Enabling access to birth in a midwife-led unit: Implementation of a co-produced evidenced-based guideline


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ENABLING ACCESS TO BIRTH IN A MIDWIFE-LED UNIT:
IMPLEMENTATION OF A CO-PRODUCED EVIDENCED-BASED GUIDELINE

There is an increasing emphasis on the need to support women in planning their place of birth. In order to make a truly informed choice, women and midwives can benefit from evidence-based guidelines that provide them with easy-to-access information that will support their decision-making. In Northern Ireland there are currently eight midwife-led units (MLU) (with potential for more), which are most suitable as the place of birth for a woman with a straightforward pregnancy. This paper provides an overview of the ‘GAIN (RQIA) Guideline for admission to midwife-led units in Northern Ireland’. The guideline was informed by the evidence, co-produced by women and maternity care professionals.

BACKGROUND
The majority of healthy women (both nulliparous and multiparous) with a straightforward pregnancy are generally at low risk of complications during labour and childbirth. For these women and their babies, planning and giving birth in a midwife-led unit (MLU) (freestanding or alongside) if they choose, is highly recommended, as they are ‘particularly suitable... because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit’ (National Institute for Health and Care Excellence [NICE] 2014;). Other studies support this recommendation, as they have found great benefits and no significant difference in the adverse outcomes between births planned in labour wards and in MLUs (also known as birth centres) (Birthplace in England Collaborative Group [BECG] 2011; Laws et al 2010; Homer et al 2014). The Welsh Department of Health and Social Services recently recommended a midwife-led setting for all women who want a normal birth, unless there is a medical reason for intervention (Wales 2013). The majority of healthy women (both nulliparous and multiparous) with a straightforward pregnancy are generally at low risk of complications during pregnancy if they are healthy and at low risk of complications during birth. In Northern Ireland (NI) there are currently eight MLUs (five AMUs and three FMUs). Healy (2013) undertook an EU-funded STSM (short term scientific mission) and found inconsistency in the admission criteria. In addition, both women and maternity care professionals across NI were keen to have guidelines that would assist their decision-making for planning birth in a MLU. The Guideline Audit and Implementation Network (GAIN) (now Regulation Quality Improvement Authority [RQIA]) granted funding in 2014 for the development of regional guidelines through collaboration and co-production with key maternity care stakeholders.

In a follow-up to the study of the Birthplace in England Research Programme (BECG 2011), a recent paper by McCourt et al (2018) has highlighted the importance of guidelines in enhancing safety of care in the development and sustainability of MLUs. The GAIN/RQIA guideline for admission to midwife-led units and the normal labour and birth care pathway in NI (GAIN/RQIA 2016a) (along with an information resource for women and their partners entitled Planning birth in a midwife-led unit in NI (GAIN/ RQIA 2016b)), and a transfer proforma were developed and launched following consultation and peer review in January 2016. The comprehensive process undertaken is detailed in Healy and Gillen (2016). The guideline is evidence-based and was written using carefully chosen, inclusive wording, with additional midwifery...
practice recommendations indicated in superscript (see Table 1). This guideline predominantly relates to women with a straightforward singleton pregnancy at the point of labour, though women in NI are signposted and supported by the midwife to plan their birth in a MLU setting if they choose) from the first antenatal point of contact (Health and Social Care Board NI [HSC] 2016). There are two sets of criteria: the criteria to be used for decision-making which enables women to access any MLU (FMU or AMU – highlighted in the green box within Table 1), and expanded criteria to assist decision-making for women to plan their birth within an AMU only (highlighted in blue box).

