Guideline for Intrapartum Care of Women and Babies

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1.0 Introduction

The guideline uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but who are pregnant.

This guideline is designed to provide a framework to enable consistent provision of high quality, evidence based holistic care to pregnant women when Barnsley Hospital NHS Foundation Trust is their chosen place to birth.

All women in labour must be treated with respect and must be in control of and involved in what is happening to them (NICE, 2007). The way that care is given to the women is key to their birth experience. Every childbearing woman in the United Kingdom has the right to midwifery care in labour in whatever environment she chooses.

Labour is a physiological process characterised by an uncomplicated pregnancy with a spontaneous onset of labour between 37 and 42 weeks gestation.

2.0 Objective

The guideline supports the philosophy that women are treated as individuals with care tailored to their specific needs, circumstances and preferences. Women will be empowered and enabled to make informed choices regarding the care they receive.

The aim of this guideline is to provide clear guidance to staff when assessing and caring for women in latent and established labour both by telephone and in person. The guideline is suitable for all women but must be used alongside other guidelines as appropriate.

The guideline encourages a consistent approach whilst not forgetting the uniqueness of each woman's experience and the importance of evidence-based practice, team approach and good communication.

It is also to help facilitate a safe birth for all women, whatever their risk status, with the minimum amount of intervention and maximum amount of support and choice for the woman.

3.0 Scope

All maternity staff caring for women in latent or established labour.

4.0 Main body of the document

4.1 Practice Recommendations

The National Institute for Health and Clinical Excellence (NICE, 2007) state that a woman in established labour should receive supportive one-to-one care.

4.2 Ongoing Risk Assessment

Women who are assessed to be high risk antenatally will be offered an appointment with an obstetrician and may be more suitable to birth in the obstetric unit, however a woman may choose to birth outside of guidance – refer to Supporting maternal choices in pregnancy

Women who have specific medical conditions/issues will be advised to be admitted under obstetric care in labour (**see appendix 2).**

For high risk women in the intrapartum period:

- The midwife will regularly update the BBC coordinator and obstetric registrar
- The Multidisciplinary Team (MDT) including the consultant, registrar and labour ward coordinator will review women during consultant led ward rounds at 09:00hrs and 18:00hrs in line with the Immediate and Essential Actions from the Ockenden Report (2020). If indicated, a further review will take place when the care plan needs to be updated.
- Consultant or senior obstetrician and anaesthetist to be informed on admission / change of lead professional.

Follow NICE Intrapartum Care for women with existing medical conditions or obstetric complications and their babies.

It is important to recognise that women in labour with obstetric complications or no antenatal care may be more anxious than other women in labour and are likely to have a better experience of labour and birth if they receive information about the benefits and risks of options for their care and are fully involved in decision making (NICE, 2019). Choices and decisions may need to be discussed again if problems or changes occur during pregnancy or labour (NICE 2023).

4.3 Definitions:

For the purpose of this guideline, use the following definitions 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 dilation up to 4cm

- Established first stage of labour – when:
  - there are regular painful contractions **and**
  - there is progressive cervical dilation from 4cm (NICE, 2007)

4.4 Latent first stage of Labour

The latent phase of labour requires careful assessment as it may impact upon the prospective care of established labour and the health and wellbeing of the mother and baby.

Inclusion criteria for this guideline applies to low risk women experiencing a normal labour defined as spontaneous in onset between 37 and 42 completed weeks in pregnancy. All women in the

latent phase, who are not low risk, will be reviewed by a senior doctor in the Maternity Assessment Unit and an individual plan of care will be made.

The latent phase of labour must include an assessment of the woman's observations (MOEWS) obstetric risk, parity, uterine contractions, cervical changes, the woman's perception of pain and the woman's social circumstances.

It is important to establish;

- the best place for the woman during this stage (inclusive of maternal choice)
- the recognition of the transition to established first stage of labour
- options for any required pain relief and the woman's psychological wellbeing
- when the woman or baby's condition requires intervention due to the development of risk factors or a deterioration in their condition

Women are encouraged to contact the birthing centre via telephone triage for help, advice and support if they believe they are in labour. An early assessment of labour can be undertaken by telephone provided by a dedicated triage midwife for all women (NICE, 2014). A telephone assessment is performed and consideration must be given to whether the woman requires a face to face assessment on the Maternity Assessment Unit (MAU) or whether to recommend staying at home with a plan to re-evaluate based upon individual need, acknowledging the woman's choice. Clinical judgment-based information gained during the telephone conversation is used to decide if admission and assessment are required.

See Admission To The Maternity Assessment Unit for more information.

4.4.1 Pain relief during the latent Phase of labour Discuss coping strategies for pain:

- Encourage the use of breathing techniques and relaxation
- Encourage the use of water for pain relief and relaxation (warm shower/bath)
- Use distraction (e.g.) listening to music or watching TV
- Use a hot water bottle
- Adopt different positions and use a birthing ball
- Try massage, especially for back pain
- Commence hypnobirthing techniques if planning to use them
- Consider using a TENS machine

Pharmacological pain relief available:

- **Paracetamol** – women can self-medicate at home but must be made aware of safe dosage and frequency of medication. See table in section 4.7.2
- **Codeine phosphate** – prescribed medication, see table in section 4.7.2 for dosage and frequency of medication
- **Oramorph 10mgs** – Can be offered as a once only dose to a primigravida at term with no evidence of fetal or maternal compromise. The woman must remain in hospital for 1 hour after administration. Maternal and fetal observations and assessment of contractions must be completed prior to discharge.

NB – the midwives must identify any drug allergies and ensure drugs are prescribed unless they are governed by a PGD. All drugs must be recorded on the drug chart as per Medications Using PGD And ME By Midwives - Maternity

4.4.2 Women who go home

Following an individualised risk assessment (appendix 3). The latent phase risk assessment tool is to help determine the care offered to low risk women. The tool is not prescriptive; women's individual circumstances will vary. The woman's choice and the midwives clinical judgement remain key elements when determining care

The tool is to be used for low risk women following a comprehensive assessment of maternal and fetal wellbeing (as per guideline for admission to triage). The women must fulfil the following criteria:

- Spontaneous labour between 37 and 42 weeks
- Cephalic presentation
- No evidence of SROM
- Maternal and fetal observations within normal parameters

The risks and benefits of being home during the latent phase of labour should be discussed and documented within the woman's Electronic Patient Record (EPR).
Being at home in her normal environment will encourage the production of oxytocin and endorphins.
The woman's choice and the midwife's clinical judgement remain key elements when determining care

Women should be encouraged to carry on with normal daily activities as much as possible:

- Remain mobile – go for a walk
- Try to sleep/rest/nap
- Keep well hydrated
- Eat well in order to maintain energy levels during in labour
- Monitor fetal movements

Discuss:

- Braxton Hicks contractions and the latent phase of labour in relation to the diagnosis of active first stage
- Help and support at home and the woman's ability to return to the Birthing Centre when established in labour

Give advice regarding the circumstances in which the woman must recontact the Birthing Centre/ Maternity Assessment Centre:

- Feels unable to cope with contractions irrespective of strength and frequency
- Constant abdominal pain
- SROM
- Any vaginal bleeding
- Diminished fetal movements

- General malaise
- Signs of maternal fever
- Headaches, visual disturbances

If a woman, following assessment, is found not be in established labour but is having painful contractions:

- recognise that a woman may experience painful contractions without cervical change, and although is described as not being in labour, she may well think of herself as being 'in labour' by her own definition.
- offer her individualised support, and 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 (Nice 2014).

