Document Control

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CONTENTS

1. Introduction

Giving birth is a life-changing event. The care that a woman receives during labour has the potential to affect her – both physically and emotionally, in the short and longer term – and the health of her baby. Good communication, support and compassion from staff, and having her wishes respected, can help her feel in control of what is happening and contribute to making birth a positive experience for the woman and her birth companion(s).

About 700,000 women give birth in both England and Wales each year, of which about 40% are having their first baby. Most of these women are healthy and have a straight forward pregnancy. Almost 90% of women will give birth to a single baby after 37 weeks of pregnancy, with the baby presenting head first.

This guideline covers the care of healthy women who go into labour at term (37+0 to 41+6 weeks). It was produced by North Devon District Hospital, but is based upon NICE guidance (2014) and is intended to cover the care of healthy women with uncomplicated pregnancies entering labour at low risk of developing intrapartum complications. In addition, recommendations are included that address the care of women who start labour as 'low risk' but who go on to develop complications.

This guideline includes Fetal Monitoring in Labour.

Woman-Centred Care

Treatment and care should take into account individual needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the patient is under 16, their family or carers should also be given information and support to help the child or young person to make decisions about their treatment. Healthcare professionals should follow the Department of Health's advice on consent. If someone does not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

Patients and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England; this guideline offers best practice advice on the care of women in labour. Further information on Place of Birth, Experience, One to One care in Labour, Service Organisation and Governance, Communication, Mobilisation, Support in Labour and Hygiene Needs can be found in Appendices 1 and 2.

Please refer to separate guidelines for:

Preterm Pre-Labour Rupture of Membranes PPROM Guidelines

Pre-Labour Rupture of Membranes PROM at Term Guidelines

Post-Partum Haemorrhage Guidelines

Care of Newborn Immediately After Birth Guidelines

Epidural Analgesia in Labour Guidelines

Transfer of care from home to hospital

2. Latent First Stage of Labour

Definitions of the latent and established first stages of labour

- Latent first stage of labour – a period of time, not necessarily continuous, when:
    - there are painful contractions **and**
    - there is some cervical change, including cervical effacement and dilatation up to 4 cm.
- Established first stage of labour – when:
    - there are regular painful contractions **and**
    - there is progressive cervical dilatation from 4 cm.

Early assessment (SBAR)

An early assessment of labour will be carried out by telephone triage:

- A telephone triage SBAR form must be fully completed by a midwife for each woman who contacts the labour ward for advice
- The SBAR must be filed in the woman's main notes when no longer required.
- Any concerns regarding the clinical triage assessment must be escalated to the labour ward coordinator for support and advice.
- Consider a face to face assessment of labour at home or in hospital depending upon the woman's planned place of birth.
- Give information about what the woman can expect in the latent first stage of labour and how to work with any pain she experiences
- Give information about what to expect when she accesses care

- Agree a plan of care with the woman, including guidance about who she should contact next and when
- Provide guidance and support to the woman's birth companion(s) if required.

If a woman seeks advice or attends the obstetric unit with painful contractions, but is *not in established labour:*

- Recognise a woman may experience painful contractions without cervical change; although she is described as not being in labour, she may well think of herself as being 'in labour'.
- Offer individualised support, and advice on analgesia if needed
- Encourage her to remain at or return home, unless doing so leads to a significant risk that she could give birth without a midwife present or become distressed.

Pain relief in latent phase of labour

Advise the woman and her birth companion(s) the following may reduce pain during the latent first stage of labour:

Breathing exercises, immersion in water and massage

Do not offer or advise:

- Aromatherapy, yoga or acupressure for pain relief during the latent first stage of labour. If a woman wants to use any of these techniques, respect her wishes.

3. On-Going Assessment: Initial assessment

NB. An assessment must take place for all women upon admission, when their status changes (e.g. they become unwell) and/ or they are in labour or are transferred to labour ward.

Carry out an initial assessment to determine if midwifery-led care in any setting is suitable for the woman, irrespective of any previous plan:

Observations of the woman:

- Review the antenatal notes (including all antenatal screening results and previous admissions and SBARs) and discuss these with the woman.
- Ask her about the length, strength and frequency of her contractions.
- Ask her about any discomfort she is experiencing and discuss her options for pain relief.
- Record her pulse, blood pressure and temperature, and urinalysis.
- Record if she has had any vaginal loss.

Observations of the unborn baby

- Ask the woman about the baby's movements in the last 24 hours and previously.

- Palpate the woman's abdomen (and use a measuring tape) to determine fundal height, baby's lie, presentation, and position, engagement of presenting part, frequency and duration of contractions.

- Auscultate the fetal heart rate for a minimum of 1 minute immediately after a contraction.

- Palpate the woman's pulse to differentiate between the heart rates of the woman and the baby.