### Table 1 RQIA (GAIN) Guideline for admission to midwife-led units in Northern Ireland

<table>
<thead>
<tr>
<th>Planned birth in any MLU (FMU and AMU) for women with the following:</th>
<th>Planned birth in AMU only for women with the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maternal Age ≥ 16 years and ≤ 40 years</td>
<td>1. Maternal age ≥ 16 years or ≤ 40 years</td>
</tr>
<tr>
<td>2. BMI at booking ≥ 18 kg/m² and ≤ 35 kg/m² (5)</td>
<td>2. BMI at booking ≥ 15 kg/m2 and ≤ 40 kg/m2 with good mobility</td>
</tr>
<tr>
<td>3. Last recorded Hb ≥ 100g/L</td>
<td>3. Last recorded Hb ≥ 105g/L (6a)</td>
</tr>
<tr>
<td>4. No more than four previous births</td>
<td>4. No more than five previous births (6e)</td>
</tr>
<tr>
<td>5. Assisted conception with Clomifene or similar</td>
<td>5. Assisted conception with Ovum donation and maternal age ≥ 40 years</td>
</tr>
<tr>
<td>6. SROM ≤ 24hrs and no signs of infection</td>
<td>6. SROM &gt;24hrs, in established labour and no signs of infection</td>
</tr>
<tr>
<td>7. Women on Tier 1 of the SEHSC; Integrated Perinatal Mental Health Care Pathway (6b)</td>
<td>7. Women on Tier 2 of the SEHSC; Integrated Perinatal Mental Health Care Pathway, following individual assessment (6c)</td>
</tr>
<tr>
<td>8. Threatened miscarriage, now resolved</td>
<td>8. Previous PPH, not requiring blood transfusion or surgical intervention</td>
</tr>
<tr>
<td>9. Threatened preterm labour, now resolved</td>
<td>9. Previous extensive vaginal, cervical, or third degree perineal trauma following individual assessment</td>
</tr>
<tr>
<td>10. Suspected low lying placenta, now resolved</td>
<td>10. Prostaglandin induction resulting in the onset of labour (6d)</td>
</tr>
<tr>
<td>11. Medical condition that is not impacting on the pregnancy or the woman’s health</td>
<td>11. Group B Streptococcus positive in this pregnancy with no signs of infection</td>
</tr>
<tr>
<td>12. Women who have required social services input and there is no related impact on the pregnancy or the woman’s health</td>
<td>Notes relating to planning place of birth (place of birth)</td>
</tr>
<tr>
<td>13. Previous congenital abnormality, with no evidence of recurrence</td>
<td>(1) Straightforward singleton pregnancy, is one in which the woman does not have any pre-existing condition impacting on her pregnancy, a recurrent complication of pregnancy or a complication in this pregnancy which would require ongoing consultant input, has reached 37 weeks gestation and ≤ 40 years</td>
</tr>
<tr>
<td>14. Non-significant (light) meconium in this pregnancy with no signs of infection</td>
<td>(4) Uncomplicated third degree tear</td>
</tr>
<tr>
<td>15. Serum antibodies of no clinical significance</td>
<td>(5) Women with BMI 16-18 kg/m²</td>
</tr>
<tr>
<td>16. Women who have had previous cervical treatment, now term</td>
<td>(6) Women who are aged ≥40 years and ≥43 weeks and wish to give birth in an AMU should be no more than 40 weeks gestation. Primigravid women who are ≥40 years of age and women who are 44 years and older also require individual assessment with a consultant obstetrician. In the case of a pregnant teenager who is under 16 requiring intravenous fluids in labour, the paediatric fluid protocol must be followed, and care transferred to a consultant-led unit.</td>
</tr>
</tbody>
</table>

### Additional supporting midwifery practice recommendations

(6a) South Eastern Health and Social Care Trust (SEHSCST) (2013: 3) Integrated perinatal mental health care pathway NI: “Tier 1: Women with mild depressive illness, anxiety, adjustment disorders and other minor mental illnesses associated with pregnancy or the postnatal period are unlikely to require referral to psychiatric services. In general, they can be managed within the primary care team, by their own GP, health visitors and practice-based counsellors if required. Social factors should always be considered and social support offered. Most of these women will not require medication”.

(6b) Definition of significant meconium: ‘Dark green or black amniotic fluid that is thick or tenacious or any meconium-stained amniotic fluid containing lumps of meconium’ (NICE 2014: 32).

### Practice Challenges

**Practice Challenge 4**

What is the definition of significant meconium?

(6c) Women who are aged ≥40 years and ≥43 weeks and wish to give birth in an AMU should be no more than 40 weeks gestation. Primigravid women who are ≥40 years of age and women who are 44 years and older also require individual assessment with a consultant obstetrician. In the case of a pregnant teenager who is under 16 requiring intravenous fluids in labour, the paediatric fluid protocol must be followed, and care transferred to a consultant-led unit.

(6d) A woman presenting with last recorded Hb >100g/L requires a repeat full blood count at point of admission. If rechecked Hb is ≤100g/L, secure intravenous (IV) access, take blood and send to laboratory for Group and Hold. Then follow the NI normal labour and birth care pathway for active management of third stage.

