Clinical Guideline

LABOUR CARE

SETTING Maternity Services – hospital & community

FOR STAFF Midwives, Obstetricians.

PATIENTS Women in labour

Guidance

Communication

All women in labour should be treated with respect and should be in control of and involved in what is happening to them; the way in which care is given is key to this. To facilitate this, healthcare professionals and other caregivers should establish a rapport with the labouring woman, asking her about her wants and expectations for labour, being aware of the importance of tone and demeanour, and of the actual words they use. This information should be used to support and guide her through her labour.

To establish communication with the woman:

- Introduce yourself and establish her language needs. Explain your role.
- Maintain a calm and confident approach; this approach will reassure the woman.
- Knock and wait before entering the woman's room
- Ask permission before all procedures and observations.
- Show the woman and her birthing partner how to summon help. When leaving the room, let her know that you will return.
- Involve the woman in any handover of care to another health professional.

Support in labour

A woman in established labour should receive supportive one-to-one care.

A woman in established labour should not be left on her own except for short periods or at the woman's request.

Documentation of observations

- Observations should be carried out on admission, in established first stage of labour, and second stage of labour as per NICE Intrapartum Guideline (listed below)
- When not in established labour observations are recorded on the blue antenatal pages in the hand held records or the MOEWS chart.
- In established labour observations are recorded on the pink partogram and labour record
- For guidance on referral to obstetric care in labour see appendix 1

On admission/first labour contact

1. Listen to the woman's story. Consider her emotional and psychological needs.
2. Review her clinical records – risk assessment (see Appendix 2 and Clinical risk Assessment and Selection of Lead Professional guideline)

3. Assess maternal wellbeing:
    a. Pulse
    b. Blood pressure
    c. Temperature
    d. Urinalysis
    e. Vaginal loss – show, liquor, blood
    f. Contractions – length, strength, frequency
    g. Behaviour
4. Assess fetal wellbeing:
    a. abdominal palpation including symphysis fundal height measurement
    b. fetal movements in the last 24hrs
    c. auscultation of the fetal heart with Pinnard or Doppler for at least one minute after a contraction as per Monitoring the Fetus in Labour guideline. Differentiate between maternal and fetal heart rate at this point.
5. Discuss birth plan including coping strategies for labour and options for pain relief
6. Consider a vaginal examination (VE):
    a. If the woman does not appear to be in established labour, after a period of assessment it may be helpful to offer a VE
    b. If the woman appears to be in established labour, a VE should be offered
    Note: Healthcare professionals who conduct VEs should:
        - Be sure that the VE is really necessary and will add important information to the decision- making process
        - Be sensitive to the fact that VEs are an invasive procedure and that for many women they can be very distressing
        - Explain the reason for the examination and what will be involved
        - Be aware that women may decline a VE – if a woman declines a VE document that a VE has been offered and declined
        - Ensure informed consent is obtained
        - Ensure the woman's privacy, dignity and comfort
        - Explain the findings and their impact sensitively to the woman and her birth companion
        - Document the findings, discussion and plan
7. Based on the initial assessment the decision should be made as to the appropriate place of birth. If the birth is imminent and the current location is deemed unsuitable, the decision to transfer should be based on whether the current location is preferable to the birth occurring before the transfer is complete.

Latent phase of labour

Definition: A period of time, not necessarily continuous when:

- There are painful contractions
- There is some cervical change including cervical effacement and dilatation up to 4cm

See Latent Phase of labour Guideline

http://nww avon.nhs uk/dms/download.aspx?did=23735

Established first stage of labour

Definition:

- Regular painful contractions (there is no defined pattern of contractions it is an individual interpretation of how well the woman is coping
- Progressive cervical dilatation from 4cm

Duration of first stage of labour

Women should be informed 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.

