Supporting women/birthing people who choose to birth outside of guidance in midwife-led birth settings

University Hospitals of Leicester NHS Trust

Trust ref:C55/2021

Contents

1. Introduction and who Guideline applies to

This guideline sets out the guidance for the planning of care for women/birthing people who make requests outside of recommended Trust guidance to birth in a low-risk environment. The steps required in this process are detailed together with flowcharts and care plans for use by community midwives in the appendices.
Currently UHL utilises the terms 'woman' and 'women' within their obstetric and maternity guidelines, but these recommendations will also apply to people who do not identify as women but are pregnant or have given birth.

In this organisation we, as a multidisciplinary team of clinicians within the maternity service, believe that the safest way for women/birthing people to labour and give birth is to follow the Trust's agreed guidance. We also acknowledge the importance of close multiprofessional working between clinicians to ensure good outcomes for parents and babies. This is particularly important within maternity services when it involves complex decision making surrounding the planning of care with women/birthing people who wish to understand their birth options in greater detail, explore the risks and benefits of these choices and make decisions about their care even if outside of Trust guidance. All women/birthing people have the right to make their own decisions as a basic human right protected by the common law unless they lack the legal capacity to decide (Montgomery V Lanarkshire Health Board 2015). This document aims to set out the process to be followed for women/birthing people who have requested care outside of Trust guidance.

University Hospitals Leicester (UHL) currently offers women/birthing people four choices of birth setting across its sites at the Leicester Royal Infirmary, Leicester General Hospital and St Mary's: two obstetric delivery suites; two alongside birth centres; homebirth; and a freestanding birth centre in Melton Mowbray.

Women/birthing people are considered to be 'higher risk' if they do not meet the 'low risk' criteria outlined below:

Low risk criteria -

- Do not have a history of medical diseases.
- Are experiencing an uncomplicated pregnancy.
- Are under the age of 40 years.
- Do not have a drug or alcohol addiction.
- Are carrying a singleton pregnancy.
- Are carrying a baby in a cephalic presentation.
- Are having their 1st – 4th baby without previous complications.
- Have a body mass index (BMI) greater than 18.5 or less than 35 at booking.
- No Safeguarding concerns at 36-week risk assessment

For a comprehensive list of considerations to take into account when assessing women/birthing people for low-risk maternity care please see - Intrapartum Care: Healthy Women and their Babies

Where a woman/birthing person falls outside of the low-risk criteria and requests to birth at home or in one of the birth centres, they must have a documented, evidenced-based discussion and involvement from the multidisciplinary team to ensure they make an informed decision and an individualised plan of care made. The woman/birthing person or midwife can request further discussion with the consultant midwife, matron for the area or named/link consultant obstetrician where there are medical or obstetric issues (NICE 2017). Previous maternity notes should be accessed and reviewed. This discussion needs to be documented and recorded on the electronic record.

The role of the consultant midwife is to be a role model and an expert practitioner in midwifery. He/she will empower midwives and obstetricians to promote better births, informed choice and a positive experience throughout the maternity services. The consultant midwife will support the community, home birth, birth centre and hospital midwives, and obstetricians, in supporting women/birthing people to make informed decisions about their care and individualising care plans where required. Where the consultant midwife is not available, senior midwifery support may be sought from the matron for the area.

During the birth choices consultation, the consultant midwife/matron/consultant obstetrician will take a full history and gain an understanding of the person holistically and the reasons for the requests they are making. A full discussion will take place clearly outlining what the agreed Trust guidance recommends and the benefits and risks associated with the decision they wish to consider. The woman/birthing person should be offered the opportunity of birth reflections or psychological therapy, if appropriate, to address any psychological trauma or phobias. The discussion should be clearly documented and recorded on their personal maternity electronic record.

Related UHL documents:

- Intrapartum Care: Healthy Women and their Babies
- Home Birth Operational Guideline including management and risk assessment
- Induction and Augmentation of labour UHL Obstetric Guideline
- Referrals to the Maternal Mental Health Service (MMHS), Birth Reflections and Consultant Midwife

2. Guideline Standards and Procedures

Where women/birthing people have existing medical conditions or obstetric complications, a multidisciplinary team led by a named healthcare professional should involve the woman/birthing person and prepare an individualised plan for intrapartum care (NICE 2019).

Women/birthing people who request birth in a midwife-led setting outside of the recommended guidelines must have an individualised plan of care and a documented evidence-based discussion. Examples of where a woman/birthing person may request care outside of guidance include:

- History of a previous postpartum haemorrhage (PPH).
- History of Group B Streptococcus (GBS) in previous or current pregnancy.
- Raised BMI ≥ 35 at booking.
- Maternal use of antidepressants.
- Gestational diabetes in pregnancy.
- History of antepartum haemorrhage (APH) in current pregnancy.
- Maternal age ≥ 40 years at booking.
- History of a previous caesarean section (CS).

(NB. This is not an exhaustive list).

Homebirth

Where a woman/birthing person requests a home birth and they do not meet the criteria, they must have an evidenced-based discussion and individualised plan of care made, following the pathway in appendix one.

An individualised care plan is agreed with the woman /birthing person and obstetric team and the discussion must be recorded on the electronic record. The woman/birthing person is added to a "live" high risk home birth booking register on the high-risk home birth shared drive. This will be updated with birth outcomes and dates of birth by the home birth team. If the homebirth team attend a high-risk home birth labourer, the labour ward coordinator at LRI is informed. If normal birth achieved at home, the labour ward coordinator is informed.

Where a 'higher risk' woman/birthing person requests a homebirth and subsequently requires an induction of labour, they should be advised that the induction cannot be supported at home. An individualised plan of care can be made highlighting the birth choices for the woman/birthing person in the hospital setting.