Do not offer or advise aromatherapy, yoga or acupressure during the latent phase for pain relief but respect the wishes of any women who wish to use these methods (NICE, 2014).

The woman must be offered the following leaflets:

- Latent Phase of Labour leaflet
- Preparing for birth leaflet number 3: Relaxation
- Preparing for birth leaflet number 4: Giving birth

The woman must be informed prior to discharge that she can telephone the Birthing Centre / Maternity Assessment Centre for advice and support at any time.

The triage midwife must document the guidance that she gives the woman on the appropriate BSOTS entry within the woman's EPR.

4.4.3 Woman who remain in hospital

One to One Care

Women who score >12 for primigravidas or >13 for multigravidas on the latent phase risk assessment tool will require one to one care and be commenced on a partogram. (**Appendix 3)**

4.4.4 Transfer to the Antenatal/Postnatal Ward (ANPN)

Low risk women admitted in the latent phase of labour and the following minimal observations are recommended:

- Maternal observations – 12 hourly
- Assessment of contractions and general wellbeing – 4 hourly
- Pain assessment and options available – 4 hourly
- Fetal auscultation – 4 hourly

A comprehensive assessment of the woman and her plan of care must be undertaken by the midwife after 4 hours and documented in the woman's EPR. A medical review of the plan of care

by a Registrar must be undertaken after 8 hours. At this stage acceleration of labour must be considered if progression has not occurred

The Latent phase assessment tool **(Appendix 3)** can be used to determine a plan of care.

Please note – it is **not** always necessary to perform a vaginal examination prior to using the assessment tool. If a vaginal examination is not clinically indicated please use the score from the last vaginal examination performed.

The above timescales are minimum requirements with the understanding that midwifery care and/or medical intervention will be given more frequently should the woman's condition suggest intervention is required.

Whilst it is recognised that the duration of the latent phase of labour is variable and difficult to quantify, during assessments consideration must be given to the possibility of an obstructed labour.

All high risk women must have a prompt Obstetric Registrar or above review for documented plan of care before transfer to the ANPN ward.

4.4.5 Women who have Subsequent Admissions

It is feasible that a woman in the latent phase of labour may be discharged from triage or the ANPN. The woman will be advised to contact the Birthing Centre if she needs advice and support and where applicable, re-admission will be arranged.

If re-admission is required the woman will be admitted to triage. Any previous EPR of admissions will be reviewed including the telephone triage entries as these may be relevant in the formulation ongoing plan of care.

A comprehensive assessment will be made (as above) and the plan of care reviewed. The woman's risk status will be reviewed and the plan of care adapted accordingly.

Transfer home, transfer to the ANPN/Birthing centre will be determined as before.

Advice from a consultant must be sought if obstructed labour is suspected.

4.5 On Admission - All Women

When performing an initial assessment of a woman in labour, listen to her story and take into account her preferences and her emotional and psychological needs. (NICE, 2022)

Involve the woman in planning her care by asking about her preferences and expectations for labour and birth. Take account of previous discussions, planning, decisions and choices, and keep the woman and her birth partner(s) fully informed (NICE, 2019).

Part of the admission procedure must be to ensure that the woman's birth partner(s) are familiar with the environment and know for example, where to obtain refreshments and where the toilets are located.

Please note that the woman's parity is a factor to be considered when using the assessment tool and agreeing upon a plan of care.

Carry out an initial assessment to determine if low risk care is suitable for the woman, irrespective of any previous plan. The assessment must comprise the following:

- obtain a clinical history and review the woman's records on Care flow including antenatal screening results
- ask about length, strength and frequency of contractions
- assess the woman's pain and discussion of options for pain relief
- ask the woman about her baby's movements, including any changes

Include the following in any assessment of labour:

- ask the woman how she is, and about her wishes, expectations and any concerns she has.
- give information about what the woman can expect in 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.

Provide information to the woman and her birth partner(s) about care in labour and mode of birth, which:

- Is personalised to the woman's circumstances and needs.
- Uses local and national figures where possible.
- Expresses benefits and risks in a way that the woman can understand.
- Is presented as recommended in the NICE guideline on patient experience in adult NHS services. (NICE, 2019).

Where English is not the woman's first language, the need for an interpreter must be determined and an interpreter sought either via telephone or in-person. The use of family/birth partner as interpreter must be avoided.

4.5.1 Physical Observations (Maternal)

- Temperature, pulse, blood pressure, respiratory rate and urinalysis. (This information must be documented on the maternity obstetric early warning system **MOEWS** element within the woman's EPR with a full MOEWS being assessed, including O2 sats).
- Abdominal palpation – fundal height, lie, presentation, engagement, position, station and frequency and duration of contractions.
- Vaginal loss – show, liquor, blood.

4.5.2 Fetal Wellbeing

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

- Have there been any previous admissions for reduced fetal movements, if so, how many? Refer to the Reduced Fetal Movement Guideline if the woman has experienced reduced fetal movements.
- Auscultate the fetal heart rate:
  Use either a pinnard stethoscope or doppler ultrasound
  Carry out auscultation immediately after a contraction for at least 1 minute and record it as a single rate
  Record accelerations and decelerations if heard
  Palpate the maternal pulse to differentiate between the maternal and fetal heartbeats. (NICE 2017).

Women who are risk assessed as "low risk" do **not** require an admission CTG. *If, however, a woman is admitted more than once in the latent phase of labour, an admission CTG must be considered.* Where a low risk woman has an admission CTG, the rationale for this must be clearly documented within her EPR.

To determine the most appropriate means of fetal heart rate monitoring in labour please refer to the Guideline For Fetal Auscultation (Including Electronic Fetal Monitoring) appendix 2.

4.5.3 Vaginal Examination

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. (NICE, 2017)

Where there is a need to confirm ruptured of membranes a sterile speculum must be used in place of a vaginal examination. (**See separate guideline for the** Pre Labour rupture of Membranes at Term).

All information regarding the initial assessment including MOEWS must be documented appropriately within the woman's EPR.

4.6 Care of Women Who Have Received No Antenatal Care (NICE, 2019)

If possible, take a full medical, psychological and social history and try to find out why there has been no care during pregnancy. She will need to have an EPR created and this can be documented within the 'short booking' element.

Explore sensitively any possible vulnerability or safeguarding concerns, including:

- Young maternal age
- Maternal mental health
- Maternal learning disability
- Maternal substance misuse
- Domestic or sexual abuse
- Homelessness
- Human trafficking
- Undocumented migrant status
- Female genital mutilation

- The woman or family members being known to children's services or social services.

Carry out an assessment of the unborn baby, including ultrasound if possible, to determine:

- Viability
- The presentation
- An estimate of gestational age
- The possibility of multiple pregnancy
- The placental site.

Offer women who have had no antenatal care routine booking bloods as per the Antenatal Care - Maternity guideline. A rapid HIV screen must also be sought from women thought to be at high risk of infection.

