Care of women with an Epidural
- Meconium stained liquor
- Immediate care of the newborn
- Pre-labour rupture of membranes
- Perineal Trauma

- Management of retained placenta
- Augmentation of labour
- Standard Operational Procedure for Planned Home Birth, BBA and Transfer in via Ambulance
- Women that decline blood products

8. References:

- **NICE Guideline -** Intrapartum care for healthy women and their babies December 4014. (Updated Feb 2017)

9. DISCLAIMER

It is the responsibility of staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced.

DOCUMENT HISTORY					
Date of Issue	**Version No.**	**Next Review Date**	**Date Approved**	**Director Responsible for Change**	**Nature of Change**
January 2010	1.0	January 2012	January 2010		Maternity CSG
May 2011	2.0	May 2014	May 2011		Maternity CSG
January 2012	2.0	May 2014	January 2012		Slight amendments for CNST
July 2012	3.0	24th July 2015	24th July 2012		CNST changes. Approved at Maternity CSG
November 2012	4.0	27th November 2015	27th November 2012		Split form 'Guideline for care of women in labour in all care settings'
February 2016	5.0	10th February 2019	10th February 2016	Clinical Director of SWCH	Reviewed with no changes. Agreed with Maternity CSG members
August 2017	6.0	15th August 2020	15th August 2017	Clinical Director of SWCH	Reviewed and updated. Approved at Maternity CSG
June 2020	SOP v1	June 2023	25th June 2020	MCSG	Place of birth and risk assessment Guidelines reviwed/combined and converted to SOP format. Ratified

Appendix A

RISK ASSESSMENT IN LABOUR

Low risk women in labour should not be offered continuous CTG. (NICE, 2017)

Offer MLC ☐ Pool room ☐

Risk factors	Tick	Risk factors at initial assessment / or arise in labour	Tick
Previous Caesarean section		Maternal pulse > 120bpm on 2 occasions, 30 minutes apart	
Previous myomectomy			
Pre-eclampsia		Temperature 38°C or above on single reading or 37.5°C or above on 2 consecutive occasions 1 hour apart	
Pregnancy > 42 weeks			
Pregnancy < 37 weeks		Suspected sepsis or chorioamnionitis	
Induced labour			
Ruptured membranes for > 24 hours		Pain that differs from pain associated with contractions	
Ruptured membranes with meconium			
Recurrent antepartum haemorrhage		Fresh vaginal bleeding that develops in labour	
Fetal growth restriction			
Abnormal Doppler studies		Hypertension: either systolic BP of 140mmHg or more or diastolic BP of 90mmHg or more on 2 consecutive readings taken 30 minutes apart, measured between contractions	
Oligohydramnios			
Multiple pregnancy			
Breech presentation		Severe hypertension: a single reading of either systolic BP of 160mmHg or more or diastolic BP of 110mmHg or more between contractions	
Maternal diabetes			
↓ FM in preceding 24 hrs			
Previous still birth		A reading of 2+ of protein on urinalysis and a single reading of either raised systolic BP (140mmHg or more) or raised diastolic BP (90mmHg or more)	
Previous PPH			
Anaemia (Hb < 8.5)			
Previous manual removal of placenta		Confirmed delay in 1st or 2nd stage of labour	
Previous shoulder dystocia			
BMI > 40		Contractions that last longer than 60 secs (hypertonus) or more than 5 contractions in 10 mins (tachysystole)	
Macrosomia (EFW > 4.5kg)			
Significant maternal medical disease *(see appendix 2 of care in labour guidelines)*		Oxytocin use	
Declining blood products			
Previous anaesthetic complication		Intrapartum obstetric emergency (APH, cord prolapse, maternal seizure, collapse)	
Current substance misuse			