St Mary's Birth Centre (freestanding)

Women/birthing people requesting to birth outside of guidance at St Mary's Birth Centre (SMBC) should be advised this is not usually supported at St Mary's. If the woman/birthing person wishes to continue to plan birth in a midwife-led setting, they should be referred for discussion and individualised planning for either a homebirth or one of the alongside midwifery units or at times birth at SMBC may be supported on an individualised basis.

Alongside Birth Centres

In some clinical situations a woman/birthing person may not meet the criteria for homebirth or St Mary's birth centre but may have the option to use one of the alongside birth centres. These include:

- BMI ≤ 40.
- Induction of labour requiring one intervention to labour (Foley catheter, single Propess®, single Prostin® or artificial rupture of the membranes), providing an initial CTG of the fetal heart rate is normal. The woman/birthing person must have otherwise met the criteria for intermittent auscultation of the fetal heart rate or have an individualised care plan in place that has been agreed by the consultant midwife or consultant obstetrician.

- History of GBS requiring antibiotic prophylaxis in labour.

Where a woman/birthing person requests to use one of the alongside Birth Centres and they do not meet the criteria, they must have an evidenced-based discussion and individualised plan of care made, following the pathway in appendix two.

An individualised care plan is agreed with the woman/birthing person and obstetric team and the discussion must be recorded on the electronic record.

The consultant midwife/matron will upload the care plan to the woman's/birthing persons electronic record. Complex care plans will be emailed out to the relevant birth centre manager and labour ward coordinators for dissemination with the wider team.

The woman/birthing person will be added to a 'live' birth outside criteria register in the high-risk homebirth drive in the birth centre folder.

All women/birthing people should have their risk status and intended place of birth reviewed at every contact in line with the UHL Trust guideline 'Booking Process and Risk Assessment in Pregnancy and the Postnatal Period'. If there has been a change in risk status or additional risks have developed in the pregnancy or labour/birth, this needs full discussion with the woman/birthing person and documentation on the electronic record (or handheld notes if intrapartum). If the woman/birthing person is still in the antenatal period, further referral and review by the consultant midwife, matron or obstetrician is advised to review the individualised care plan.

Where an antenatal discussion has not occurred and women/birthing people decide to decline recommended interventions in labour/birth, wherever the setting, midwives may use the proformas in appendix four to support documented, informed discussions with women which are then kept in the labour and birth record.

3. Education and Training

- Midwifery training – NMC standards
- Midwifery registration – NMC standards.
- Post registration education and practice – NMC

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Standards against guideline	Audit	Birth Centre Team Leads	Yearly	Maternity Governance
Standards against guideline	Audit	Home Birth Team Lead	Yearly	Maternity Governance

5. Supporting References

Montgomery V Lanarkshire Health Board (2015) UKSC 11

NICE (2022) **Intrapartum care for healthy women and babies**, Clinical guideline (CG190) NICE: London.

NICE (2019) **Intrapartum care for women with existing medical conditions or obstetric complications and their babies**, NICE guideline (NG121), NICE: London.

6. Key Words:

Homebirth; Birth Centre, Birth Centres; outside guidelines

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs. As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) Helen Fakoya Consultant Midwife		**Executive Lead** Chief Nurse	
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
December 2021	1	Maternity guidelines group Maternity Governance Committee	New Document
April 2022	1.1	Maternity guidelines group Maternity Governance Committee	Added Maternal age care plan (full review not undertaken)
Oct 2022	1.2	Maternity Governance Committee	Added templates to appendix four for declining of IV access in labour, decline continuous electronic fetal movements, declining active management 3rd stage of labour (full review not undertaken)
August 2023	2	Maternity guidelines group and Maternity governance group	Removed reference to E3 and changed to electronic record. Included Matron as appropriate person for individualised care plan support. Updated individualised care plan templates PPH Risk in line with new PPH guidance. GBS neonatal care in line with neonatal sepsis guidance, BMI recommendation for advising CEFM updated

Appendix 1: **High Risk Homebirth Pathway**

Home birth team midwife visits woman/birthing person at home to discuss individual risks for birth at home, including discussion in relation to considering birth in an alongside birth centre as an alternative option.

↓

Woman/birthing person with risk factors requesting to birth in a setting outside of local and national guidance, specifically at home.

↓

Women/birthing people presenting with a history of PPH, GBS, high BMI, antidepressant use, or recurrent episodes RFMs , as a single risk factor, may be seen by the home birth midwife and the associated pro-forma completed. Women/birthing people presenting with risks other than these or with multiple risk factors, will be seen by the Consultant Midwife/Matron. The Consultant Midwife/Matron will review previous maternity notes, meet with the woman/birthing person and liaise with the named/link Obstetric Consultant. An individualised care plan is agreed with the woman/birthing person and obstetric team. *When the Consultant Midwife/Matron is not available (e.g. A/L) the midwife should liaise with the named/link ObstetriC Consultant or MAU Consultant for urgent referrals*.

↓

Individualised care plan discussed with woman/birthing person and signed. Care plan then uploaded to patient's electronic record.

↓

Weekly list saved to high risk home birth shared drive. Contact recorded on each woman's/birthing person's electronic record.

↓

Woman's/birthing person's details added to a "live" high risk home birth booking register on the high risk home birth shared drive. This will be updated with birth outcomes and dates of birth by the home birth team.

↓

If the homebirth team attend a high risk home birth labourer, labour ward coordinator at LRI informed. If normal birth achieved at home, labour ward coordinator informed.