Other actions

- If there is uncertainty about whether the woman is in established labour, a vaginal examination may be helpful after a period of assessment, but is not always necessary.

- If the woman appears to be in established labour, offer a vaginal examination.

Conducting a vaginal examination

- Be sure that the examination is necessary and will add important information to the decision-making process

- Recognise that a vaginal examination can be very distressing for a woman, especially if she is already in pain, highly anxious and in an unfamiliar environment

- Explain the reason for the examination and what will be involved

- Ensure the woman's informed consent, privacy, dignity and comfort

- Explain sensitively the findings of the examination and any impact on the birth plan to the woman and her birth companion(s).

Measuring fetal heart rate as part of initial assessment:

- Auscultate the fetal heart rate at first contact with the woman in labour, and at each further assessment.

- Auscultate the fetal heart rate for a minimum of 1 minute immediately after a contraction and record it as a single rate.

- Palpate the maternal pulse to differentiate between maternal heart rate and fetal heart rate.

- Record any accelerations and decelerations if heard.

- Do not perform cardiotocography (CTG) on admission for low-risk women in suspected or established labour as part of the initial assessment.

- Offer continuous CTG if any of the risk identified on initial assessment, and explain to the woman why this is necessary.

- Offer CTG if intermittent auscultation indicates possible fetal heart rate abnormalities, and explain to the woman why this is necessary. Remove the CTG if the trace is normal after 20 minutes.

- If fetal death is suspected, despite the presence of an apparently recorded fetal heart rate, offer real-time ultrasound assessment to check fetal viability.

4. An On-Going Assessment: Transfer of women to obstetric-led care:

Obstetric Led Care is advised if any of the conditions/factors in tables 1-4 Appendix 1 are present.

However, if any of the following are then observed on initial assessment, or a woman requests, also transfer to obstetric led care.

If any of the following factors are observed but birth is imminent, assess whether birth in the current location is preferable to transferring the woman to obstetric care and discuss this with the coordinating midwife:

Observations of the woman:

- Pulse over 120 beats/minute on 2 occasions 30 minutes apart
- A single reading of either raised diastolic blood pressure of 110 mmHg or more or raised systolic blood pressure of 160 mmHg or more
- Either raised diastolic blood pressure of 90 mmHg or more or raised systolic blood pressure of 140 mmHg or more on 2 consecutive readings taken 30 minutes apart
- A reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (90 mmHg or more) or raised systolic blood pressure (140 mmHg or more)
- Temperature of 38°C or above on a single reading, or 37.5°C or above on 2 consecutive readings 2 hours apart
- Any vaginal blood loss other than a show
- Rupture of membranes more than 24 hours before the onset of established labour
- The presence of *significant* meconium
- Pain reported by the woman that differs from the pain normally associated with contractions
- Any risk factors recorded in the woman's notes that indicate the need for obstetric led care (see Appendix 1 Table 1). This may include a prolonged latent stage with 2 or more admissions to delivery suite.

Observations of the unborn baby:

- Any abnormal presentation, including cord presentation transverse or oblique lie
- High (4/5–5/5 palpable) or free-floating head in a nulliparous woman

- Suspected fetal growth restriction or macrosomia
- Suspected anhydramnios or polyhydramnios
- Fetal heart rate below 110 or above 160 beats/minute
- A deceleration in fetal heart rate heard on intermittent auscultation
- Reduced fetal movements in the last 24 hours reported by the woman.

When a woman's pathway switches from midwifery to obstetric led care, a senior doctor (staff grade or above) must undertake a review and assessment (face to face).

On admission, all existing obstetric led patients must have a full review and assessment (face to face) by a senior obstetrician (staff grade or above) on the ward round or immediately if required

All in patient obstetric led patients must be reviewed during twice daily ward rounds (morning and evening).

5. Presence of meconium

As part of on-going assessment, document the presence or absence of significant meconium. This is defined as dark green or black amniotic fluid that is thick or tenacious, or any meconium-stained amniotic fluid containing lumps of meconium.

If significant meconium is present, ensure that:

- Healthcare professionals trained in fetal blood sampling are available during labour and
- Healthcare professionals trained in advanced neonatal life support are readily available for the birth.

If significant meconium is present, transfer the woman to obstetric-led care.

6. Care in Established Labour

Do not offer or advise clinical intervention if labour is progressing normally and the woman and baby are well.

Support

- Provide a woman in established labour with supportive one-to-one care.
- Do not leave a woman in established labour on her own except for short periods or at the woman's request.

Controlling gastric acidity

- Do not offer either H2-receptor antagonists or antacids routinely to low-risk women.

- Either H2-receptor antagonists or antacids should be considered for women who receive opioids or who have or develop risk factors that make a general anaesthetic more likely.
- Inform the woman that she may drink during established labour and that isotonic drinks may be more beneficial than water.
- Inform the woman that she may eat a light diet in established labour unless she has received opioids or she develops risk factors that make a general anaesthetic more likely.