Explain to a woman who has had no antenatal care why and when information about her pregnancy may need to be shared with other agencies. Contact the woman's GP and, if appropriate, other health or social care professionals for more information about the woman's history and to plan ongoing care.

Obstetric-led intrapartum care must be provided for women who have had no antenatal care and if required ensure that both the neonatal and anaesthetic team are aware.

A referral to social services must be made for all women who present in labour and have received no antenatal care. The reasoning for this must be fully explained to the woman and this must be documented on the woman's electronic maternity record.

4.7 Transfer to Obstetric Led Care

Ongoing risk assessment may initiate transfer to obstetric led care rather than midwifery led care if any of the risk factors in **appendix 4** arise.

If any of these risk factors arise as birth is imminent a CTG must be commenced and the coordinator made aware immediately. The coordinator must then alert the Registrar or Consultant Obstetrician.

4.8 Coping with Pain in Labour

Many factors will influence the way which a woman is able and/or wishes to cope with pain during labour. It is essential that every woman is given as much information as possible about the options that are available, and that she is supported in her chosen method.

At the onset of active labour or induction of labour there must be a documented discussion with the woman about her choices for pain relief recorded within her EPR careplan.

4.8.1 Non-pharmacological methods

- Include support from a birthing partner, breathing and relaxation techniques, massage, birthing balls, music and water birth. Inform women that there is insufficient high-quality evidence to either support or discourage giving birth in water (NICE, 2007) (see waterbirth guideline Use Of Water In Labour.)

- If a woman chooses to use breathing and relaxation techniques in labour support her in this choice. Support the playing of music of the woman's choice.

- If a woman chooses to use massage techniques in labour that have been taught to birth companions, support her in this choice (NICE, 2007)

- Do not offer Transcutaneous Electrical Nerve Stimulation (TENS) to women in established labour (NICE, 2007)

- Do not use injected water papules (NICE, 2007)

- Do not offer acupuncture, acupressure or hypnosis however, women who wish to use these techniques must not be prevented from doing so (NICE, 2007). Any use of these must be documented in the partogram .

Inform women that the following interventions during intrapartum care have also not been shown to influence the likelihood of caesarean birth, although they can affect other outcomes:

- Walking in labour
- Non-supine position during the second stage of labour
- Immersion in water during labour
- Epidural analgesia during labour
- The use of raspberry leaves. (NICE, 2021).

4.8.2 Pharmacological Pain Relief in Labour - Methods of Pain Relief Oral Analgesia

Women with mild to moderate pain in labour can be offered simple oral analgesia often in combination with non-pharmacological methods such as relaxation, a warm bath. This particularly applies to women being induced or not yet in established labour. The options include:

Mild Pain	Paracetamol	ORAL / PR	Paracetamol dosage is dependent on the weight of the woman (see table below)	
Moderate Pain	Codeine Phosphate	Oral	30 - 60mg every 6 hours	Max 240mg (8 tablets) in 24 hours. Consider only two separate doses

Patient Weight	Oral/IV Paracetamol dosage
50kg and above	1g every 4 - 6 hours, maximum 4g in 24 hours
35 - 49kg	500mg every 4 – 6 hours, maximum 2g in 24 hours
Under 35kg	Contact Medicines Information

4.8.3 Inhalational Analgesia

Entonox (a 50:50 mixture of nitrous oxide and oxygen) is rapid acting, non-accumulative and does not harm the baby. Evidence suggests that it is moderately effective in labour and may be offered to any woman but is not appropriate for women in the latent phase of labour. It is self-administered and available in every birthing room. Entonox may cause increased nausea and light headedness and women must be informed of these side effects when discussing it as an option for pain relief. If used in the birthing pool, mothers need to be aware that they may require physical support due to the side effects mentioned. In addition, when used for prolonged periods, it causes fluid loss from the upper airways and additional fluid intake must be encouraged.

4.8.4 Parenteral Opiates

Diamorphine/Pethidine are narcotic analgesics given intramuscularly during labour for pain relief. They can be administered by a midwife during the course of her professional practice according to the exemptions laid down in the Medicines Act 1968. The dose may be repeated after 4 hours but repeated doses need prescribing by a doctor.

Women must be informed that opiates will only provide limited pain relief during labour and may have significant side effects for both herself and her baby. This includes maternal drowsiness, nausea and vomiting, and neonatal respiratory depression and drowsiness which may last a few days. They may also interfere with breastfeeding (NICE, 2007)

If an opioid is used, it is advisable to administer an antiemetic. (NICE, 2007)

Women must not enter the water within 2 hours of opioid administration or if they feel drowsy (NICE 2007).

4.8.5 Naloxone

Naloxone is used to reverse opiate side-effects in the mother, in particular respiratory depression, and must be immediately available on all wards. Staff must be aware of its location and the procedures around its administration.

4.8.6 Epidural Analgesia – Refer to Anaesthetic Guidance For Epidural Analgesia In Labour

Women in labour who desire regional analgesia must not be denied it, including women in severe pain in the latent first stage of labour (NICE 2007). A documented conversation enabling women to make an informed choice and ensure an appreciation of the risks and benefits must occur prior to using regional analgesia.

Provide information about epidural analgesia, including the following:

- It provides more effective pain relief than opioids.
- It is not associated with long-term backache.
- It is not associated with a longer first stage of labour or an increased chance of a caesarean birth. • It is associated with a longer second stage of labour and an increased chance of vaginal instrumental birth.
- It will be accompanied by a more intensive level of monitoring and intravenous access, and so mobility may be reduced. (NICE 2007, amended 2014)

Once informed the anaesthetist will aim to attend the Birthing Centre to perform the epidural within 30 minutes. The time between receiving the request and performing the epidural must not exceed 60 minutes unless there are exceptional circumstances as per our local guidelines. If the anaesthetist is likely to be more than 30 mins, consider your first on call Anaesthetist (if they have obstetric competencies) or inform the consultant Anaesthetist on call.

4.9 Care in the First Stage of Labour

Labour is confirmed when a woman has regular contractions in association with progressive dilatation and effacement of the cervix. Once labour is established, a partogram must be commenced.

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. (NICE, 2007) In addition to the EPR partogram, clinical note entries, written in retrospect must clearly state this together with the time and date and the time that the entry refers to.

It is vital that women are treated as individuals and their care planned in collaboration. Where there are deviations from the guidance this must be clearly documented.

It is of vital importance to consider a woman’s emotional and psychological desire for pain relief. Women must be encouraged to communicate their needs throughout labour.

Care must be taken to ensure women change position regularly throughout labour, to reduce the risk of pressure sores developing. Ensure position changes are clearly documented within the woman’s EPR ‘Labour and Birth’.

See the next page for table of the first stage of labour observations

If there is a raise in the baseline fetal heart rate or decelerations are suspected on intermittent auscultation, actions must include:

- Carrying out intermittent auscultation more frequently, for example after 3 consecutive contractions initially
- Thinking about the whole clinical picture, including the woman's position and hydration, the strength and frequency of contractions and maternal observations.

If a rising baseline or decelerations are confirmed, further actions must include:

- Summoning help
- Advising continuous cardiotocography, and explaining to the woman and her birth companion(s) why it is needed
- Transferring the woman to obstetric-led care, provided that it is safe and appropriate to do so. (NICE, 2017).