(6f) SEHSCST (2013: 3) Integrated perinatal mental health care pathway NI: “Tier 2: These are women with more significant illness who may require medication as well as some form of psychological intervention. In [some trusts] women may be referred to antenatal perinatal mental health clinic. However, some women may be managed by their own GP, midwife/health visitor. If a significant illness develops and if GPs have concerns about prescribing in pregnancy or in the postnatal period, they should be referred to mental health services via the mental health assessment centre. The referral will then be seen as a priority, triaged and forwarded to the relevant team, depending on a [woman’s] past mental health history, current mental health service input and severity of illness. At this level most of the referrals will be assessed by the mental health centre staff, which can include assessment by a psychiatrist if it is deemed appropriate. Medication may be started or a brief focused psychological intervention may be offered. In this event those women who are within midwife-led services will be referred to a consultant obstetrician due to the need for medical management of their mental health condition”.

(6g) A woman who has gone into labour following induction with either one Prosterg© or up to two Prostin© only.

(6h) Women with group B Streptococcus positive in current pregnancy require intravenous antibiotics in labour as per NICE Guideline 149 (2012). In the absence of a midwife prescriber, the doctor on call should be consulted to prescribe antibiotics as per the guideline.
IMPLEMENTATION OF THE GUIDELINES

In order to promote and support normal physiological birth processes (along with positive labour and birth experiences) (WHO 2018), awareness raising education sessions for implementation of the guideline and pathway were provided in Northern Ireland midwife-led units (MUNet) across NI. These were provided by midwife education consultants from the HSC Clinical Education Centre, further to support from the Chief Nursing Officer.

Co-production and collaboration during the development of this guideline have been seen it being accepted in all five trusts across NI. For ease of access for midwives and women, key elements have been included in the Health Social Care (HSC) maternal hand held record and a link to the RQIA web page is highlighted in the Public Health Agency pregnancy book, for all women to book online. Laminated copies of the guideline were made available in each MLU, antenatal ward, assessment unit, labour ward and community midwifery facility across NI. The review of the NI maternity care strategy (RQIA 2017) acknowledges how the guideline and pathway promote the care of women with an uncomplicated pregnancy.

To ensure quality of maternity care within midwife units, along with reduced variability of practices that promote a bio-psycho-social model of care, a collaboration between the Midwifery Unit Network (MUNet) and the European Midwives Association (EMA) recently published midwife unit standards (MUNet 2018). These standards follow a bio-psycho-social model of care and emphasise equality, diversity and social inclusion for all women. In addition, the midwifery standards promote interdisciplinary collaboration; encouraging a positive organisational culture involving strong midwifery leadership, adequate infrastructure and staff; and continuing development of knowledge, skills and training. The GAIN/RQIA guideline (2016a) is endorsed within the midwife unit standards as an evidenced-based guideline for decision-making relating to individual women’s suitability for planning birth in a MLU.

DISSEMINATION OF THE GUIDELINES AND INTERNATIONAL IMPACT

During the development of the guideline and through presentation at local, national and international conferences and meetings, there have been many opportunities to share the guidelines with multidisciplinary colleagues. This has been important in receiving feedback on their application in an international context, but has also led to the guidelines being shared with maternity care leading bodies in a number of countries. Further evidence of the importance of these guidelines in shaping practice in other countries is evidenced outside NI by their translation into other languages, including Spanish and Swedish, with others planned.

At a recent meeting of the joint WHO-ICM-UNFPA general consultation midwifery meetings held at the WHO, Geneva in March 2018, Dr Healy presented an overview of how the guideline was developed and implemented in NI. Many of the global leaders present highlighted the potential of future impact through translation of the guideline and pathway into practice within lower- and middle-income countries.

**REFERENCES**


HSC (2016). Health and social care maternity services care pathway for antenatal care, Belfast: HSC.


CONCLUSION

Midwife-led units are particularly suitable for women with a straightforward pregnancy, as the evidence strongly suggests that the outcomes and benefits are good for them and their baby. Women’s experiences of MLCs are also positive, with reduced likelihood of unnecessary interventions, and increased rates of established breastfeeding. These benefits can further enable women to care for themselves and their families post birth. There is also significant financial cost savings from MLC care provision.

As a large percentage of women have a straightforward pregnancy, many women globally should receive the health and wellbeing benefits of giving birth in a MLU, if they choose. In order to provide optimum quality care, MLUs are strongly urged to demonstrate the midwifery unit standards (MUNet 2018). Women and midwives require easily accessible, evidence-based information to enable individual care and personalised decision-making when planning their place of birth. TPU

For further information about the guideline including implementation or feedback, please contact us at The Practising Midwife and we will pass on your enquiry.

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Northern Ireland