1. Assume normality unless proven otherwise
2. Ensure privacy and confidentiality
3. Use positive, empowering language
4. Encourage mobilisation and the use of birthing aids such as balls, immersion in water and mats
5. Ensure hydration and encourage nutrition in early labour - Isotonic drinks reduce maternal ketosis without increasing gastric volume
6. Encourage the woman to empty her bladder 2-4 hourly. If the woman has an epidural and the labour is likely to be prolonged consider after discussion with the woman an indwelling catheter rather than repeated in out catheters which are likely to increase the likelihood of a potential infection.
7. Explain how to summon help, and if leaving her alone inform her when you will return
8. Consider ongoing emotional and psychological wellbeing and changes in behaviour and requirements for pain relief.
9. Assess & document maternal wellbeing (Observations as per NICE intrapartum guideline):
    a. Frequency and strength of contractions half-hourly
    b. Pulse hourly
    c. Blood pressure and temperature* 4-hourly
    d. *If maternal temperature >37.5^{O}C at any stage in labour it should be rechecked after an hour
    e. Frequency and volume of emptying the bladder – see bladder care guideline
    f. Abdominal palpation prior to vaginal examination
    g. Vaginal examination offered 4-hourly to assess descent of the presenting part, position of presenting part, and cervical dilatation, or where there is concern about progress or in response to the woman's wishes. A sticker should be used for all

vaginal examinations and completed fully. If there are any concerns about the position such as cannot feel a suture line think is it an abnormal presentation, consider your earlier palpation and a second opinion should be sought if appropriate. Any mal-presentations MUST be escalated to a Consultant led care setting immediately for delivery. Vaginal examinations are not recommended in the birthing pool to ensure you can undertake a complete assessment. NB see point e above this cannot be done in the pool.

h. Assessment of vaginal loss hourly and prior to vaginal examination

10. Assess & document fetal wellbeing
    a. Monitoring of the fetal heart as per Monitoring the Fetus in Labour guideline
    b. Vaginal loss – liquor, blood, meconium staining of the liquor.
        - Significant meconium staining is defined as either dark green or black fluid that is thick or tenacious, or any meconium stained fluid containing lumps of meconium thick or fresh
        - If significant meconium is present ensure that the woman is transferred to a consultant led obstetric unit
11. Progress of labour: Assessment of progress needs to take into consideration all aspects of progress in labour and should include:
    a. Cervical dilatation of less than 2 cm in 4 hours for nulliparous women
    b. Cervical dilatation of less than 2cm in 4 hours or a slowing in the progress of labour for second or subsequent labours.
    c. Overall progress in labour – whether progress is maintained or slows
    d. Descent and rotation of the fetal head
    e. Changes in the strength, duration and frequency of uterine contractions. In case of uterine Hyperstimulation see Oxytocin use in labour.

If concerns around sepsis, see Pyrexia in Labour on page 8.

Where a diagnosis of delay is made see section below: Management of Delay in Labour

Second stage of labour

1. Assess maternal wellbeing as in first stage of labour (Observations as per NICE intrapartum guideline)
2. Assess fetal wellbeing as in Monitoring the Fetus in Labour guideline
3. Encourage all fours, upright or left lateral positions
4. Ensure adequate hydration
5. Encourage frequent bladder emptying
6. Women should be reassured making noise is normal

Passive second stage of labour

The finding of full dilatation of the cervix prior to or in the absence of involuntary expulsive contractions.

Leave one hour and then:

1. Abdominal palpation
2. Vaginal assessment

3. Assess fullness of the bladder, encourage bladder emptying
4. Assessment of frequency and strength of contractions
5. Consider change of position
6. Offer obstetric referral and transfer to consultant unit if still no urges to push

Active second stage of labour

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.

1. Allow the woman to be guided by her own urge to push
2. Encourage maternal effort as appropriate (including where epidural analgesia in use)
    a. Use positive language
    b. Avoid prolonged Valsalva (breath holding) pushes
3. Encourage the mother to change position to maintain comfort and facilitate pushing. Avoid lithotomy and recumbent positions as this increases fetal distress and the risk of perineal trauma.