7. Pain relief in labour: non-regional

Attitudes to pain and pain relief in childbirth

- Healthcare professionals should think about how their own values and beliefs inform their attitude to coping with pain in labour and ensure their care supports the woman's choice.

Pain-relieving strategies

- Offer the woman the opportunity to labour in water for pain relief.
- For women labouring in water, please see SOP (Water Birth)
- If a woman chooses to use breathing and relaxation techniques in labour, support her in this choice.
- If a woman chooses to use massage techniques in labour that have been taught to birth companions, support her in this choice.
- Do not use injected water papules.
- Do not offer acupuncture, acupressure or hypnosis, but do not prevent women who wish to use these techniques from doing so.
- Support the playing of music of the woman's choice in labour.

Non-pharmacological analgesia

- Do not offer transcutaneous electrical nerve stimulation (TENS) to women already in established labour.

Inhalational analgesia

- Ensure that Entonox (a 50:50 mixture of oxygen and nitrous oxide) is available in all birth settings.
- Inform the woman that it may make her feel nauseous and light-headed.

Intravenous and intramuscular opioids

- Ensure that Diamorphine or other opioids are available in all birth settings.
- Inform the woman that these will provide limited pain relief during labour and may have significant side effects for both her (drowsiness, nausea and vomiting) and her baby (short-term respiratory depression and drowsiness which may last several days).
- Inform the woman that Diamorphine or other opioids may interfere with breastfeeding.
- If an intravenous or intramuscular opioid is used, also administer an antiemetic. Suggested medication is Cyclizine: 50mgs in 1 ml by intramuscular injection.
- Women should not enter water (a birthing pool or bath) within 2 hours of opioid administration or if they feel drowsy.
- It is recommended that vaginal examination to confirm progress and stage of labour be performed before administration due to the potential of the maximum efficacy of the drug coinciding with delivery, with the known side effects to the baby.
- When considering the use of opioids, it is important to consider the woman's medical history and use of illicit drugs during the pregnancy. If in any doubt, discuss with an obstetrician.

8. First stage of labour

Do not offer or advise clinical intervention if labour is progressing normally and the woman and baby are well.

In all stages of labour, women who have left the normal care pathway because of the development of complications can return to it if/when the complication is resolved.

Duration of the first stage

Inform women that, while the length of established first stage of labour varies between women:

- first labours last on average 8 hours and are unlikely to last over 18 hours
- second and subsequent labours last on average 5 hours and are unlikely to last over 12 hours.

Observations during the established first stage

Do not routinely use verbal assessment using a numerical pain score.

Use a pictorial record of labour (Partogram) once labour is established.

Record the following observations during the first stage of labour:

- half-hourly documentation of frequency of contractions
- hourly pulse
- 4-hourly temperature and blood pressure
- frequency of passing urine
- offer a vaginal examination 4-hourly or if there is concern about progress or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss).

If any of the indications for transfer are met, transfer the woman to obstetric-led care.

Give on-going consideration to the woman's emotional and psychological needs, including her desire for pain relief.

Encourage the woman to communicate her need for analgesia at any point during labour.

Possible routine interventions in the first stage

In normally progressing labour, do not perform ARM routinely.

Do not use combined early ARM with use of oxytocin routinely.

Delay in the first stage

If delay in the established first stage is suspected, take the following into account:

- parity

- cervical dilatation and rate of change
- uterine contractions
- station and position of presenting part
- the woman's emotional state
- referral to the appropriate healthcare professional.

Offer the woman support, hydration, and appropriate and effective pain relief.

If delay in the established first stage is suspected, assess all aspects of progress in labour when diagnosing delay, including:

- cervical dilatation of less than 2 cm in 4 hours for first labours
- cervical dilatation of less than 2 cm in 4 hours or a slowing in the progress of labour for second or subsequent labours
- descent and rotation of the baby's head
- changes in the strength, duration and frequency of uterine contractions.

For all women with confirmed delay in the established first stage of labour:

- Transfer the woman to obstetric-led care for an obstetric review face to face assessment and a decision about management options, including the use of oxytocin.

- ARM should be considered (for women with intact membranes) after explanation of the procedure and advice that it will shorten her labour by about an hour and may increase the strength and pain of her contractions.

- Whether or not a woman has agreed to an ARM, advise all women with suspected delay in the established first stage of labour to have a vaginal examination 2 hours later, and diagnose delay if progress is less than 1 cm.

- Explain to her that using oxytocin after spontaneous or ARM will bring forward the time of birth, but will not influence the mode of birth or other outcomes.

- Offer all women with delay in the established first stage of labour support and effective pain relief.

- Inform the woman that oxytocin will increase the frequency and strength of her contractions and that its use will mean that her baby should be monitored continuously. Offer the woman an epidural before oxytocin is started.