Please refer to Fetal heart rate monitoring guideline further advice regarding fetal monitoring.

Observations in the Established First Stage of Labour to be documented on the EPR partogram		
Maternal Observation	**High Risk Women Frequency**	**Low Risk Women Frequency**
Temperature	4 hourly If over 37.5 ºC then repeat hourly until normal and refer to medical staff	4 hourly If over 37.5 ºC then repeat hourly until normal and refer to medical staff
Blood pressure (BP)	4 hourly	4 hourly
Maternal pulse	1 hourly	1 hourly
Colour of amniotic fluid	Hourly and at each vaginal examination (VE)	Hourly and at each vaginal examination (VE)
Uterine contractions Duration strength & frequency	Every 30 minutes	Every 30 minutes
Urine (test all specimens including for ketones)	Encourage woman to pass urine regularly and at least every 4 hours	Encourage woman to pass urine regularly and at least every 4 hours
Fetal Observation	**High Risk Women Frequency**	**Low Risk Women Frequency**

Fetal Heart rate (FHR)	Continuous fetal monitoring	• Intermittent auscultation with a pinard or Doppler ultrasound • Every 15 minutes • Immediately after a contraction for at least 1 minute, at least every 15 minutes, and record it as a single rate • Record accelerations and decelerations if heard.
Observations in the Established First Stage of Labour		
Documentation		
• All maternal and fetal observations must be documented on the partogram. • Fetal heart rate must be documented every 15 minutes on the partogram, for both continuously monitored and intermittently auscultated women • Clearly document maternal position changes throughout labour		

4.9.1 Vaginal Examination

Women must be offered 4 hourly vaginal examinations to assess progress or more frequently if there are concerns in labour or in response to women's wishes. Vaginal examinations must only be offered when the information they provide will add important information to the decision making process (NICE, 2007).

When a vaginal examination is performed an abdominal palpation must also be undertaken, first noting the presentation and engagement of the presenting part.

Healthcare professionals who conduct vaginal examinations must:

- Ensure the woman's consent, privacy, dignity and comfort.
- Offer a chaperone (the name of the birth partner/s must be documented).
- Explain the reason for the examination and what will be involved.
- Explain the findings and their impact to the woman in a sensitive manner.

Consent and all findings must be documented in the birth record. As a minimum, findings must include:

- Dilatation and effacement of the cervix.
- Station of the presenting part.

- Position of baby.
- Colour of the liquor or confirmation of the presence of membranes.
- Presence of any caput / moulding.

Vaginal examinations must be clearly documented on the vaginal examination element of the woman's EPR.

4.9.2 Slow Progress

The duration of labour varies and is influenced by parity. 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. (NICE, 2007).

A diagnosis of delay in the established first stage of labour must take into consideration all aspects of progress and must include:

- Cervical dilatation of less than 2cm in 4 hours for first labours
- Cervical dilatation of less than 2cm in 4 hours or a slowing of the progress of labour for second and subsequent labours
- Descent and rotation of the fetal head
- Changes in the strength, duration and frequency of uterine contractions.

Do not routinely offer the following as they do not influence the likelihood of caesarean birth for slow progression in labour, although they can affect other outcomes:

- Active labour (comprising a strict definition of established labour, early routine amniotomy, routine 2-hourly vaginal examination, oxytocin if labour becomes slow).
- Early amniotomy (NICE, 2021).

4.9.3 Interventions for Delay in the First Stage of Labour

When assessing the progress of labour where there is a delay then the following must be considered:

- Parity.
- Cervical dilatation and rate of change.
- Uterine contractions.
- Station and position of presenting part.
- The woman's emotional state.
- Escalation for face to face obstetric review.

All women with a delay must be offered:

- Support
- Consider hydration (with appropriate fluid balance)
- Appropriate and effective pain relief.

Women (and their birth partners – if appropriate) must be kept informed at all times to enable informed choice.

4.9.4 Amniotomy (ARM)

- In all women with intact membranes where there is delay in the first stage of labour is confirmed, an amniotomy must be considered.
- Women need to be given an explanation, of the procedure, with advice that it will shorten labour by approximately 1 hour, but may increase the strength and pain of her contractions.
- Following an amniotomy, a vaginal examination must be undertaken 2 hours later, to ensure labour is now progressing normally.
- If progress is not made then a medical review must be obtained (ST3 or above) and a plan of care documented in the labour and birth element of the EPR. This may include the use of oxytocin.

Do not perform an ARM in a normally progressing labour (NICE, 2007).

- Where an ARM has been performed the rationale must be clearly documented within the women's EPR as a clinical note.
- It must also be noted that progress in labour is not only assessed on the dilation of the cervix but also on other relevant factors for example the decent of the fetal head.

4.9.5 Oxytocin

Please refer to the guideline for Induction Of Labour

4.9.6 Bladder Care

- Inform woman in labour of the importance of emptying her bladder regularly
- The bladder must be emptied by normal voiding or by intermittent catheter regularly and the volume and urinalysis documented in the EPR birth record-fluid input/output .
- Urinalysis of voids must be documented in the women's EPR and action taken for any anomalies after discussion with a senior midwife or coordinator as appropriate.
- Consider indwelling catheter in discussion with the woman, at the second intermittent catheterisation if birth not imminent (increased risk of introducing infection with repeated catheterisation).
- Remove indwelling catheter at the beginning of second stage if applicable.
- A fluid balance chart must be commenced for all women who are receiving intravenous fluids or that where reduced urine output is suspected and the woman closely monitored for evidence of hyponatraemia.

4.9.7 Controlling Gastric Acidity and Nutrition in Labour

- Neither H2-receptor antagonists nor antacids must be given routinely to low-risk women, but must be considered for women who have received opioids or who have or developed risk factors that make a general anaesthetic more likely (NICE, 2007)
- Women must be encouraged to drink during established labour and be informed that isotonic drinks may be more beneficial than water

- Low risk women may eat a light diet in established labour unless they have received opioids or develop risk factors that make a general anaesthetic more likely (NICE, 2007).

Those women deemed high risk must be given an initial oral dose of Omeprazole 40mg , then a 20mg dose orally every 12 hours.

4.9.8 Women Whose Baby is at an Increased Risk of Neonatal Infection

To maintain communication with a woman in labour whose baby is at increased risk of early onset neonatal infection:

- Involve the woman in any handover of care, either when additional expertise is brought in because of the risk of infection or during planned changes in staff
- Include an update in the handover about the presence of any infection.

See the guideline for the plan of care for women and neonates for the prevention of Early Onset Neonatal Infection Including GBS

Intrapartum antibiotics

- Offer antibiotics during labour to women who:
- Have group B streptococcal colonisation, bacteriuria or infection during the current pregnancy (see Early Onset Neonatal Infection Including GBS).
- Have had group B streptococcal colonisation, bacteriuria or infection in a previous pregnancy, and have not had a negative test for group B streptococcus by enrichment culture or PCR on a rectovaginal swab samples collected between 35 and 37weeks' gestation or 3-5 weeks before the anticipated delivery date in the current pregnancy.
- Have had a previous baby with an invasive group B streptococcal infection.
- Are in pre-term labour.
- Have a clinical diagnosis of chorioamnionitis. (NICE, 2021).