Appendix Two: High Risk Birth Centre Pathway

Woman/birthing person with risk factors requesting to birth in a setting outside of local and national guidance specifically the alongside birth centres

↓

Community midwife arranges for a review by the Consultant Midwife/Matron to be made for review: in particular if a woman/birthing person has multiple risk factors. The Consultant midwife/Matron will review previous maternity notes, speak with the woman/birthing person and liaise with the named/link Obstetric Consultant. When the Consultant Midwife/Matron is not available (e.g. A/L) the Midwife should liaise with the named/link Obstetric Consultant or D/S Consultant for urgent referrals. An individualised care plan is agreed with the woman/birthing person and obstetric team. Individualised care plan discussed with woman/birthing person and care plan then uploaded to woman's/birthing persons electronic record.

↓

The woman/birthing person must consent to the individualised care plan being shared with the staff via email. Complex care plans will be emailed to the relevant birth centre manager and labour ward coordinators.

↓

The individualised care plan will be disseminated by the Birth Centre Manager to the core staff on the alongside birth centre the woman/birthing person wishes to use as well as the band 7 co-ordinators at that site. The core staff and band 7 co-ordinators at the other site will be copied in to the email in case of transfer of activity.

↓

Individualised care plan is then uploaded to the woman's/birthing persons electronic record

↓

Woman added to a 'live' birth outside criteria register in the high risk Homebirth shared drive, birth centre folder. This will be updated with birth outcomes and dates of birth by the Birth Centre Manager

↓

When the woman/birthing person arrives at the alongside birth centre, the Midwife caring for that woman/birthing person will inform the D/S co-ordinator and the Obstetric Consultant of their arrival and keep them informed of their progress

Hospital Copy
HBT copy
Handheld notes copy

PLAN OF CARE – AT RISK OF Postpartum Haemorrhage (PPH)

NAME:	**EDD:**
DOB:	**ADDRESS:**
Booking Hospital:	
NHS:	**TEL NO:**
OBSTETRIC HISTORY:	

REASON FOR PLAN

The named woman/birthing person is at increased risk of postpartum haemorrhage and as such should be advised to birth in an obstetric unit.

Identified Risk Factor (please circle as appropriate)

- Previous PPH >1000ml, or requiring treatment or blood transfusion
- Previous retained placenta
- History of antepartum haemorrhage (APH) in current pregnancy
- Placenta Praevia/Placenta Accreta
- Para 5 or more
- BMI >40
- Booking weight <40kg
- Haemoglobin <95g/dl
- Uterine anomalies or fibroids
- Multiple pregnancy
- Polyhydramnios
- Macrosomia >90th centile on ultrasound
- Female Genital Mutilation
- Known blood clotting problems including platelets <100 x10^9/L

CURRENT PREGNANCY

SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE

- Primary Postpartum Haemorrhage (PPH) is the most common form of obstetric haemorrhage. It is defined as >500ml blood loss within the first 24 hours after birth.
- PPH can be minor 500-1000mls, major 1000-2000mls or massive >2000mls (NICE, 2017).
- The chance of repeat PPH in a subsequent birth is 15 women in 100.
- The chance of repeat retained placenta in women/birthing people with previous retained placenta is 25 women/birthing people in 100.
- In the majority of cases bleeding can be controlled with simple measures and may only cause minor problems such as feeling faint, nauseous and tired.
- Following a PPH it is not uncommon to become anaemic and require iron replacement therapy. Occasionally a blood transfusion may be recommended.
- In extreme cases, a hysterectomy may be required to treat a massive PPH. (RCOG (1) 2016)
- The risk of death as a result of obstetric haemorrhage is very small 0.56 women per 100, 000 births (MBRRACE, 2020).
- Only basic maternal resuscitation measures are available in the home environment.
- Emergency treatment will be delayed due to ambulance transfer into hospital.
- For the above reasons UHL guidelines recommend that women/birthing people should be screened for predisposing risk factors and advised to birth in an obstetric unit where appropriate (UHL, 2017)

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth at home according to the following plan of care:

- Midwives will provide routine intrapartum care at home according to UHL guidance
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance
- During the intrapartum or immediate postnatal period should the midwife recognise any deviations from the norm she will recommend a transfer to hospital
- Consents to active management of third stage using syntometrine as first line uterotonic wherever possible.
- Basic maternal & neonatal resuscitation equipment will be available at the birth.
- Information leaflet regarding PPH provided (RCOG (2)2016)

Care Plan reviewed and agreed by Consultant Obstetrician or Consultant Midwife/Matron

Discussed with …….. on ……by ……

Patient signature……Date……

Midwife signature……Date…….

MBRRACE-UK (2020) Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18. Oxford: National Perinatal Epidemiology Unit, University of Oxford;

NICE: National Institute for Health and Care Excellence (2017) Intrapartum Care for Healthy Women and Babies. Clinical Guideline. [ONLINE]

Nikolajsen S1, Løkkegaard EC, Bergholt T. (2013). Reoccurrence of retained placenta at vaginal delivery: an observational study. Acta Obstet Gynecol Scand 92(4):421-5 {ONLINE}

RCOG: (1) Royal College of Obstetrics and Gynaecology) (2016) Postpartum Haemorrhage, Prevention and Management. (Green-top Guideline No. 52) {ONLINE}

RCOG: (2) Royal College of Obstetrics and Gynaecology (2016) Information for you – Heavy Bleeding after birth (postpartum haemorrhage) {ONLINE}

©UHL (2011) (Reviewed 2020) Postpartum Haemorrhage in a Midwife Led Unit/Low Risk Setting.

Hospital Copy
HBT copy
Handheld notes copy

PLAN OF CARE – GBS

Name	**EDD**
DOB	**ADDRESS :**
Booking Hospital:	
NHS	**TEL NO:**

OBSTETRIC HISTORY

REASON FOR PLAN

The named woman/birthing person has been identified as a carrier of GBS, which increases the risk of GBS infection in the newborn and as such should be advised to birth in an obstetric unit.