- If oxytocin is used, ensure that the time between increments of the dose is no more frequent than every 30 minutes. Increase oxytocin until there are 4–5 contractions in 10minutes.

  Advise the woman to have a vaginal examination 4 hours after starting oxytocin in established labour:

- If cervical dilatation has increased by less than 2 cm after 4 hours of oxytocin, further obstetric review is required to assess the need for caesarean section.

- If cervical dilatation has increased by 2 cm or more, advise 4-hourly vaginal examinations.

9. Second stage of labour

Definition of the second stage

- Passive second stage of labour:
    - the finding of full dilatation of the cervix before or in the absence of involuntary expulsive contractions.

- Onset of the active second stage of labour:
    - the baby is visible
    - expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix
    - active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions.

Observations during the second stage

Carry out the following observations in the second stage of labour, record all observations on the Partogram and assess whether transfer of care may be needed:

- half-hourly documentation of the frequency of contractions
- hourly blood pressure
- continued 4-hourly temperature
- frequency of passing urine
- offer a vaginal examination hourly in the active second stage, or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss).

In addition:

- Continue to take the woman's emotional and psychological needs into account.
- Assess progress, which should include the woman's behaviour, the effectiveness of pushing and the baby's wellbeing, taking into account the baby's position and station at the onset of the second stage. These factors will assist in deciding the timing of further vaginal examination and any need for transfer to obstetric led care.
- Perform intermittent auscultation of the fetal heart rate immediately after a contraction for at least 1 minute at least every 5 minutes. Palpate the woman's pulse every 15 minutes to differentiate between the two heart rates. [
- On-going consideration should be given to the woman's position, hydration, coping strategies and pain relief throughout the second stage.
-

Duration of the second stage & definition of delay

For a nulliparous woman:

- birth would be expected to take place within 3 hours of the start of the active second stage in most women
- diagnose delay in the active second stage when it has lasted 2 hours and refer the woman to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.

For a multiparous woman:

- birth would be expected to take place within 2 hours of the start of the active second stage in most women
- diagnose delay in the active second stage when it has lasted 1 hour and refer the woman to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.

Definition of delay

For a nulliparous woman, suspect delay if:

- Progress in terms of rotation and/or descent of the presenting part, is inadequate after 1 hour of active second stage.
- Offer vaginal examination and then offer ARM if the membranes are intact.

For a multiparous woman, suspect delay if:

- Progress in terms of rotation and/or descent of the presenting part, is inadequate after 30 minutes of active second stage.
- Offer vaginal examination and then offer ARM if the membranes are intact.

For all women:

- If full dilatation of the cervix has been confirmed in a woman without regional analgesia, but she does not get an urge to push, carry out further assessment after 1 hour.

- If there is delay in the second stage of labour, or if the woman is excessively distressed, support and sensitive encouragement and the woman's need for analgesia/anaesthesia are particularly important.

- An obstetrician should assess a woman with confirmed delay in the second stage before contemplating the use of oxytocin.

- After initial obstetric assessment of a woman with delay in the second stage, maintain on-going obstetric review every 15–30minutes.

Oxytocin in the second stage

Consideration should be given to the use of oxytocin, with the offer of regional analgesia, for nulliparous women if contractions are inadequate at the onset of the second stage.

Refer to Augmentation and Induction of Labour Guideline.

The woman's position and pushing in the second stage

- Discourage the woman from lying supine or semi-supine. Encourage adopting any other position that she finds most comfortable.
- Inform the woman that in the second stage she should be guided by her own urge to push.
- If pushing is ineffective or if requested by the woman, offer strategies to assist birth, such as support, change of position, emptying of the bladder and encouragement.
- Encourage women to have skin-to-skin contact with their babies as soon as possible after the birth

Intrapartum interventions to reduce perineal trauma

- Do not perform perineal massage in the second stage of labour.
- Either the 'hands on' (guarding the perineum and flexing the baby's head) or the 'hands poised' (with hands off the perineum and baby's head but in readiness) technique can be used to facilitate spontaneous birth.
- Do not offer Lidocaine spray to reduce pain in the second stage of labour.
- Do not carry out a routine episiotomy during spontaneous vaginal birth.
- Inform any woman with a history of severe perineal trauma that her risk of repeat severe perineal trauma is not increased in a subsequent birth, compared with women having their first baby.
- Do not offer episiotomy routinely at vaginal birth after previous third- or fourth-degree trauma.

In order for a woman who has had previous third- or fourth-degree trauma to make an informed choice, talk with her about the future mode of birth (preferably in the AN period), encompassing:

- current urgency or incontinence symptoms
- the degree of previous trauma risk of recurrence
- the success of the repair undertaken
- the psychological effect of the previous trauma
- management of her labour.

Where possible this should occur during the antenatal period.