First labours

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

Second and subsequent labours:

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

Where a diagnosis of delay is made see section below: Management of Delay in Labour.

Management of Delay in Labour

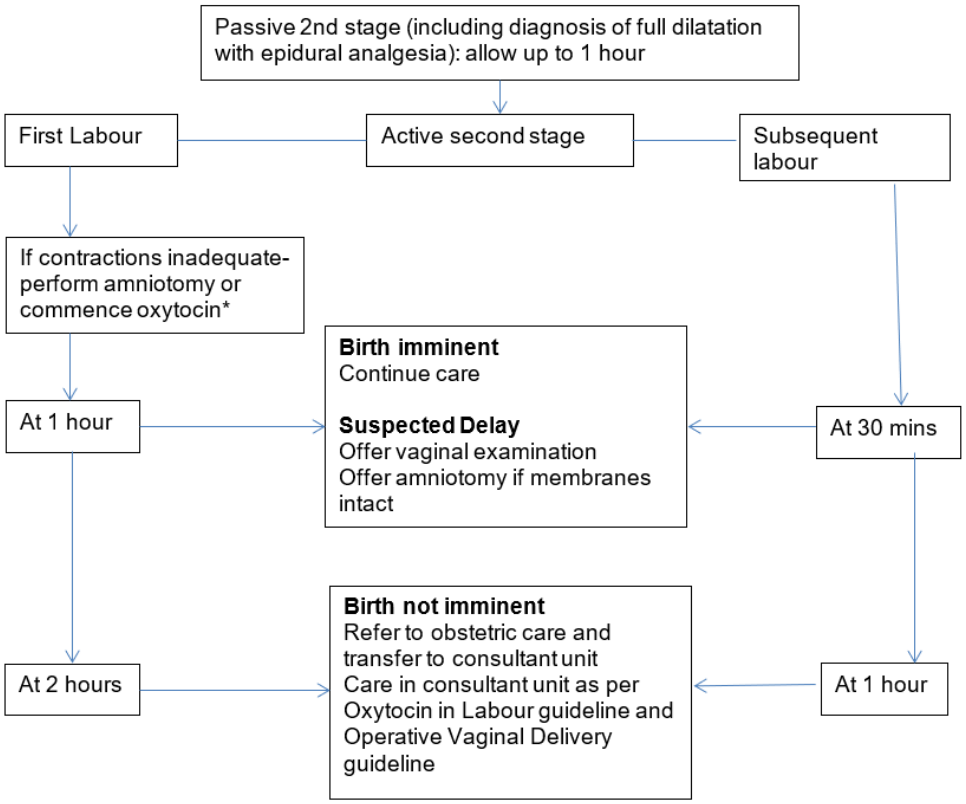
First stage

1. Change position – encourage upright position, avoid lithotomy and recumbent positions
2. Ensure good hydration
3. Ensure bladder empty
4. Consider Artificial Rupture of Membranes
5. Consider referral to obstetric care and transfer to consultant unit
6. Care in consultant unit as per Oxytocin in Labour guideline

Second stage

1. Change position – encourage upright position, avoid lithotomy and recumbent positions
2. Ensure good hydration
3. Ensure bladder empty
4. Support and encouragement

Second stage of labour flowchart:



*** See use in Oxytocin Labour Guideline** http //nww.avon.nhs.uk/dms/download.aspx?did=10474

Pyrexia in labour

Tympanic temperature of >38^{O}C on one occasion or >37.5^{O}C on two consecutive occasions at least an hour apart

- Inform obstetric team
- Commence continuous electronic fetal monitoring
- Administer Paracetamol 1 gram orally or intravenously
- Recheck temperature in 1 hour
  (If at high risk of sepsis such as prolonged rupture of membranes, consider early recourse to antibiotic therapy.)