Identified risk factor (Please circle as appropriate)

- Previous baby affected by GBS
- Positive GBS culture identified in this pregnancy
- Positive GBS culture in a previous pregnancy

CURRENT PREGNANCY

SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE

- GBS is a normal bacterium found in the bowel flora of approximately 20 - 40% of Adults (RCOG, 2017)
- GBS is not harmful to adults but if transmitted to the baby during labour can cause infection in the newborn
- Approximately 1 in 1750 babies are diagnosed with early-onset GBS in the first week of life. No screening test is entirely accurate. Between 17% and 25% of women/birthing people who have a positive swab at 35–37 weeks of gestation will be GBS negative at the time of birth. Between 5% and 7% of women/birthing people who are GBS negative at 35–37 weeks of gestation will be GBS positive at the time of birth.
- Babies with early-onset GBS infection may show the following signs:
  - grunting, noisy breathing, or not breathing at all
  - be very sleepy and/or unresponsive
  - be crying inconsolably
  - be unusually floppy

- not feeding well or not keeping milk down
- have a high or low temperature and/or their skin feels too hot or cold
- have changes in their skin colour (including blotchy skin)

- With suitable and timely treatment over 80% of affected babies will fully recover
- 1 in 14 affected babies will recover but with some form of disability
- 1 in 19 affected babies will die (RCOG, patient leaflet 2017)
- In women/birthing people who carry GBS, the risk of newborn infection is significantly increased when there has been prolonged rupture of membranes (>18hrs) or a maternal temperature >38.0c during labour
- If a woman/birthing person who carries GBS is given prophylactic intravenous antibiotics during labour the baby's risk of developing infection is significantly reduced from 1:400 to 1:4000. However, it is pertinent to understand that with or without treatment the overall risk remains low
- Only basic newborn resuscitation measures are available in the home environment.
- Any necessary emergency treatment will be delayed due to ambulance transfer into hospital; ambulance response times are currently approximately 8-14 minutes which needs adding onto the travel time into hospital.
- For the above reasons UHL guidelines recommend that women/birthing people identified as a GBS carrier should be advised to birth in an obstetric unit in order to receive prophylactic intrapartum antibiotics and receive a paediatric assessment within 2 hours of birth if indicated (UHL, 2020)
- A paediatric assessment in hospital and 12 hours of NEWS observations is indicated for <u>all</u> babies born to GBS colonised mothers who have not received intrapartum antibiotics at least 2 hours before birth. Where intrapartum antibiotics have been received at least 2 hours before birth, and the baby is >37 weeks with no additional risk factors, the baby does not need a paediatric assessment or NEWS observations.

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth at home according to the following plan of care:

- Midwives will provide routine intrapartum care at home according to UHL guidance
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance
- Should membranes rupture prior to labour onset or should you develop a temperature in labour, the midwife will recommend a transfer into hospital for induction.
- Basic neonatal resuscitation equipment will be available at the birth.
- A full set of newborn observations including a pulse oximetry screen will be performed at home following the birth. Should the baby display any signs of early onset GBS the midwife in attendance will recommend transfer to hospital so that the baby can be reviewed by a neonatologist.
- On the primary home visit a further set of newborn observations will be performed to assess for early onset GBS. Should any of these observations deviate from the norm, the midwife in attendance will recommend an urgent assessment in hospital.
- Information leaflet regarding GBS infection provided (RCOG, 2017) Further information can be

found online at http://www.gbss.org.uk/

Care Plan reviewed and agreed by Consultant Obstetrician or Consultant Midwife/Matron

Discussed with …….. on ……by ……

Patient signature…….Date……

Midwife signature……Date…….

NICE (2017) Clinical Guideline - Neonatal infection early onset: antibiotics for prevention and treatment [ONLINE]

O'Sullivan C, Lamagni T, Efstratiou A, Patel D, Cunney R, Meehan M et al (2016) Group B Streptococcal (GBS) disease In UK and Irish infants younger than 90 days, 2014–2015. Arch Dis Child

UHL (2020) Group B Streptococcus – Management in pregnancy and the newborn obstetic guidelines

RCOG: Royal College of Obstetrics and Gynaecology (2017) Group B streptococcus infection in pregnancy and newborn babies, Patient information leaflet [ONLINE]

RCOG: Royal College of Obstetrics and Gynaecology (2017) Green Top Guideline: Prevention of Early onset Neonatal Group B Streptococcal Disease. [ONLINE]

http://www.gbss.org.uk/ Management .

Hospital Copy
HBT copy
Handheld notes copy

PLAN OF CARE – BMI of ≥35-40 kg/m2

NAME:	**EDD:**
DOB:	**ADDRESS:**
Booking Hospital:	
NHS:	**TEL NO:**

OBSTETRIC HISTORY:

REASON FOR PLAN

The named woman/birthing person has been identified as having a BMI of ≥35-40 kg/m2 at booking and as such should be recommended to birth in an obstetric unit.