Genital Mutilation: Inform any woman with infibulated genital mutilation of the risks of difficulty with vaginal examination, catheterisation and application of fetal scalp electrodes. Inform her of the risks of delay in the second stage and spontaneous laceration together with the need for an anterior episiotomy and the possible need for defibulation in labour.

Episiotomy

If an episiotomy is performed, the recommended technique is a mediolateral episiotomy originating at the vaginal fourchette and usually directed to the right side. The angle to the vertical axis should be between 45 and 60 degrees at the time of the episiotomy.

Perform an episiotomy only if there is a clinical need, such as suspected fetal compromise.

Provide tested effective analgesia before carrying out an episiotomy, except in an emergency because of acute fetal compromise.

Instrumental birth, analgesia and delayed second stage

Operative Vaginal Delivery Guideline

Because instrumental birth is an operative procedure, advise the woman to have tested effective anaesthesia.

If a woman declines anaesthesia, offer a pudendal block combined with local anaesthetic to the perineum during instrumental birth.

If there is concern about fetal compromise, offer either tested effective anaesthesia or, if time does not allow this, a pudendal block combined with local anaesthetic to the perineum during instrumental birth.

Expediting birth

If the birth needs to be expedited for maternal or fetal reasons, assess both the risk to the baby and the safety of the woman. Assessments should include:

- the degree of urgency
- clinical findings on abdominal and vaginal examination
- choice of mode of birth (and whether to use forceps or ventouse if an instrumental birth is indicated)
- anticipated degree of difficulty, including the likelihood of success if instrumental birth is attempted
- location
- any time that may be needed for transfer to obstetric-led care
- the need for additional analgesia or anaesthesia
- the woman's preferences.
- encourage women to have skin-to-skin contact with their babies as soon as possible after the birth

Talk with the woman and her birth companion(s) about why the birth needs to be expedited and what the options are.

Inform the team about the degree of urgency.

Record the time at which the decision to expedite the birth is made.

Third stage of labour

See Appendix 3 for Information for Women (3rd stage of labour)

Recognise that the time immediately after the birth is when the woman and her birth companion(s) are meeting and getting to know the baby.

Encourage women to have skin-to-skin contact with their babies as soon as possible after the birth.

Ensure that any care or interventions are sensitive to this and minimise separation or disruption of the mother and baby.

Definition of the third stage

- The third stage of labour is the time from the birth of the baby to the expulsion of the placenta and membranes.

- Active management of the third stage involves a package of care comprising the following components:

    - routine use of uterotonic drugs
    - deferred clamping and cutting of the cord
    - controlled cord traction after signs of separation of the placenta.

- Physiological management of the third stage involves a package of care that includes the following components:

  - no routine use of uterotonic drugs
  - no clamping of the cord until pulsation has stopped
  - delivery of the placenta by maternal effort

Prolonged third stage

Diagnose a prolonged third stage of labour if it is not completed within 30 minutes of the birth with active management or within 60 minutes of the birth with physiological management.

Observations in the third stage

Record the following observations for a woman in the third stage of labour:

- her general physical condition, as shown by her colour, respiration and her own report of how she feels
- vaginal blood loss.

If there is postpartum haemorrhage, a retained placenta or maternal collapse, or any other concerns about the woman's wellbeing:

- transfer her to obstetric-led care
- carry out frequent observations to assess whether resuscitation is needed.

Active and physiological management of the third stage

Explain to the woman antenatally about what to expect with each package of care for managing the third stage of labour and the benefits and risks associated with each.

If a woman at low risk of postpartum haemorrhage requests physiological management of the third stage, support her in her choice.

Document in the records the decision that is agreed with the woman about management of the third stage.

For active management, administer 10 IU of oxytocin by intramuscular injection with the birth of the anterior shoulder or immediately after the birth of the baby and before the cord is clamped and cut. Use oxytocin as it is associated with fewer side effects than oxytocin plus Ergometrine.

Note: In theatre, for active management, the anaesthetist will administer 5 IU IV syntocinon

After administering oxytocin, clamp and cut the cord.

- Do not clamp the cord earlier than 1 minute from the birth of the baby unless there is concern about the integrity of the cord, the baby has a heartbeat below 60 beats/ minute that is not getting faster or there are any maternal or fetal concerns
- Clamp the cord before 5 minutes in order to perform controlled cord traction as part of active management.
- If the woman requests that the cord is clamped and cut later than 5 minutes, support her in her choice.

After cutting the cord, use controlled cord traction.

Perform controlled cord traction as part of active management only after administration of oxytocin and signs of separation of the placenta.

Record the timing of cord clamping in both active and physiological management.

Advise a change from physiological management to active management if either of the following occur:

- haemorrhage
- the placenta is not delivered within 1 hour of the birth of the baby.

Offer a change from physiological management to active management if the woman wants to shorten the third stage.