Give the first dose of antibiotics as soon as possible after labour starts (or as soon as infection is suspected, in the case of chorioamnionitis), and continue until the birth of the baby.

Inform neonatologist in the event of postnatal maternal sepsis to allow consideration of neonatal antimicrobial treatment.

4.10 Care in the Second Stage of Labour

There is accepted to be two phases in the second stage of labour:

The Definition of the Second Stage of Labour
The second stage of labour begins on confirmation of full dilatation from vaginal examination with or without expulsive contractions.
If the progress of labour gives reason to believe that the cervix is not fully dilated, a vaginal examination must be performed

Passive second stage of labour	Active second stage of labour
This is defined as: The finding of full dilatation of the cervix prior to, or in the absence of involuntary expulsive contractions.	*This is defined as:* - When the baby is visible - And / or there are expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix - And / or there is active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions.

4.10.1 Nulliparous woman

Birth would be expected to take place within 3 hours of the start of the active second stage in most women.

A woman with no urges to push must be reassessed after one hour where further suggestions of care could be made. For example; alteration in position, full assessment of contractions strength and regularity, maternal hydration.

While maternal and fetal conditions are satisfactory and there is clear progress with descent of the presenting part, there are no grounds for intervention.

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 offer amniotomy if the membranes are intact. (NICE, 2014).

NICE guidelines (2007) state “a diagnosis in a delayed second stage of labour must be made following 2 hours of **ACTIVE** second stage. At this point a woman must be referred to a registrar for in person review.

4.10.2 Multiparous woman

Birth would be expected within 2 hours of active second stage. A diagnosis of delay must be made after 1 hour and referral made to an Obstetric Registrar or Consultant Obstetrician.

Limited quality of evidence makes it difficult to assess the significance of prolonged second stage (NICE 2007). There is little ground for intervention while maternal and fetal conditions are satisfactory and there is clear progress with descent of the presenting part.

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 amniotomy if the membranes are intact. (NICE, 2014)

Observations for BOTH passive and active second stage are as below:

Observations in the Second Stage of Labour to be documented on the EPR partogram	
Maternal Observation	**Frequency**
Temperature	4 hourly (If over 37.5 ºC then repeat hourly until normal and refer to medical staff)
Blood pressure (BP)	1 hourly
Maternal pulse	Palpate the maternal pulse every 15 minutes to differentiate between maternal and fetal heart rate
Colour of amniotic fluid	Every 30 minutes
Uterine contractions: • Duration • Frequency	Every 30 minutes
Abdominal Palpation	Prior to vaginal examination
Vaginal examination	Offer hourly in active second stage
Urine (test all specimens for ketones)	As necessary (encourage woman to a pass urine every 2 hours)
Fetal Observation	**Frequency**
Fetal heart rate (FHR)*	• Every 5 minutes for intermittent auscultation • Every 15 minutes for continuous EFM.

4.10.3 Positions for second stage

- Discourage from lying supine or semi-supine and encourage her to adopt any other position that she finds most comfortable (NICE, 2007)
- Inform the woman that in second stage she should be guided by her own urge to push (NICE, 2007)

4.10.4 Pushing

There is no high-level evidence that directed pushing affects outcomes. Women must be informed that they need be guided by their own urge to push. If pushing is ineffective, or if requested by the woman, then strategies to assist birth can be used. These include:

- Support
- Change of position

- Emptying the bladder
- Encouragement • Adequate Hydration
- Pain Relief.

Continue to take the woman's emotional and psychological needs into account. (NICE, 2007)

Assess progress, which must include the woman's behaviour, the effectiveness of pushing and the baby's wellbeing, considering 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. (NICE 2014) Placing a woman's legs **in lithotomy** for second stage is outdated, poor practice, uncomfortable for women and can cause vasoconstriction and therefore fetal compromise. There is NO evidence to suggest descent is quicker or a normal birth more likely.

4.10.5 Episiotomy and Perineal Care

Interventions to reduce perineal trauma must be based on the following advice / recommendations:

Intrapartum perineal massage – Do not perform perineal massage in the second stage of labour (NICE, 2007**)**

Hand position during the birth of the baby – For spontaneous births, manual perineal protection (MPP) must be used unless the woman declines, or her chosen position/ place for birth doesn't allow MPP e.g. the birthing pool
For assisted births, manual perineal protection must be used.
Please refer to the guideline for Perineal Tear Repair, for images of how to perform MPP. For documentation, please use the PEACHES approach see appendix 5 and document under 'perineal repair' within the woman's EPR.

Episiotomy - A routine episiotomy must not be carried out during spontaneous vaginal birth. Where 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 must be 60 degrees at the time of the episiotomy. An episiotomy will be performed if there is a clinical need e.g. fetal distress, delayed 2nd stage, cases where a severe tear is judged to be imminent or instrumental delivery, with the woman's consent. Episiotomy must be performed for all nulliparous women undergoing an instrumental delivery (RCOG, OASI Care Bundle 2018) with maternal consent.. Tested effective analgesia must be provided prior to carrying out an episiotomy, except in an emergency due to acute fetal compromise (NICE 2007). Documentation of this discussion must be completed in the woman's EPR.

Previous 3rd / 4th degree tears - in order for a woman who has had previous third- or fourth degree trauma to make an informed choice, discuss with her about any future mode of birth, 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
- labour plan of care. [2007]

FGM - 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. (NICE, 2007). Please see the FGM policy for more information Female Genital Mutilation - FGM

Warm Compresses - Where possible apply warm compresses to the perineum (continuously between contractions) during the second stage.

4.10.6 Interventions for perceived delay in the second stage of labour

When assessing the progress of labour where there is a perceived delay then the following must be considered:

- Parity
- Uterine contractions
- Station and position of presenting part
- The woman's emotional state.

All women with a perceived delay must be offered:

- Support
- Hydration
- Appropriate and effective pain relief • Review by the obstetric ST3 or above.

4.10.7 Oxytocin in the Second Stage of Labour

Consideration must 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. (NICE, 2007) Commencing oxytocin at this stage must not be undertaken without a face to face assessment by the obstetric registrar or consultant. Use oxytocin with extreme caution in multiparous women.

4.11 Care in the 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. There must be a discussion with the woman of the plan of care and the risk factors involved to support women with their choice. Document in the EPR the decision that is agreed with the woman about her plan of care for the third stage. (NICE, 2014).

The Definition of the Third Stage of Labour	
The third stage of labour is defined as the time from the birth of the baby to the expulsion of the placenta and membranes.	
Active	**Physiological**

This is defined as: Active care of the third stage involves a package of care which includes all of these three components: - Routine use of uterotonic drugs - Deferred clamping and cutting of the cord if baby condition allows - Controlled cord traction.	*This is defined as:* Physiological care of the third stage involves a package of care which includes all of these three components: - No routine use of uterotonic drugs - No clamping of the cord until pulsation has ceased - Delivery of the placenta by maternal effort.

The third stage of labour is diagnosed as prolonged if not completed within:

- 30 minutes of the birth of the baby with active care
- 60 minutes of the birth of the baby with physiological care.