On rechecking: if temperature still >38ºC or 37.5^{O}C with other signs of maternal infection (e.g. maternal tachycardia, tachypnoea or fetal tachycardia)

- Perform investigations:
  - Blood cultures
  - Full blood count, CRP
  - Throat swab
  - High vaginal swab
  - Midstream specimen of urine
- Commence intravenous antibiotics as per antibiotic policy
- Ensure Neonatologists are aware of concerns re maternal sepsis at delivery as baby may require a septic screen.
- See maternity sepsis guideline
- Commence Modified Obstetric Early Warning Score (MOEWS) chart postnatally Note: Where there is any concern about changes in any maternal observations consider increasing the frequency of the observations and referring for obstetric opinion.

Intrapartum interventions to reduce perineal trauma

- Good communication with the mother to control delivery of the head.
- Do not perform perineal massage or offer lidocaine spray in the second stage of labour
- Warm compress on the perineum during and between the contractions
- RCOG and RCM OASI2 care bundle supports that: At the time of birth and with the woman's consent, the delivering clinician should use their hands to support both the perineum and baby's head (known as manual perineal protection, MPP, hands-on or Finish Grip) while communicating with the woman to encourage a slow and guided birth.
  MPP should be used unless the woman's chosen birth position (i.e. water births) doesn't enable MPP or she declines this technique.
- If clinically indicated and with the woman's consent, an episiotomy should be performed at an angle of 60 degrees from the midline at crowning.

Third Stage of Labour

The third stage of labour is the time from the birth of the baby to the expulsion of the placenta and membranes. To facilitate informed choice all women should have been referred to the third stage

of leaflet labour on the My Pregnancy app. The benefits and risks of each method should be discussed.

NICE 2017 recommend women to have an active management to lower the risk of haemorrhage. The management should also be discussed when they are in labour and their choice confirmed.

Physiological third stage

- No routine use of uterotonic
- Do not clamp or divide the cord until the cord has stopped pulsating
- Avoid controlled cord traction (CCT)
- Deliver the placenta by maternal effort

See over managed third stage

- If baby requires resuscitation
- Women desires to change
- If you suspect an increasing blood loss or post partum

60 minutes

Managed Third Stage

Recommended if the woman has an increased risk of haemorrhage or intervention in labour e.g. IOL, augmentation epidural

- Routine use of uterotonic drugs Oxytocin 10units or syntometrine im with delivery of the anterior shoulder or as soon as possible.
- deferred clamping and cutting of the cord for approximately 2 minutes
- controlled cord traction after signs of separation of the placenta.
- Deliver the placenta by controlled cord traction

30 minutes

Delay in third stage

- Administer uterotonic if not administered
- Empty Bladder
- Consider change of position
- Encourage breastfeeding
- Ensure consent and adequate analgesia and you communicate clearly with the woman
- Perform CCT

Observations

Document maternal observations:

Colour, BP, pulse, temperature, vaginal blood loss

If placenta fails to deliver and or Post -partum Haemorrhage is suspected or maternal collapse occurs

Transfer to an Obstetric Unit for Obstetric Led care and a manual removal of placenta

Active Management of the Third Stage in Women at risk of

Hypertension or with Maternal Cardiac Disease

- If a blood pressure assessment has not been undertaken during labour avoid Syntometrine for a managed third stage of labour.
- Any woman with antenatal evidence of proteinuric hypertension, pregnancy induced hypertension requiring medication, or who has had a blood pressure ≥ 140/90 mmHg during labour will not receive Syntometrine.
- Oxytocinon is used to avoid the blood pressure rise associated with use of Syntometrine.
- A plan for the management of women with cardiac disease should have been made in the antenatal period. A copy of this plan should be in the handheld notes and may suggest 10 units of oxytocin IM or alternately a slow iv injection of 5 units of oxytocin (diluted to total volume of 10ml with normal saline) to be given over 10 minutes followed by an oxytocin infusion of 30 IU (usually in 500ml normal saline – this volume can be reduced if concerns re heart function/failures) over 4 hours.