Do not use either umbilical oxytocin infusion or prostaglandin routinely in the third stage of labour.

Retained placenta

Secure intravenous access if the placenta is retained, and explain to the woman why this is needed.

Do not use umbilical vein agents if the placenta is retained.

Do not use intravenous oxytocic agents routinely to deliver a retained placenta.

Give intravenous oxytocic agents if the placenta is retained and the woman is bleeding excessively.

If the placenta is retained and there is concern about the woman's condition:

- offer a vaginal examination to assess the need to undertake manual removal of the placenta
- explain that this assessment can be painful and advise her to have analgesia.

If the woman reports inadequate analgesia during the assessment, stop the examination and address this immediately.

If uterine exploration is necessary and the woman is not already in an obstetric unit, arrange urgent transfer.

Do not carry out uterine exploration or manual removal of the placenta without an anaesthetic.

Also see Post-Partum Haemorrhage Guidelines

10. Care of the woman after birth

For care of newborn, please refer to Care of Newborn Immediately After Birth Guidelines

Also see Care and Repair of Perineal Trauma After Childbirth Guideline

Initial assessment

Carry out the following observations of the woman after birth:

- Record her temperature, pulse and blood pressure.
- Uterine contraction and lochia.
- Examine the placenta and membranes: assess their condition, structure, cord vessels and completeness. Transfer the woman (with her baby) to obstetric-led care if the placenta is incomplete.
- Early assessment of the woman's emotional and psychological condition in response to labour and birth.
- Successful voiding of the bladder. Assess whether to transfer the woman (with her baby) to obstetric-led care after 6 hours if her bladder is palpable and she is unable to pass urine.

11. Education and Training

Responsibility for education and training lies with the lead Obstetrician and lead midwife for labour ward. It will be provided through formal study days and informal training on the ward.

12. Appendices

Appendix 1: Planning care: place of birth and pathway (midwifery or obstetric led care)

Further information for women and healthcare professionals on planning place of birth is available at:

https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-for-healthy-women-and-babies-35109866447557

Treatment and care should take into account individual needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the patient is under 16, their family or carers should also be given information and support to help the child or young person to make decisions about their treatment. Healthcare professionals should follow the Department of Health's advice on consent. If someone does not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

Women's experience in all birth settings

Providers, senior staff and all healthcare professionals should ensure that in all birth settings there is a culture of respect for each woman as an individual undergoing a significant and emotionally intense life experience, so that the woman is in control, is listened to and is cared for with compassion, and that appropriate informed consent is sought.

Senior staff should demonstrate, through their own words and behaviour, appropriate ways of relating to and talking about women and their birth companion(s), and of talking about birth and the choices to be made when giving birth.

One-to-one care in all birth settings

Our Maternity services should: provide a model of care that supports one-to-one care in labour for all women and benchmark services and identify overstaffing or understaffing by using workforce planning models and/or woman-to-midwife ratios.

Service organisation and clinical governance

Ensure that all women giving birth have timely access to an obstetric unit if they need transfer of care for medical reasons or because they request regional analgesia.

Women at low risk of complications:

Explain to both multiparous and nulliparous women who are at low risk of complications that giving birth is generally very safe for both the woman and her baby.

Explain to both multiparous and nulliparous women that there is a choice to deliver at home or in an obstetric led unit. Support them in their choice of setting wherever they choose to give birth.

Explain to low-risk multiparous women that:

- planning birth at home (or in a freestanding midwifery unit) is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside midwifery unit, and these 3 settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit
- planning birth in an obstetric unit is associated with a higher rate of interventions, such as instrumental vaginal birth, caesarean section and episiotomy, compared with planning birth in other settings
- there are no differences in outcomes for the baby associated with planning birth in any setting.
- planning birth at home is associated with an overall small increase (about 4 more per 1000 births) in the risk of a baby having a serious medical problem compared with planning birth in other settings.

Medical conditions and other factors that may affect planned place of birth *(and advice for Obstetric Led Care)*

Ensure that all healthcare professionals involved in the care of pregnant women are familiar with the types and frequencies of serious medical problems that can affect babies and mothers (see table 1-4). *This information can be used for discussions with women if they request it, as well as indications for obstetric led care pathway.*

If further discussion is wanted by either the midwife or the woman about the choice of planned place of birth, arrange this with a senior midwife or supervisor of midwives, and/or a consultant obstetrician if there are obstetric issues.

When discussing the woman's choice of place of birth with her, do not disclose personal views or judgements about her choices.