CURRENT PREGNANCY

SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE

- BMI is your body mass index which is a measure of your weight in relation to your height.
- A woman/birthing person is considered to be obese if they have a BMI ≥30 at booking (WHO, 2017). However, UHL's upper limit for low risk midwifery care is a BMI ≥35.
- Most women/birthing people who are overweight have a straightforward pregnancy and birth and deliver healthy babies.
- However, being overweight increases the risk of complications for pregnant women /birthing people and their babies. With increasing BMI, the additional risks become gradually more likely, the risks being much higher for women/birthing people with a BMI of 40 or above.
- **Antenatal risks** associated with maternal obesity include; miscarriage, gestational diabetes, hypertension, preeclampsia, thromboembolism, IUGR, macrosomia & stillbirth (CEMACRCOG, 2010)
- **Intrapartum risks** associated with maternal obesity include; premature birth, shoulder dystocia, increased risk of instrumental delivery, increased risk of caesarean section and failed VBAC (where applicable), prolonged labour, anaesthetic complications, difficulties monitoring the fetal heart and stillbirth (CEMACRCOG, 2010).
- **Postnatal risks** associated with maternal obesity include; PPH, thromboembolism, wound complications, sleep apnoea, baby admitted to NNU & neonatal death (CEMACRCOG, 2010).

Information for consideration

- Women/birthing people booking with a BMI ranging from 35 to 40 who are otherwise low risk can now have the choice of an alongside birthing centre as place of birth (NICE 2019, Rowe 2018 and UHL, 2021). Here they will be offered intermittent auscultation. If there is difficulty

with this they can then be offered electronic fetal monitoring in the consultant unit

- Only basic maternal & neonatal resuscitation measures are available in the home environment.
- Emergency treatment will be delayed due to ambulance transfer into hospital.

Use of Water for Pain Relief and Labour:

- There is no maternal weight restriction for the fixed pool in hospital but the inflatable 'birth pool in a box' has a manufacturing weight limit of 113Kg with a maximum weight for sitting on the side of the pool of 100Kg (Edel Immersys 2019).
- It must be possible for the midwife to auscultate the fetal heart and for the woman/birthing person to enter and exit the pool unaided.
- If there are concerns with the condition of the mother or the baby, there should be a lower threshold for asking the mother to get out of the pool due to difficulties with evacuation from the pool in an emergency.

In view of the numerous and potentially serious complications associated with obesity UHL guidelines recommend that women/birthing people with a BMI ≥35 kg/m2 are advised to birth in an obstetric unit in case of the need for obstetric or neonatal assistance (UHL, 2021).

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth at home according to the following plan of care:

- Midwives will provide routine intrapartum care at home according to UHL guidance.
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance rather than CEFM as recommended.
- During the intrapartum or immediate postnatal period should the midwife recognise any deviations from the norm she will recommend a transfer to hospital.
- Is aware that labouring and birthing in a birth pool would not be recommended due to the risk of shoulder dystocia and the health & safety aspects of assisting evacuation from the pool in the event of collapse.
- Consents to active management of third stage using syntometrine as first line uterotonic wherever possible.
- Basic maternal & neonatal resuscitation equipment will be available at the birth.
- Patient leaflet regarding raised BMI provided (RCOG, 2018)
- If your baby weighs <2kg or >4.5kg at birth the midwife will recommend a transfer to hospital for a period of newborn blood glucose monitoring to assess for signs of hypoglycaemia.
- Is aware to remain well hydrated and mobile to reduce the risks of thromboembolism & to seek urgent medical attention should any symptoms of DVT/PE present following birth.

Care Plan reviewed and agreed by Consultant Obstetrician or Consultant Midwife/Matron

Discussed with …….. on ……by ……

Patient signature……..Date……

Midwife signature……Date…….

UHL (2021) Clinical Guideline – Obesity in Pregnancy, labour and the Puerperium

CEMACRCOG: Centre for Maternal and Child Enquiries and the Royal College of Obstetricians and Gynaecologists (2010) Joint guideline – Management of women with obesity in pregnancy [ONLINE]

Edel Immersys (2019) The Good Birth Company, http://www.edelimmersys.com/uk/

NICE (2019) Intrapartum care for women with existing medical conditions or obstetric complications and their babies . Evidence reviews for obesity NH121 March 2019

Rowe R Knight M et al (2018) Outcomes for women with BMI >35kg/m2 admitted for labour care to alongside midwifery units in the UK. A national prospective cohort study using the UK Midwifery Study System (UKMisSS)

Royal College of Obstetricians and Gynaecologists (2018) Green top Guidelines No. 72 – Care of women with obesity in pregnancy [ONLINE]

RCOG: Royal College of Obstetrics and Gynaecology (2018) Being overweight in pregnancy and after birth [ONLINE]

WHO: World Health organisation (2017) Recommendations on maternal health [Online

Hospital Copy
HBT copy
Handheld notes copy

PLAN OF CARE – BMI of ≥40 kg/m2

NAME:	**EDD:**
DOB:	**ADDRESS:**
Booking Hospital:	
NHS:	**TEL NO:**
OBSTETRIC HISTORY:	
REASON FOR PLAN The named woman/birthing person has been identified as having a BMI of ≥40 kg/m2 at booking and as such should be recommended to birth in an obstetric unit.	
CURRENT PREGNANCY	
SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE • BMI is your body mass index, which is a measure of your weight in relation to your height. • A woman/birthing person is considered to be obese if they have a BMI ≥30 at booking (WHO, 2017). However, UHL's upper limit for low-risk midwifery care is a BMI ≥35. • Most women/birthing people who are overweight have a straightforward pregnancy and birth and deliver healthy babies. • However, being overweight increases the risk of complications for pregnant women/birthing people and their babies. With increasing BMI, the additional risks become gradually more likely, the risks being much higher for women with a BMI of 40 or above. • **Antenatal risks** associated with maternal obesity include; miscarriage, gestational diabetes, hypertension, preeclampsia, thromboembolism, IUGR, macrosomia & stillbirth (CEMACRCOG, 2010) • **Intrapartum risks** associated with maternal obesity include; premature birth, shoulder dystocia, increased risk of instrumental delivery, increased risk of caesarean section and failed VBAC (where applicable), prolonged labour, anaesthetic complications, difficulties monitoring the fetal heart and stillbirth (CEMACRCOG, 2010) . • **Postnatal risks** associated with maternal obesity include; PPH, thromboembolism, wound complications, baby admitted to NNU & neonatal death (CEMACRCOG, 2010) **Recommendations and care:**	