The Placenta

All placentae that are not required for investigations are placed in a small yellow bag provided in each room and taken to sluice in Central Delivery Suite and placed in the yellow clinical waste bin. The bag must be labelled with the woman's name, date and time (use of a sticker with details on is recommended)

1. **Taking a placenta home**

Any woman wishing to take a placenta home must be told that it is human tissue and therefore an infection risk if not disposed of in a suitable way. It must be disposed of in a safe manner and she must sign in her buff notes that she understands that she is taking responsibility for its disposal.

Lotus birth, or umbilical nonseverance, is the practice of leaving the umbilical cord attached to both the baby and the placenta following birth, without clamping or severing, and allowing the cord the time to detach from the baby naturally. In this way the baby, cord and placenta are treated as a single unit until detachment occurs, generally two to three days after birth.

2. **Cytogenetics**

In the case of a stillbirth or abortion a small portion of the placenta may be sent for cytogenetics if requested by the obstetrician. The transport medium is found in the freezer on CDS in the treatment room. Consent is required by the mother.

3. **Placentae requiring histological examination**

All Placentae should be placed in a bucket of formalin and sent to: The mortuary if a stillbirth or neonatal death has occurred

The BRI Histopathology department with a placental histopathology request if:

- Suspected chorioamnonitis
- Fetal abnormality
- Intra-uterine growth retardation (<2.5kg)
- Preterm <34 weeks
- Birth asphyxia (Apgar <7/10 at 5 mins or arterial cord pH equal to or less than 7.05)

- Unplanned admission to NICU
- Placentae that look abnormal
- Placental abruption
- Vasa praevia
- All multiple pregnancies. The cords must be clearly marked.

It is essential that they are transported in the transport box to comply with health and safety regulations.

This is not an exhaustive list and a clinician (midwife, neonatologist or obstetrician may request placental histology on a case by case basis).

Ensure the ICE system is completed correctly for full histology if the placenta is sent.

Please ensure the name of the consultant is written on the request form it to ensure the report is processed accurately.

NHS University Hospitals Bristol and Weston NHS Foundation Trust

For **all vaginal births:** Were all four components of the OASI Care Bundle* applied to this birth?

❑ Yes
❑ No
❑ Birth not eligible**

* If an episiotomy was **not** indicated and **not** done, tick yes if the other three components were applied
**Birth is not eligible if consent not given, if it is a water birth, if the birth position did not allow for MPP

Date: Time: Signature: Print: Designation:

Commented [Au1]: OASI Bundle sticker copy

Appendix x – Evidence of Learning from Incidents

The following table sets out any incidents/ cases which informed either the creation of this document or from which changes to the existing version have been made.

Incidents	Summary of Learning

Table A

REFERENCES	OASI | RCOG
RELATED DOCUMENTS AND PAGES	
AUTHORISING BODY	CDS Working party
SAFETY	
QUERIES AND CONTACT	[redacted] PDM [redacted]
AUDIT REQUIREMNTS	

Plan Elements	**Plan Details**
The Dissemination Lead is:	
Is this document: A – replacing the same titled, expired SOP, B – replacing an alternative SOP, C – a new SOP:	
If answer above is B: Alternative documentation this SOP will replace (if applicable):	
This document is to be disseminated to:	
Method of dissemination:	
Is Training required:	

Document Change Control

Date of Version	Version Number	Lead for Revisions	Type of Revision	Description of Revision
Mmm yy	0.00	(Job title only)	Major/ Minor	Include ALL changes completed in this revision, including title of section in the document.

Appendix 1 – Sign off process

Once your document has been written, it should go to the relevant group for approval. This might include the Steering Group for the relevant speciality, or the Governance Group for the relevant division, especially if the document covers many different specialities/departments.

If you are unsure of who your document should be signed off by, please contact Clinical Guidelines [redacted] where the team can advise you.

Once your document has been signed off, include the name of the authorising group in **Table A** above and send the document to Clinical Guidelines [redacted] for uploading. Please note: this can take up to **two weeks** to be completed.