Table 1: Medical conditions indicating increased risk suggesting planned birth at an obstetric unit (Obstetric Led Care advised)

Disease area	Medical condition
Cardiovascular	Confirmed cardiac disease Hypertensive disorders
Respiratory	Asthma requiring 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 below 100×109/litre Von Willebrand's disease Bleeding disorder in the woman or unborn baby Atypical antibodies which carry a risk of haemolytic disease of the newborn
Endocrine	Endocrine Hyperthyroidism Diabetes
Infective	Risk factors associated with group B streptococcus whereby antibiotics in labour would be 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
Immune	lupus erythematosus Scleroderma
Renal	Abnormal renal function Renal disease requiring supervision by a renal specialist
Neurological	Epilepsy Myasthenia gravis Previous cerebrovascular accident
Gastrointestinal	Liver disease associated with current abnormal liver function tests
Psychiatric	Psychiatric disorder requiring current inpatient care

Table 2: Other factors indicating increased risk suggesting planned birth at an obstetric unit (Obstetric Led Care advised)

Factor	Additional information
Previous complications	Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty Previous baby with neonatal encephalopathy Pre-eclampsia requiring preterm birth Placental abruption with adverse outcome Eclampsia Uterine rupture Primary postpartum haemorrhage requiring additional treatment 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 Preterm labour or preterm prelabour rupture of membranes Placental abruption Anaemia – haemoglobin less than 85 g/litre 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 BMI at booking of greater than 35 kg/m2 Recurrent antepartum haemorrhage Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound) Abnormal fetal heart rate/Doppler studies Ultrasound diagnosis of oligo-/polyhydramnios
Previous gynaecological history	Myomectomy

Table 3: Medical conditions indicating individual assessment when planning place of birth (Obstetric Led Care advised)

Disease area	Medical condition
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 85–105 g/litre at onset of labour
Infective	Hepatitis B/C with normal liver function tests
Immune	Non-specific connective tissue disorders
Endocrine	Unstable hypothyroidism such that a change in treatment is required
Skeletal/ neurological	Spinal abnormalities Previous fractured pelvis Neurological deficits
Gastrointestinal	Liver disease without current abnormal liver function Crohn's disease Ulcerative colitis

Table 4: Other factors indicating individual assessment when planning place of birth (Obstetric Led Care advised)

Factor	Additional information
Previous complications	Stillbirth/neonatal death with a known non-recurrent cause Pre-eclampsia developing at term Placental abruption with good outcome History of previous baby more than 4.5 kg Extensive vaginal, cervical, or third- or fourth-degree perineal trauma Previous term baby with jaundice requiring exchange transfusion
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation) BMI at booking of 30–35 kg/m2 Blood pressure of 140 mmHg systolic or 90 mmHg diastolic or more on two occasions Clinical or ultrasound suspicion of macrosomia Para 4 or more Recreational drug use Under current outpatient psychiatric care Age over 35 at booking
Fetal indications	Fetal abnormality
Previous gynaecological history	Major gynaecological surgery Cone biopsy or large loop excision of the transformation zone Fibroids

Appendix 2: Other care throughout labour

Communication

Treat all women in labour with respect. Ensure that the woman is in control of and involved in what is happening to her, and recognise that the way in which care is given is key to this. To facilitate this, establish a rapport with the woman, ask her about her wants and expectations for labour, and be aware of the importance of tone and demeanour, and of the actual words used. Use this information to support and guide her through her labour.

To establish communication with the woman:

- Greet the woman with a smile and a personal welcome, establish her language needs,
- Introduce yourself and explain your role in her care.
- Maintain a calm and confident approach so that your demeanour reassures the woman that all is going well.
- Knock and wait before entering the woman's room, respecting it as her personal space, and ask others to do the same.
- Ask how the woman is feeling and whether there is anything in particular she is worried about.
- If the woman has a written birth plan, read and discuss it with her.
- Assess the woman's knowledge of strategies for coping with pain and provide balanced information to find out which available approaches are acceptable to her.
- Encourage the woman to adapt the environment to meet her individual needs.
- Ask her permission before all procedures and observations, focusing on the woman rather than the technology or the documentation.
- Show the woman and her birth companion(s) how to summon help and reassure her that she may do so whenever and as often as she needs to. When leaving the room, let her know when you will return.
- Involve the woman in any handover of care to another professional, either when additional expertise has been brought in or at the end of a shift.

Mobilisation

Encourage and help the woman to move and adopt whatever positions she finds most comfortable throughout labour.

Support

Encourage the woman to have support from birth companion(s) of her choice.

Hygiene measures

Tap water may be used if cleansing is required before vaginal examination.

Routine hygiene measures taken by staff caring for women in labour, including standard hand hygiene and single-use non-sterile gloves, are appropriate to reduce cross-contamination between women, babies and healthcare professionals.

Selection of protective equipment must be based on an assessment of the risk of transmission of microorganisms to the woman, and the risk of contamination of the healthcare worker's clothing and skin by women's blood, body fluids, secretions or excretion.