- Women/birthing people with a BMI of >40 would have a medical review on delivery suite, early intravenous access for medication to control possible haemorrhage and offered an early epidural. This is not available in the home birth setting.
- Women/birthing people with a BMI ≥40 kg/m2 are recommended continuous electronic fetal monitoring (CEFM) throughout labour (UHL, 2021), which is unavailable at home.
- All women/birthing people with a BMI ≥40 are recommended to commence 7 days of thromboprophylaxis (UHL, 2021) provided by the hospital at discharge.
- Only basic maternal & neonatal resuscitation measures are available in the home environment.
- Emergency treatment will be delayed due to ambulance transfer into hospital.

Use of Water for Pain Relief and Labour:

- There is no maternal weight restriction for the fixed pool in hospital but the inflatable 'birth pool in a box' has a manufacturing weight limit of 113Kg with a maximum weight for sitting on the side of the pool of 100Kg (Edel Immersys 2019).
- It must be possible for the midwife to auscultate the fetal heart and for the woman to enter and exit the pool unaided.
- If there are concerns with the condition of the mother or the baby, there should be a lower threshold for asking the mother to get out of the pool due to difficulties with evacuation from the pool in an emergency.
- Advise the woman/birthing person against labouring or birthing in water and involve senior staff in any discussions where there is a strong maternal request for water birth against medical advice.

In view of the numerous and potentially serious complications associated with obesity, UHL guidelines recommend that women/birthingh people with a BMI ≥40 kg/m2 are advised to birth in a consultant led unit in case of the need for obstetric or neonatal assistance (UHL, 2021).

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth at home according to the following plan of care:

- Midwives will provide routine intrapartum care at home according to UHL guidance.
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance rather than CEFM.
- During the intrapartum or immediate postnatal period should the midwife recognise any deviations from the norm she will recommend a transfer to hospital.
- Is aware that labouring and birthing in a birth pool would not be recommended due to the risk of shoulder dystocia and the health & safety aspects of assisting evacuation from the pool in the event of collapse.
- Consents to active management of third stage using syntometrine as first line uterotonic wherever possible.
- Basic maternal & neonatal resuscitation equipment will be available at the birth.
- Patient leaflet regarding raised BMI provided (RCOG, 2011).
- If your baby weighs <2kg or >4.5kg at birth the midwife will recommend a transfer to hospital for a period of newborn blood glucose monitoring to assess for signs of hypoglycaemia.
- Is aware to remain well hydrated and mobilise early after birth to reduce the risks of thromboembolism & to seek urgent medical attention should any symptoms of DVT/PE

present following birth.

Care Plan reviewed and agreed by Consultant Obstetrician or Consultant Midwife/Matron

Discussed with …….. on ……by ……

Patient signature…….Date……

Midwife signature……Date…….

UHL (2021) Clinical Guideline – Obesity in Pregnancy, labour and the Puerperium

CEMACRCOG: Centre for Maternal and Child Enquiries and the Royal College of Obstetricians and Gynaecologists (2010) Joint guideline – Management of women with obesity in pregnancy [ONLINE]

Edel Immersys (2019) The Good Birth Company, http://www.edelimmersys.com/uk/

RCOG: Royal College of Obstetrics and Gynaecology (2011) Information for you – Why your weight matters during pregnancy and after birth [ONLINE]

WHO: World Health organisation (2017) Recommendations on maternal health [Online]

Hospital Copy
HBT copy
Handheld notes copy

PLAN OF CARE
– Selective Seretonin Reuptake Inhibitors (SSRI's) Medication

NAME:	**EDD:**
DOB:	**ADDRESS:**
Booked Hospital:	
NHS:	**TEL NO:**

OBSTETRIC HISTORY

REASON FOR PLAN

The named woman/birthing person is currently taking SSRI's medication, which may lead to persistent pulmonary hypertension of the newborn (PPHN) and as such should be advised to birth in an obstetric unit.

CURRENT PREGNANCY:

SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE

- There is evidence that taking SSRIS early in pregnancy slightly increases the risk of your baby developing cardiac abnormalities
- Taking SSRIs in pregnancy can cause persistent pulmonary hypertension of the newborn (PPHN). Symptoms of this include rapid or slow breathing, grunting, recession, blue colour to the skin or lips, low blood pressure and low blood oxygen levels.
- Infants of mothers who have taken SSRIs in pregnancy should be observed for signs of PPHN. While usually mild and self-limiting, if they occur the infant should receive neonatal assessment (RCOG, 2011).
- Therefore, UHL advises that women/birthing people taking any SSRIs should birth in an obstetric unit to allow the baby to be observed for signs of withdrawal for the first 12-24 hours of life. This also allows for general observation of the mothers' emotional wellbeing in the early post birth period.
- Sertraline is the preferred drug of choice in breastfeeding with a transmission rate of 0.2% into the breastmilk. Citalopram transmission is dose dependent with a transmission rate of 10-15%, and Fluoxetine a transmission rate of 20%.
- New evidence has identified there is a risk related increase of PPH associated with SSRIs (Grzeskowiak, LE et al (2015)). **Active management of the third stage should be advised.**
- If a woman/birthing person is taking psychotropic medication other than SSRIs, she should be seen in consultant clinic for an individualised care plan.

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth at home according to the following plan of care:

- Midwives will provide routine intrapartum care at home according to UHL guidance
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance
- During the intrapartum and immediate postnatal period should the midwife recognise any signs of deteriorating mental health she will recommend a transfer to hospital
- Basic neonatal resuscitation equipment will be available at the birth.
- Following delivery the midwife in attendance will recommend transfer to hospital should she observe any congenital abnormalities or possible symptoms of PPHN.
- As per UHL guidelines Pulse oximetry to be performed after birth.
- The named woman/birthing person has been advised of the signs of PPHN and will contact a midwife should she have any concerns with her baby.
- On the primary home visit within the first 24 hours of life should the midwife identify any symptoms of PPHN she will recommend a transfer to hospital for further newborn assessment.

Reviewed and agreed by

Care Plan reviewed and agreed by Consultant Obstetrician or Consultant Midwife/Matron

Discussed with …….. on ……by ……

Patient signature……..Date……

Midwife signature……Date…….

Grzeskowiak, LE et al (2015) Antidepressant use in late gestation and risk of postpartum haemorrhage: a retrospective cohort study, BJOG, https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.13612

NICE: National Institute for Health and Care Excellence (2014) Antenatal and Postnatal Mental Health: Clinical management and service guideline.

RCOG: Royal College of Obstetrics and Gynaecology (2011) Management of Women with Mental Health Problems during Pregnancy and the Postnatal Period.

Hospital Copy
HBT copy
Handheld notes copy

PLAN OF CARE –
MATERNAL AGE

NAME:	**EDD:**
DOB:	**ADDRESS:**
Booking Hospital:	
NHS:	**TEL NO:**

OBSTETRIC HISTORY

REASON FOR PLAN

The named woman/birthing person has been identified being over 40 years of age at booking and as such should be advised to birth in an obstetric unit.

CURRENT PREGNANCY

SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE

- Most women/birthing people, including those over 40 years of age, will have a normal pregnancy and a healthy baby.
- However, maternal age is found to be associated with an increase in antenatal and intrapartum stillbirth. The reason for this remains unknown.
- At 41 weeks of gestation the risk of stillbirth is 0.75 in 1000 women under the age of 35 years old, and 2.5 in 1000 women/birthing people aged ≥ 40 years old (Reddy et al, 2006)
- Due to the above, UHL guidelines recommend offering IOL from 39+4 weeks or around the woman's/birthing persons EDD (UHL, 2019). This service is not available in the home environment.
- The guidance also states that since the overall risk is small, in the absence of other risk factors, women/birthing people should be supported to avoid IOL if this is their wish (UHL, 2019)
- Due to the increased risk of stillbirth electronic fetal monitoring is advised in labour. This type of fetal monitoring is not available in the home environment
- **Other antenatal complications** including placenta praevia, preeclampsia, gestational diabetes,

thromboembolism, placental abruption, malpresentation & IUGR occur more frequently in older mothers (RCOG, 2013)

- **Intrapartum complications** including premature labour, labour dystocia, instrumental delivery, caesarean and PPH occur more frequently in older mothers (RCOG, 2013)
- Only basic maternal & neonatal resuscitation measures are available in the home environment.
- Emergency treatment will be delayed due to ambulance transfer into hospital.
- For the above reasons UHL guidelines recommend that women/birthing people OVER 40 years at the time of booking should be advised to birth in an obstetric unit (UHL, 2019)

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth at home according to the following plan of care:

- Midwives will provide routine intrapartum care at home according to UHL guidance
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance
- During the intrapartum or immediate postnatal period should the midwife recognise any deviations from the norm she will recommend a transfer to hospital
- Consents to active management of third stage due to increased risk of PPH
- Basic maternal & neonatal resuscitation equipment will be available at the birth.

The midwife should discuss with the woman/birthing person when she may accept induction of labour and also offer monitoring via the MAU twice per week if the woman/birthing person wants this. CTG and USS do not have any predictive value but can ascertain the baby's wellbeing at the time of the monitoring. It is the midwife's responsibility to book the induction. The woman's/birthing persons preference in relation to this is:

……..

……

……

Reviewed and agreed by consultant obstetrician or consultant midwife/Matron

Discussed with…… on……by……..

Patient signature…….…… Date ……..

Midwife signature……. Date ……

Reddy UM, Ko CW, Willinger M (2006) Maternal age and the risk of stillbirth throughout pregnancy in the United States. American Journal of Obstetrics & Gynecology 195:764–70.

RCOG: Royal College of Obstetrics & Gynaecology (2013) Induction of Labour at Term in Older Mothers – Scientific Paper [ONLINE}

UHL (2019) Clinical Guideline – Induction of Labour

Hospital Copy
HBT copy
Handheld notes copy

PLAN OF CARE REDUCED FETAL MOVEMENTS

NAME:	**EDD**
DOB:	**ADDRESS:**
Booking Hospital:	
NHS	**TEL NO:**

OBSTETRIC HISTORY

REASON FOR PLAN

The named woman/birthing person has experienced 2 or more episodes of reduced fetal movements within a 21-day period in the third trimester **OR** reports reduced fetal movements in the 24 hours preceding labour and as such should be advised to birth in an obstetric unit (UHL, 2017)