Midwives must be competent in both active and physiological care of the 3rd stage of labour and must be clear about the components of physiological care in order to ensure safe practice.

4.11.1 Physiological

Women may elect to have a physiological third stage and they must be fully informed of the risks and benefits of this decision. Physiological third stage of labour must be actively supported in women who have been assessed as low risk for postpartum haemorrhage. Physiological care 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. (NICE, 2014)

Changing from physiological care to active care of the third stage is indicated in the case of:

- Haemorrhage
- Failure to deliver the placenta within 1 hour
- The woman's desire to artificially shorten the third stage.

Following the birth of the baby:

- At the birth, place baby at the level of the fundus to prevent polycythaemia and initiate breast feeding, this encourages the production of oxytocin.
- Ensure the mother is in an upright position preferably sitting to use gravitational aid.
- Do not touch the cord or be tempted to check that it has stopped pulsating as this interferes with the physiology of this phase and is a predisposing factor to PPH.
- Inform medical staff or senior midwifery staff if there is excessive blood loss.
- The mother will then have the urge to push and deliver the placenta by maternal effort into a receiver; the cord can then be clamped and cut.
- If after 1 hour the placenta has not been delivered it may be necessary to revert to active care, discuss this with senior midwifery staff or medical staff.
- If removal of the baby and early clamping and cutting the cord occurs before the cord stops pulsating, thus compromising the physiological process, then active care must be recommended to the mother and her consent obtained.

4.11.2 Maternal Observations in the Third Stage of Labour - Physiological Care

The midwife must closely observe the woman in the third stage of labour to assess her general physical condition, as shown by her colour, respiration and her own report of how she feels and the amount of vaginal blood loss. If the third stage of labour lasts for 15 minutes or less, there is no need to document these observations unless there is a deviation from normal. However, observations must be commenced if the third stage is not completed after 15 minutes and documented in the observations record, within the EPR, every 15 minutes until the third stage is complete.

Observations - Third Stage of Labour - Physiological Care		
Maternal Observation	**Frequency**	**Documentation**
	*For the first 15 minutes following birth:	Observe closely however this does not require documenting in the labour & birth record
- The woman's general physical condition, as shown by her: - colour, - respiration - her own report of how she feels - Vaginal blood loss.	*At 15 minutes	These observations must be documented in the labour & birth record
	*At 30 minutes	These observations must be documented in the labour & birth record
	*At 45 minutes	These observations must be documented in the labour & birth record
	*At 60 minutes	These observations must be documented in the labour & birth record
For both active and physiological care of the 3rd stage of labour whilst the placenta is in situ the mother must not be left unattended.		
***** If there is evidence of haemorrhage, retained placenta or maternal collapse then a full MOEWS assessment must be undertaken and the frequency of observations increased to every 10 minutes to assess the need for resuscitation. These must be plotted onto a MOEWS chart and appropriately scored and managed.		

4.11.3 Active Care

Women must be informed that active care of the third stage is associated with a lower risk of a postpartum haemorrhage and/or blood transfusion and includes the use of Oxytocin, clamping and cutting of the cord and controlled cord traction. Inform the woman that the use of oxytocin is associated with fewer side effects than oxytocin plus ergometrine (NICE, 2014).

Explain to the woman that active care:

- Shortens the third stage compared with physiological care
- Is associated with nausea and vomiting in about 100 in 1,000 women
- Is associated with an approximate risk of 13 in 1,000 of a haemorrhage of more than 1 litre
- Is associated with an approximate risk of 14 in 1,000 of a blood transfusions (NICE, 2014)

Active Care

- Use Syntocinon for women with no risk factors for postpartum haemorrhage as it is associated with fewer side effects than Syntometrine (NICE 2014). Administer 10 IU of Syntocinon (IM) with the delivery of the anterior shoulder or immediately after the birth of the baby before the cord is clamped and cut.
- Women with risk factors for postpartum haemorrhage should be given Syntometrine unless the administration of Ergometrine is contra-indicated.
- Ergometrine should not be given to women with the following conditions:
    - Cardiac disease
    - Hypertensive disorders
    - Raynaud's disease
    - Severe asthma
- Following this the cord must then be clamped and cut. 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 or the baby has a heartbeat below 60 beats/minute. (NICE 2014).
- Clamp the cord before 5 minutes, unless the woman requests it to be later, in which case support her choice.
- Attention must be paid for signs of separation: cord lengthening, trickle of blood
- Guard the uterus with the non-dominant hand
- Secure a clamp to the cord at the introitus
- Using the dominant hand use continuous slightly downward traction to facilitate delivery of the placenta and place in a receiver.

4.11.4 Maternal Observations in the Third Stage of Labour - Active Care

The midwife must closely observe the woman in the third stage of labour to assess her general physical condition, as shown by her colour, respiration and her own report of how she feels and the amount of vaginal blood loss. If the third stage of labour lasts for 15 minutes or less, there is no need to document these observations unless there is a deviation from normal. However, observations must be commenced if the third stage is not completed after 15 minutes and documented in the birth record every 15 minutes until the third stage is complete.

The woman must not be left unattended until the third stage is complete whichever method has been utilised.

Observations - Third Stage of Labour - Active Care		
Maternal Observation	**Frequency**	**Documentation**
- The woman's general condition, as shown by her: The woman's general physical condition, as shown by her: - Colour - Respiration - Her own report of how she feels. - Vaginal blood loss. Vaginal blood loss.	* For the first 15 minutes following birth	Observe closely, however this does not require documenting in the labour & birth record
	* At 15 minutes	These observations must be documented in the labour & birth record
	* At 30 minutes	These observations must be documented in the labour & birth record
For both active and physiological care of the 3rd stage of labour whilst the placenta is in situ the mother must not be left unattended.		

If there is evidence of haemorrhage, retained placenta or maternal collapse then a full MOEWS assessment must be undertaken and the frequency of observations increased to every 5-15 minutes to assess the need for resuscitation. These must be plotted onto a MOEWS chart and appropriately scored and managed.

4.11.5 Retained Placenta

Please refer to the Management Of A Retained Placenta for plan of care.

4.11.6 Delayed cord clamping

Women must not have the cord clamped earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's condition.

The benefits of delayed cord clamping include higher haemoglobin concentrations, a decreased risk of iron deficiency and greater vascular stability in babies. If they wish, women can ask healthcare professionals to wait longer to clamp the cord

Term Infants (Equal to or More Than 37 Weeks Gestation)

Women and their families must be informed that the cord will not be clamped routinely before one minute, unless the woman requests this or the clinical condition of the baby indicates immediate clamping and cutting. The need for resuscitation of the baby must be assessed at birth and if the baby appears well the following actions must be taken:

- Initiate skin to skin where vaginal birth has taken place
- Keep the baby warm

- Place baby between woman's legs if caesarean birth has taken place • Do not clamp or cut the cord for at least 1 minute after birth of the baby.

Care must be taken not to raise the infant much above the level of the placenta until the cord is clamped. The baby can be put to the breast straight away if wished; the mother can be lying down, semi-recumbent or sitting upright at this stage.

There is no evidence of benefit, or harm, for delaying cord clamping beyond two minutes.

If the baby appears in need of resuscitation or resuscitation is anticipated then clamp and cut the cord immediately and begin resuscitative measures as per protocols.