Handover between healthcare professionals

Handover of care (shift to shift, when going on breaks/ taking over care) must be undertaken using the SBAR Handover Tool when caring for women in labour

Appendix 3: Information for Women on Management of Third Stage of Labour

Explain to the woman that active management:

- shortens the third stage compared with physiological management
- is associated with nausea and vomiting in about 100 in 1000 women
- is associated with an approximate risk of 13 in 1000 of a haemorrhage of more than 1 litre
- is associated with an approximate risk of 14 in 1000 of a blood transfusion.

Explain to the woman that physiological management:

- is associated with nausea and vomiting in about 50 in 1000 women
- is associated with an approximate risk of 29 in 1000 of a haemorrhage of more than 1 litre
- is associated with an approximate risk of 40 in 1000 of a blood transfusion.

Discuss again with the woman at the initial assessment in labour about the different options for managing the third stage and ways of supporting her during delivery of the placenta, and ask if she has any preferences.

Advise the woman to have active management of the third stage, because it is associated with a lower risk of a postpartum haemorrhage and/or blood transfusion.

Appendix 4: Audit

Audit methodology for Intrapartum care: care of healthy women and their babies during childbirth

NDHT Obstetrics, Gynaecology and Midwifery Guideline:	Intrapartum care: care of healthy women and their babies during childbirth				
CNST Ref:	Standard:	2	Criterion:	1	
Monitoring arrangements	Clinical Audit			Y	Annually
	Monitoring			Y	1% or 10 sets
Monitoring Arrangements Northern Devon Healthcare Trust Maternity Services will monitor compliance of this guidance against all minimum requirements within the CNST maternity standards by an annual audit, supported by specific audits during the year that are triggered by the clinical incident reporting system, or in response to a change in practice.					
Lead for Monitoring Compliance	Name Job Role			Post Holder Lead Midwife for Normal Birth	
Method					
• Sample	1% or 10 sets, whichever is the greater, of all records of women who have delivered				
• Audit tool	An audit tool will be developed using the standard statements set out in Appendix 2				
• Data collection process	Patient notes will be audited by a clinically qualified member of staff. The information will be recorded using the audit tool.				
• Process for collating and reporting data	Data will entered and analysed using appropriate software to show compliance levels. All the results of the audit will be reviewed by a multi-disciplinary team at the Maternity Services Patient Safety Forum which meet on a monthly basis				
Frequency of monitoring/audit	Annual				
Process for reviewing results and ensuring improvements in performance occur	The Maternity Services Patient Safety Forum will develop an action plan to improve compliance and ensure improvements in performance occur. Action plans will be implemented by the Maternity Risk Manager and Practice Development Midwives to ensure learning takes place. The Maternity Services Patient Safety Forum will monitor				

	progress of action plan monthly and exceptions will be reported via this group to the Clinical Governance Committee. Identified risks related to non-compliance with these guidelines through audit will be registered on the Trust Risk System by the Maternity Risk Manager

Audit criterion for Intrapartum care: care of healthy women and their babies during childbirth

Criterion statements to be included in the audit tool							
Ref	Criterion statements	Target	Exceptions	Indicator/Location of information		National guidance Reference	Trust guideline reference
				Where the information against which compliance can be audited is recorded? eg: Postnatal notes eg: Stork screen	Page no/ Field	Which national guidance does this demonstrate compliance with eg: NICE CG13 p22	On which page of the Trust guideline is the relevant statement?
1	Were maternal observations carried out and documented on admission in accordance with NICE guidance						
2	Were maternal observations carried out and documented in the first stage of labour in accordance with NICE guidance						
3	Were maternal observations carried out and documented in the second stage of labour in accordance with NICE guidance						
4	Were maternal observations carried out and documented in the third stage of labour in accordance with NICE guidance						
5	Were the						

	duration of the stages of labour within NICE recommendations						
6	Was the women referred to obstetric care if her labour was no longer within normal limits.						

Appendix 5: Stickers

Name:	**Date + Time of Handover/Review**
S	**Situation** (Gest, Parity, Stage of labour, reason for admission etc)
B	**Background** (AN history, Risk Factors, Birth preferences etc)
A	**Assessment** (Actions/Interventions if any, Monitoring, Reviews etc)
R	**Recommendations** (Actions required eg Escalate, continue, repeat VE in 4hrs)
Escalate to (name and grade) **Care handed from** (sign and print) **Care handed to** (sign and print)	

13. REFERENCES

References:

This guidance is based upon the NICE guideline for Intrapartum Care (2014) found at:

NICE (2014) *Intrapartum Care: Care of healthy women and their babies during childbirth found at:*

https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-for-healthy-women-and-babies-35109866447557

For all references and other reading material, please see:

NICE (2014) *Intrapartum Care: Care of healthy women and their babies during childbirth*

Clinical Guideline 190 Methods, evidence and recommendations

found at:

https://www.nice.org.uk/guidance/cg190/evidence/full-guideline-248734765