CURRENT PREGNANCY

SPECIFIC RISKS DISCUSSED BY COMMUNITY MIDWIFE

- Fetal movements can be described as the maternal sensation of any discrete kick, flutter, swish or roll. Such fetal activity provides an indication of the integrity of the central nervous and musculoskeletal systems (RCOG, 2011)
- A significant reduction or sudden alteration in fetal movement is a potentially important clinical sign.
- Fetal physiology studies utilising ultrasound technology have shown an association between reduced fetal movements and poor perinatal outcome (Harrington, 1998)
- More than 50% of women/birthing people who have experienced a stillbirth perceived a reduction in fetal movements prior to diagnosis (Efkarpidis et al, 2004)
- UHL guidelines recommend women/birthing people who have experienced reduced fetal movements fetal movements in the 24 hours preceding labour should be advised to have electronic fetal monitoring in labour. This facility is not available in the home environment (UHL, 2017)
- That being said the Cochrane review of continuous electronic fetal monitoring found that it is not more effective at picking up distress in babies than intermittent monitoring and does not reduce the number of babies that die or have brain damage (Alfirevic et al 2015)

- For the above reasons, following an antenatal risk assessment should a woman/birthing person be considered at increased risk due to her history of fetal movements, UHL guidelines recommend they be advised to birth in an obstetric unit (UHL, 2017)
- Only basic maternal & neonatal resuscitation measures are available in the home environment.
- Emergency treatment will be delayed due to ambulance transfer into hospital.

AGREED PLAN OF CARE

The named woman/birthing person has considered the above evidence-based information and has made an informed choice to birth at home according to the following plan of care:

- Midwives will provide routine low risk intrapartum care at home according to UHL guidance
- Fetal heart rate monitoring will be provided using intermittent auscultation according to UHL guidance
- During the intrapartum or immediate postnatal period should the midwife recognise any deviations from the norm she will recommend a transfer to hospital
- Basic maternal & neonatal resuscitation equipment will be available at the birth.

Reviewed and agreed by

Care Plan reviewed and agreed by Consultant Obstetrician or Consultant Midwife/Matron

Discussed with …….. on ……by ……

Patient signature……..Date……

Midwife signature……Date…….

UHL (2017) Reduced Fetal Movements – Guideline for assessment of risk and management

Alfirevic Z, Devane D, Gyte GML, Cuthbert A (2017) Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour. Cochrane Database of Systematic Reviews 2017 [ONLINE]

Harrington, K. Thompson, O. Jordan, L. Page, J. Carpenter, R. Campbell, S (1998) *Obstetric Outcome in Women who present with a reduction in fetal movements in the third trimester of pregnancy.* Journal of Perinatal Medicine, 26: 77-82.

Efkarpidis, S. Alexopoulous Elkin, L. Liu, D. Fay, T (2004) *Case Control Study of Factors associated with Intrauterine Fetal Deaths.* MedGenMed, 6:53.

RCOG: Royal College of Obstetrics and Gynaecology (2011) Green Top Guideline – Reduced Fetal Movements [ONLINE]

Appendix Four – Proformas for women declining intravenous access, continuous electronic fetal monitoring and active management of 3rd stage of labour

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Care plan for persons declining intravenous (IV) access in labour	
Reason IV access recommended	IV access is recommended as you have a higher chance of postpartum haemorrhage (PPH) or need for operative intervention. The reason for IV access in your case is:
Person's reason for declining	
Benefits of IV access	IV access sited during labour allow for the rapid administration of drugs and fluids in the event of an emergency situation. If an emergency event happens it may delay the progress of further care/intervention whilst IV access is secured. In the case of PPH, where there is heavy blood loss, it can be more difficult to secure IV access if the maternal veins have constricted.
Risks	Some people will feel pain at the insertion site and may feel their movement is restricted. There is a small risk of infection at the insertion site.
Alternatives	Not to have a routine insertion and have an IV inserted when clinically needed.
Intuition	What does the person feel about the above information?
Nothing	If no IV cannula is sited then IV drugs and fluids cannot be given.

Care plan discussed with (MW/Doctor): ……

Care plan signed by woman/birthing person:
……...

Date signed: ……..

Care plan for persons declining continuous electronic fetal monitoring (CEFM)	
CEFM is recommended as your pregnancy is 'higher risk' and there is a greater chance of hypoxia and adverse outcome for your baby.	The reason for CEFM is:
Person's reason for declining	
Benefits	CEFM is able to identify changes in baseline rate, variability, presence of accelerations and decelerations. IIA can only identify changes in baseline rate and decelerations that occur after a contraction or those that tale a long time to recover. It cannot identify all types of changes. In women/birthing people with a history of previous caesarean section, an abnormal fetal heart rate pattern will be identified in 60-70% of cases of uterine scar rupture
Risks	Increased chance of intervention such as instrumental birth or caesarean section CEFM has not been shown to reduce the number of babies born with acute brain injury or cerebral palsy. Perceived reduction in mobility of the birthing person during labour and birth
Alternatives	To have IIA in line with UHL and national guidelines.
Intuition	What does the person feel about the above information?
Nothing	Fetal monitoring is the only clinically accurate way of ascertaining wellbeing throughout labour and birth.

Care plan discussed with (MW/Doctor): ……

Care plan signed by woman/birthing person:
……...

Date signed: ……..

Care plan for persons declining active management 3rd stage	
Reason active management is recommended	Active management of the 3rd stage of labour is where an oxytocic injection is given to assist with the birth of the placenta & membranes. It helps to reduce the amount of blood loss post-birth and minimises the chance of postpartum haemorrhage (PPH) Sometimes a doctor will also recommend a drip with an oxytocin infusion to help reduce the chance of PPH The reason for active management of the 3rd stage is recommended in your case is:
Person's reason for declining	
Benefits	Reduction in chance of PPH Early administration of oxytocic drugs may help reduce the amount of PPH
Risks	Pain at insertion site Nausea and vomiting
Alternatives	Not to have a routine insertion and have an IV inserted when clinically needed.
Intuition	What does the person feel about the above information?
Nothing	There may be an increased chance of PPH

Care plan discussed with (MW/Doctor): ……

Care plan signed by woman/birthing person:
……...

Date signed: ……..