Give oxytocic drugs for the third stage of labour at the usual times. Uterotonics (oxytocin or Ergometrine) can be given at the normal time in babies having delayed cord clamping. If given intravenously, the oxytocic may speed up the placental transfer of blood to the baby. If given intramuscularly it probably has no effect as the drug does not reach the circulation until after the transfusion is complete.

If there is a significant maternal haemorrhage at any time the cord must be clamped and cut.

Document time of cord clamping in the partogram. It is important to document the time of birth as well as the time the cord is clamped and cut whenever delayed cord clamping is undertaken.

Delayed cord clamping may affect cord pH values, therefore, where cord gas analysis is indicated the cord must be clamped / cut immediately and cord gas analysis undertaken before the cord stops pulsating. The woman must be informed that delayed cord clamping is not recommended in these circumstances.

Pre-Term Infants (36+6 Weeks Gestation and Below)

Babies 30 weeks gestation and over may be considered for delayed cord clamping provided they do not require active resuscitation or have not been identified as possible intrauterine growth restriction or have abnormal end diastolic flow identified on ultrasound scan in the antenatal period. The professional leading the resuscitation must make the decision as to whether delayed cord clamping must be undertaken on these babies.

If a preterm baby needs to be moved away from the mother for resuscitation, or there is significant maternal bleeding clamp the cord as soon as possible.

Wait at last 30 seconds, but no longer than 3 minutes, before clamping the cord of babies if the mother and baby are stable.

Position the baby at or below the level of the placenta before clamping the cord.

Stem Cell Collection

If a woman chooses to purchase private cord blood collection stem cells, under no circumstances will staff be able to collect or store cord blood samples where a commercial company is involved.

4.12 Complications of Labour

4.12.1 Referral to Obstetric Care

Women with identified risk factors or who develop risk factors during the first, second or third, stages of labour must have input from an experienced obstetrician (ST3 or above). The labour ward coordinator must be aware of the referral to an obstetrician and a plan of care developed, agreed with the woman and documented in the EPR labour and birth record. This includes poor progress in labour, fresh meconium / heavily blood-stained liquor, vaginal bleeding, abnormal fetal heart rate or maternal pyrexia. Any midwife who has concerns regarding the mother or baby must request senior obstetric review.

4.12.2 Meconium Stained Liquor During the Intrapartum Period

The presence of meconium stained liquor at birth has been associated with increased perinatal morbidity and mortality, arising from a condition known as meconium aspiration syndrome.

4.12.3 Diagnosis

Significant meconium stained liquor is defined as either dark green or black amniotic fluid that is thick or tenacious, or any meconium stained amniotic fluid containing lumps of meconium. However, it is important to remember that meconium stained liquor has unpredictable consequences at any degree.

Passage of meconium in itself is not a risk to the fetus, however, meconium aspiration may be lethal. Aspiration can occur antenatally, intrapartum or at delivery and is more likely with significant meconium.

4.12.4 Treatment / Management:

- Continuous EFM must be commenced, for women with significant meconium stained liquor.
- Request a face to face obstetric review and plan of care
- A practitioner trained in fetal blood sampling must be available in labour and professionals trained in advanced neonatal life support must be present at all births where there is evidence of meconium stained liquor. Where there is evidence of thick meconium a paediatrician **must be called** when birth is expected.

Women must be informed of the significance of meconium liquor and an individualised care plan made. If the woman is at home and has meconium liquor, she must be offered transfer to an obstetric site where it is safe to do so, dependent on clinical situation and stage of labour.

If there has been significant meconium staining and the baby is in good condition, the baby must be closely observed for signs of respiratory distress. The baby must be reviewed by a neonatologist if the baby's condition causes concern at any time or Newborn Early Warning Trigger and Track (NEWTT) indicates review. (See Guideline For The Use Of The Newborn Early Warning Trigger And Track System (NEWTT).)

4.13 Thromboprophylaxis

All women, regardless of mode of birth, must have a full risk assessment with regards thromboprophylaxis on admission and after birth and the appropriate proforma must be completed on Careflow. See Thromboprophylaxis Guideline for Obstetric Women for more detail.

4.14 MRSA

All women must be risk assessed on admission to hospital and screening undertaken of assessed as high risk.

If a mother is identified as MRSA positive then the baby/babies must be screened and start decolonisation treatment. If the baby is MRSA negative then the decolonisation can be stopped**.** See Trust MRSA policy and Maternity MRSA pathway.

4.15 Perineum

The midwife must undertake a systematic assessment of the perineum and lower vagina with consent to assess the need for sutures and to advise the mother on aftercare. See separate Perineal Repair guideline. All blood loss must be measured following the SOP for weighing blood loss.

4.16 Basic Care Following Birth

All women must be encouraged to hold their baby in skin to skin contact following birth. The baby must be dried and passed to the mother as soon as possible. To ensure the baby maintains its temperature they must be covered with a dry towel and a hat applied. Almost immediately after a baby is born they must be offered an initial examination to ensure they have no obvious physical abnormality, by the midwife attending the birth. A detailed NIPE screen must be undertaken within 72 hours of birth to enable early detection of congenital defects of the heart, hips, eyes and testes, in line with National Screening Committee NIPE Programme Standards 2016/17. Refer to the Newborn Examination (NIPE) guideline.

- Record the Apgar routinely at 1 minute, 5 minute and 10 minutes
- Record the time from birth to onset of regular respirations (NICE 2014)
- Commence neonatal resuscitation if required (see Newborn Resuscitation guideline).
- Do not take paired cord blood samples unless the baby is in poor condition, or there has been concern regarding fetal wellbeing during labour (NICE 2014)
- Encourage women to have skin to skin with their babies as soon as possible after birth. Skin contact must last as long as the mother wishes and at least until the first feed
- Encourage initiation of breastfeeding as soon as possible after birth, ideally within 1 hour
- All women must be offered help to breastfeed their baby
- If a mother wishes to formula feed she must be supported with this
- Skin to skin contact and offer of help with breastfeeding must be documented. (Refer to The Barnsley Joint Infant Feeding Polcy)
- Avoid separation of a woman and her baby within the first hour of the birth for routine postnatal procedures, for example, weighing, measuring and bathing, unless these measures are requested by the woman, or are necessary for the immediate care of the baby (NICE 2007)

- If the woman is unable to give skin to skin contact, the birth partner/s can be encouraged to undertake this
- Record the woman's temperature, pulse and blood pressure
- Observe uterine contraction and lochia
- Remove epidural catheter and document before mobilisation
- Examine the placenta and membranes: assess their condition, structure, cord vessels and completeness
- Early assessment of the woman's emotional and psychological condition in response to labour and birth
- Providing the woman and baby are well, privacy must be given to the new family when it is practicable to do so
- Prior to leaving the woman, soiled sheets and pads must be changed and the room tidied and this must be documented as a clinical note within the EPR
- The woman and the baby must have identity bands in place. Refer to New-Born Security. Light diet and fluids must be offered to all birth partners and the woman and again this must be documented
- The time and volume of the first void must be documented within the EPR – 'fluid input/output' by the midwife caring for the woman postnatally in the postnatal record. Ensure there is documentation as a clinical note whether or not a woman can void *normally* following birth, either within six hours postnatal, or within six hours post catheter removal. This must be documented in the self-retaining catheter care pathway and the postnatal records. See separate guideline Postpartum Bladder Care
- When it is suitable the woman must be offered a bath or shower. If this is declined it must be documented as a clinical note within EPR.
- Initiate and complete the postnatal care plan prior to transfer to the ward or community
- A discussion must take place surrounding early transfer to the community or transfer to the postnatal ward and this discussion and any decisions documented within the EPR

- On transfer to the postnatal ward an SBAR record within her EPR must be completed.

ALL LOW RISK WOMEN WITH A WELL BABY WHO HAVE BIRTHED NORMALLY MUST BE OFFERED A DISCHARGE HOME DIRECTLY FROM THE LABOUR SUITE. Her decision must be documented in her EPR.

5.0 Associated documents and references

National Institute of Clinical Excellence (NICE) (2007) Intrapartum care for healthy women and babies Intrapartum care for healthy women and babies (nice.org.uk)

National Institute of Clinical Excellence (NICE) (2014) Intrapartum care for healthy women and babies Intrapartum care for healthy women and babies (nice.org.uk)

National Institute of Clinical Excellence (NICE) (2017) Intrapartum care for healthy women and babies Intrapartum care for healthy women and babies (nice.org.uk)

National Institute of Clinical Excellence (NICE) (2019) Intrapartum care for women with existing medical conditions or obstetric complications and their babies Intrapartum care for women with existing medical conditions or obstetric complications and their babies (nice.org.uk)

National Institute of Clinical Excellence (NICE) (2023) Intrapartum care Intrapartum care (nice.org.uk)

RCOG (2018) OASI Care Bundle: Implementation guide for maternity sites in the roll-out phase Microsoft Word - OASI Care Bundle Guide final v0 15 to print (rcog.org.uk)

6.0 Training and resources

Training will be delivered as outlined in the Maternity Training Needs Analysis. This is updated on an annual basis.

7.0 Monitoring and audit

Any adverse incidents relating to admission to the maternity triage will be monitored via the incident reporting system. Any problems will be actioned via a case review. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for Intrapartum care of Women and Babies will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

8.0 Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavour to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

8.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1

Glossary of terms

ANPN – Antenatal/Postnatal ward
CTG – Cardiotocograph
LSCS – Lower Segment Caesarean Section
MEOWS – Modified Obstetric Early Warning Score
MAU – Maternity Assessment Unit
NICE – National Institute for Health and Clinical Excellence
PV – Per vagina
SROM – Spontaneous Rupture of Membranes

Appendix 2

Women who have any of following conditions/issues should be admitted under obstetric care in labour:

See NICE: Intrapartum care for healthy women and babies Section 1.1.10

Appendix 3 Latent phase assessment tool

Criteria		Score Primip	Woman's score	Score Multip	Woman's score
Number of admissions	First admission in latent phase	0		0	
	Second admission in latent phase	1		1	
	Third admission in latent phase	2		2	
Overall demeanour	Calm/Controlled	0		0	
	Some anxiety/ withdrawn/ inwardly focused	1		2	
	Distressed/anxious/out of control	2		3	
Analgesia	None/non pharmacological	0		0	
	Oral analgesia	1		1	
	Entonox/Opiates	3		3	
Social issues/ support	Well supported/no social issues	0		0	
	Some support/some social concerns/ problems with transport	1		1	
	No support/social concerns/ transport difficulties	3		3	
Contractions	Irregular/mild	0		1	
	Moderate/regular	1		4	
	Strong/regular/frequent	2		5	
Vaginal assessment	Closed <2cms	0		0	
	>2cms but <3cms	2		1	
	>3cms but <4cms	5		2	
			Total:		Total:

Assessment of scores and suggested management

	Advice/Home	Offer admission for observation	One to one care
Primip	0 - 6	7 - 12	>12
Multip	0 - 6	7 - 11	>13

Appendix 4

Transfer to obstetric led care should take place if any of the following are observed:

- Observations of the woman
  - Temperature of 38°C or above on a single reading, or 37.5°C or above on 2 consecutive occasions 1 hour apart
  - Maternal pulse over 120 beats/min on 2 occasions 30 minutes apart
  - Hypertension: either systolic blood pressure of 140 mmHg or more or diastolic blood pressure of 90 mmHg or more on 2 consecutive readings taken 30 minutes apart, measured between contractions
  - A reading of 2+protein on urinalysis and a single reading of either raised diastolic blood pressure of 90 mmHg or more or raised systolic blood pressure of 140 mmHg
  - Any vaginal blood loss other than a show
  - Rupture of membranes more than 24 hours before the onset of labour
  - Pain reported by the woman that differs from the pain normally associated with contractions
  - the presence of significant meconium
  - Any risk factors recorded in the woman's EPR that indicate the need for obstetric led care
  - Severe hypertension: a single reading of either systolic blood pressure of 160 mmHg or more or diastolic blood pressure of 110 mmHg or more, measured between contractions
  - Suspected chorioamnionitis or sepsis.

- Observations of the unborn baby
  - Any abnormal presentation
  - Free floating head in a nulliparous woman
  - Significant meconium stained liquor
  - FH < 110 bpm or > 160 bpm
  - Decelerations heard at auscultation
  - Suspected fetal growth restriction
  - macrosomia (following discussion with a senior obstetrician)
  - Suspected anhydramnios or polyhydramnios
  - Reduced fetal movements in the last 24 hours reported by the woman.

Appendix 5

Position: working with mum to agree the optimal birthing position for her and baby

Extra Midwife (present at birth): supporting mum and the delivery team throughout the birth

Assess the perineum: identifying the risk factors and offering massage guidance beforehand with a warm compress applied during birth where necessary

Communication: gaining a clear, shared understanding with mum of the birthing process and the interventions that may be needed to deliver her baby

Hands on technique: using this technique to reduce pressure on the perineum

Episiotomy: if required, to reduce the risk of a severe tear

Slowly: working with mum to ensure she knows the right time to push and when not to push to avoid sudden trauma to the perineum

Appendix 6 (must always be the last appendix)

Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author
2	17/03/2023		
3	28/08/2024		Emma Hey

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
WB&G	17/03/2023
CBU3 Governance	22/03/2023

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Guideline
Document title	Guideline for Intrapartum Care for Women and Babies
Document author (Job title and team)	BBC lead Midwife Obstetricians Midwives
New or reviewed document	Reviewed. Replaces; Latent Phase of Labour Assessment Tool, Management of normal labour (intrapartum)
List staff groups/departments consulted with during document development	BBC lead Midwife Obstetricians Midwives
Approval recommended by (meeting and dates):	Reviewed at Women's Business and Governance meeting Date: 16/08/2024 Approved at CBU3 Business & Governance Meeting Date: 28/08/2024
Date of next review (maximum 3 years)	16/08/2027
Key words for search criteria on intranet (max 10 words)	Labour Latent phase Triage
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the FINAL version of this document	**Name: Emma Hey** **Designation: Matron for Maternity Inpatients**

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee):
Date approved:
Date Clinical Governance Administrator informed of approval:
Date uploaded to Trust Approved Documents page: