Mid Essex Hospital Services NHS
NHS Trust

GUIDELINE FOR THE MANAGEMENT OF NORMAL LABOUR AND PROLONGED LABOUR IN LOW RISK PATIENTS	CLINICAL GUIDELINES Register No: 09079 Status: Public

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2.3	Clarification to passive second stage, point 23.6	November 2010
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INDEX

1.0 Purpose of the Guideline

1.1 To provide health care professionals with guidance regarding the management of healthy patients and their babies who wish to undergo a normal vaginal delivery.

1.2 This guideline includes patients without co-existing morbidities (including previous uterine surgery or complications of previous deliveries which may impact upon this delivery).

1.3 Patients need to have commenced labour spontaneously and who have a single healthy fetus of between 37 and under 42 weeks of gestation. The fetus needs to be presenting head first without any clinical confirmation of intrauterine growth retardation or macrosomia

2.0 Equality and Diversity

2.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Scope

3.1 This guideline covers the care of healthy patients and babies at term (37-42 completed weeks of gestation) in the following care settings:

- Home births
- In a Midwife-Led Unit (MLU)
- In a Consultant-Led Unit (CLU); to include the Co-located Birthing Unit

4.0 Definition

4.1 Labour is a normal physiological process characterised by a spontaneous onset between 37 and 42 weeks in a patient whose pregnancy has been uncomplicated.

5.0 Background

5.1 The government is committed to ensuring that all patients will have a choice in where and how they have their baby and whichever pain relief to use, depending on their individual circumstances (Department of Health, 2007).

5.3 Maternity Services throughout the UK are aiming to increase the normal birth rate towards a realistic objective of 60%. With appropriate care and support the majority of healthy patients can give birth with a minimum of medical procedures and most prefer to avoid interventions, providing that their baby is safe and they can feel that they can cope.

5.4 Throughout her pregnancy the patient should be fully involved in planning her birth so that care is flexible and tailored to meet her needs and those of her baby. Patients should have the opportunity to make informed decisions regarding their care and any treatment needed.

5.5 Decisions should be supported by the provision of evidence-based written information tailored to the needs of the individual patient.

6.0 The Key Professionals who Provide Antenatal Care

6.1 **The midwife** - the midwife specialises in normal birth. By working across a variety of health care settings, the midwife can provide optimal care for all patients regardless of the place of delivery.

6.2 Patients in established labour receive **one-to-one** care from a midwife.

6.3 **General practitioner** - the general practitioner works in collaboration with the midwife and the obstetric consultant providing overall care for the patient and her family.

6.4 **The obstetrician** - the obstetrician is the lead professional for all patients with confirmed or suspected complications of pregnancy.

6.5 **The Antenatal and Newborn Screening Coordinator** - the role of the Antenatal and Newborn Screening Coordinator is to coordinate antenatal screening services for patients and health care professionals providing advice, support and counselling. To contact the Antenatal and Newborn Screening Coordinator phone: 01245 513333 between the hours of 0900 -1700, Monday to Friday.

7.0 The Booking Procedure

7.1 Patients should be offered the choice of planning birth as follows:

- At home
- Midwife-led Unit (MLU)
- Consultant –led Unit (CLU)

7.2 Patients should be informed of the following:

- That giving birth is generally very safe for both the mother and her baby
- Although the available information on planning the place of birth is not of good quality, it suggests that there is a higher likelihood of normal birth, with less intervention for those patients who plan to deliver at home or within a MLU.
- Consideration needs to be given with regards to the time delay in transfer
- That the CLU provides direct access to obstetricians, anaesthetists and paediatricians.
- That if something goes unexpectedly, seriously wrong during labour at home or in a MLU, then the outcomes for the mother and baby could be worse than if they were in the CLU with access to specialised care

8.0 Criteria for Choosing the Place of Birth

8.1 The clinical reasons for choosing a delivery at home or in a MLU are as follows:

- Between 37 completed weeks and under 42 weeks of pregnancy
- A low risk obstetric history

(Refer to appendix A)

- A singleton pregnancy
- A cephalic presentation
- A baby of normal growth
- The absence of abnormal bleeding or meconium per vaginum

9.0 Indications for a Consultant Led Unit Booking

9.1 Maternal indications

(Refer to appendix A)

10.0 Considerations for a Consultant/Specialist Referral Regarding Individual Assessment

(Refer to Appendix B)

10.1 Patients who are referred to a consultant obstetrician or anaesthetist, or whose condition has been referred to a paediatrician may resume the normal care pathway once their condition has been assessed as appropriate for low risk care.

10.2 It should be made clear on the patient's health care records whom the lead professional is at all times. When patients are identified as requiring consultant led care the reason for this must be stipulated on the antenatal notes at the end of the booking.

11.0 Indications for Intrapartum Transfer

(Consider likelihood of delivery during transfer)

11.1 Abnormalities or uncertainty regarding presence of the fetal heart rate (FHR) necessitating continuous electronic fetal monitoring
(Refer to the 'Guide for monitoring in pregnancy'. Register number 04265)

11.2 Delay in first, second or third stages of labour, retained placenta or significant meconium stained liquor (dependent on risk factors).

11.3 Maternal request for epidural anaesthesia

11.4 Obstetric emergency (antepartum haemorrhage, cord presentation/prolapse, postpartum haemorrhage, maternal collapse or need for advanced neonatal resuscitation.

11.5 Maternal pyrexia in labour (38.0˚c on one occasion or 37.5˚c on two occasions two hours apart)

11.6 Malpresentation

11.7 Raised blood pressure:

- Raised diastolic (over 90mmHg)
- Raised systolic (over 140mmHg)
- A rise of 15mmHg above the booking diastolic
- A rise of 30mmHg above the booking systolic

On two consecutive readings taken 30 minutes apart

11.8 Third, fourth or complicated tears regarding specialist suturing or stronger anaesthesia.

12.0 Self-diagnosis of Labour

12.1 Patients may either contact their community midwife when they believe that labour has commenced or directly contact the MLU's or Labour Ward.

12.2 The community midwives may visit these patients at home to determine if labour is established prior to either delivering at home or admission to the MLU's or CLU.

12.3 Clinical intervention should not be offered where labour is progressing normally.

12.4 Patients should be encouraged to remain at home for as long as possible with analgesia, light diet and relaxation techniques such as immersion in water

13.0 The Latent Phase of Labour
(Refer to the guideline entitled 'Management of the latent phase of labour'; register number 12029)

13.1 The latent phase is described as the phase prior to the active first stage of labour and may last up to 12 hours in primigravid patients and 8 hours in multigravid patients. During this phase the cervix dilates from 0 to 4cm and the cervical canal shortens from 3cm long to less than 0.5cm long.

14.0 Determining the Latent Phase
(Refer to the guideline entitled 'Management of the latent phase of labour'; register number 12029)

14.1 There is a history of regular contractions which may be inconsistent in strength and duration but are described as painful

.

14.2 May have had a 'show'

.

14.3 The membranes are intact.

14.4 There are changes in the effacement of the cervix 4 hours following the initial assessment. (In false labour the primigravid cervix remains long or closed. The multigravid cervix is not effaced, even though it may be 1-2 cm dilated).

15.0 Diagnosis of a Prolonged Latent Phase
(Refer to the guideline entitled 'Management of the latent phase of labour'; register number 12029)

15.1 After 12 hours of painful contractions in a primigravid patient and 8 hours in a multiparous patient.

15.2 Contractions remain regular and painful, but continue to be inconsistent in strength and duration.

15.3 The cervix is completely effaced (80% in multiparous patient) but remains about 2cm dilated.

15.4 Underlying conditions such as urinary tract infection will need to be considered. Studies have shown that patients admitted to hospital in the latent phase have higher rates of obstetric intervention.

16.0 Treatment to Consider for the Prolonged Latent Phase
(Refer to the guideline entitled 'Management of the latent phase of labour'; register number 12029)

16.1 Encourage the patient to remain or stay at home to rest, offering support and reassurance, ensure adequate analgesia is offered.

16.2 Encourage ambulation and adequate hydration.

16.3 Consider management in a CLU following informed choice regarding the care pathway, such as amniotomy with active management and epidural anaesthesia.

17.0 Established labour

17.1 Support in labour - always maximise the communication between the patients and the healthcare professionals.

17.2 Ensure an approach of warmth and calm, demonstrating confidence in both the patient and her midwife.

17.3 Ensure that the patient and her partner have access to privacy, confidentiality and dignity throughout their time with the health care professionals. Permission should be sought before others enter the room.

17.4 Discuss the patient's birth plan, involve her in care decisions and staff handovers.

17.5 Encourage the patient to adapt the environment to her individual needs including her birth supporters.

17.6 Ensure consent is gained before all procedures are undertaken.

17.7 Ensure one-to-one midwifery is implemented throughout labour. If the health professional needs to leave the room for a short period she will need to stipulate why and demonstrate how assistance can be sought in her absence.

18.0 Coping strategies

18.1 Positions in labour – patients should be encouraged to adopt whichever position they find most comfortable. Use of aids and labour supports must be appropriate.

18.2 Eating and drinking in labour - encourage drinking during labour; isotonic drinks may be more beneficial than water. A light diet may be taken in established labour unless the patient has received opioids or she develops risk factors making general anaesthesia more likely. (Refer to guideline for the nutrition in labour and antacid prophylaxis for the pregnant patient at term. Register number 04253)

19.0 Pain in Labour

19.1 Healthcare professionals should ensure that their care and attitudes with regards to pain in labour supports the patient's choices.

19.2 Submersion in water is recommended for pain relief.

19.3 For patients who wish to labour and birth in the birthing pool, the normal waterbirth guidelines apply.
(Refer to 'Guideline for waterbirth, labour and delivery in water and third stage management. Register number 04237)

19.4 Breathing, relaxation and massage techniques that have been taught to the patient's birth partner may be continued in labour.

19.5 The use of non-pharmacological analgesia i.e. homeopathic remedies or aromotherapy oils.
(Refer to the guideline entitled 'Aromotherapy massage in pregnancy and labour';register number 12030 once ratified)

19.6 Transcutaneous electrical nerve stimulation (TENS) - this can be used throughout labour in all birth settings (excluding waterbirths). Its commencement is not recommended in established labour (i.e. if the cervix is dilated by 4cm or more).

19.7 Inhalational analgesia or entonox (50% nitrous oxide and 50% oxygen) can be used in all birth settings. Patients should be informed that it may make them feel nauseous and light-headed, but this is short lived.

19.8 Intramuscular opioids such as pethidine can be used in all birth settings. They will provide limited pain relief during labour and may have significant side effects for both the patient (drowsiness, nausea and vomiting, therefore administered with an anti-emetic) and her baby (short-tem respiratory depression and drowsiness which may last several days). Opioids may interfere with breastfeeding.

20.0 Regional Analgesia

20.1 Before choosing epidural analgesia, patients should be informed about the risks and benefits and the implications for their labour. Patients should be informed that epidural analgesia is:

- Only available in the obstetric unit
- Provides more effective pain relief than opioids
- Is associated with a longer second stage of labour and in increased chance of a vaginal instrumental birth
- It is not associated with long-term backache
- It is not associated with a longer first stage of labour or an increased chance of caesarean birth.
- It will be accompanied by a more intensive level of monitoring and intravenous access
- Modern epidural solutions contain opioids which can cross the placenta in larger doses (greater than 100 micrograms in total). This may cause short-term respiratory depression in the baby and make the baby drowsy
- Regional analgesia should not be denied to patients in whichever stage of labour

21.0 Normal Labour

21.1 In all stages of labour, patients who have left the normal care pathway due to the development of complications can return to it if or when the complications are resolved.

22.0 Initial Observations on Admission

22.1 The initial assessment by the midwife should involve the following:

- Maternal and fetal assessment to be undertaken within 30 minutes of admission to unit; once the woman has been shown to her bed or assessment area
- Listen to her history, assess the patient's emotional and psychological wellbeing and review of the clinical records
- Physical observation including temperature, blood pressure, pulse, respirations, urinalysis, length, strength and frequency of contractions
- Abdominal palpation to include fundal height, lie, presentation, position and station

  (Refer to 'Guideline for abdominal palpation'. Register number 07043)
- Vaginal loss to include show, liquor and blood
- Assessment of the patient's pain, including her wishes for coping with labour along with the range of options available for pain relief
- The FHR (fetal heart rate) should be auscultated for 1 minute immediately after a contraction for at least 1 minute
- The maternal pulse should be palpated to differentiate between maternal and FHR
- A vaginal examination should be offered if either the patient appears to be in established labour, or if after a period of assessment; and clearly not in established labour
- Patients who are not in established labour but report painful contractions should be offered support and analgesia. They should be encouraged to remain or return home.

23.0 The first Stage of Labour

23.1 Labour is deemed established when there are:

- Regular painful contractions,
- There is progressive cervical dilatation from 4cm.

23.2 Risk assessment is an ongoing process throughout labour. When labour is deemed established the midwife responsible for the patient should:

- Undertake a risk assessment, encompassing a full review of the antenatal health care records i.e. whether the patient is low or high risk (identifying the risk factors) and document the findings in the healthcare records
- If any risks are identified the midwife should refer the patient to the appropriate professional for advice/review; and develop or update an individual management plan

- Where a referral is required and the midwife is unable to contact the health professional concerned; this should be escalated to ensure that the identified risks are addressed appropriately

- All findings should be documented in the health care records contemporaneously by the responsible health care professional.

23.3 Duration of the first stage of labour:

- **First labours last on average 8 hours** but are unlikely to exceed 18 hours

- **Second and subsequent labours last on average 5 hours** but are unlikely to exceed 12 hours

- The length of labour will vary between individuals (Refer to Appendix D)

- The cervix is expected to dilate:

  > or equal to 2cm in 4 hours for first labours

  > or equal to 2cm in 4 hours for second and subsequent labours

- The head will rotate and descend

- The contractions will remain frequent, strong and the duration of each contraction will lengthen.

24.0 Observations during the First Stage of Labour

24.1 Obtain and review all health care records including ultrasound scans, blood results and any relevant referral reports filed in the patient's main notes.

24.2 Obtain history from the patient regarding the onset of labour and the description of any loss per vaginum. Time and date of any reports of suspected or confirmed spontaneous rupture of the membranes

24.3 Record 4 hourly blood pressure recordings and temperature; hourly pulse, urinalysis on admission and any observations regarding overall medical condition of the patient; this should be recorded on the MEOWS chart, linked to the partogram in the Labour care Record.

24.4 Undertake an abdominal palpation which will include palpation of the fundal height, lie, presentation, position and station of the fetal head measured if fifths palpated above the pelvis. Observe the abdomen for shape, any previous scars, and any specific areas of tenderness. (Refer to 'Guideline for abdominal palpation'. Register number 07043)

24.5 Contractions should be assessed and findings documented every 30 minutes. Assessment of the contractions should include the length, strength and frequency.

24.6 The bladder should be emptied 4 hourly and a urinalysis performed; this should be recorded on the MEOWS chart, linked to the partogram in the Labour care Record.

24.7 Best practice recommends that the midwife caring for the patient should assess the FHR every 15 minutes after a contraction for at least 1 minute during the first stage of labour; however, if the circumstances prevent this assessment occurring, the midwife should refer to point 24.8

24.8 If the midwife responsible for the patient is unable to assess the fetal heart rate as stipulated in point 24.7, the following reasons should be documented in the patient's healthcare records as outlined below:

- Vomitting
- Out to the toilet
- Patient declines assessment of FHR
- Vaginal examination

24.9 Best practice recommends that the midwife caring for the patient should assess the FHR every 5 minutes after a contraction during the commencement of the active phase of the second stage of labour; however, if the circumstances prevent this assessment occurring refer to point 24.8

24.10 The maternal pulse should be palpated hourly simultaneously with the FHR assessment and recorded:

- During labour, to ensure that the correct assessment of FHR is recorded
- To monitor any deviations from the baseline assessment (maternal/fetal) on admission
- If an abnormality is detected to be able to differentiate the two heart rates

These observations should be recorded in the health care records

24.11 Electronic fetal monitoring (EFM) via a cardiotogograph (CTG) is not recommended in any birth setting.

24.12 Assess the patient's pain, discussing her preferred coping strategies and advising on the available methods of pain relief.

24.13 If the patient reports having intact membranes and she appears to be in established labour a vaginal examination should be offered.

24.14 Vaginal examination should be performed 4 hourly or where there is concern about progress or in response to the patient's wishes (after abdominal palpation and assessment of vaginal loss). Obtain consent before examination, discuss findings after the examination. Ensure privacy and dignity are maintained throughout.

24.15 Consideration should be given to the patient's emotional and psychological needs, including her desire for pain relief and this should be available throughout her labour.

24.16 Observations during the first stage of labour should be recorded in the healthcare records by the midwife. (Refer to 'Guideline for completion of the partogram in pregnancy'. Register number 09064)

25.0 Complicated Labour

25.1 Delay in the first stage of labour - a diagnosis of delay will need to be taken into consideration:

- Cervical dilatation of **less than 2cm in 4 hours for first labours**
- Cervical dilatation of **less than 2cm in 4 hours for second and subsequent labours**
- Descent and rotation of the fetal head

- Changes in the strength, duration and frequency of uterine contractions.

(Refer to appendix B)

25.2 Suspected delay - an **amniotomy** should be performed (advise that it may shorten labour by about 1 hour and that it may increase the strength of the contractions).

25.3 Perform a **vaginal examination 2 hours after the amniotomy,** if the progress is less than 1cm then a delay is diagnosed.

25.4 If an amniotomy is not performed then the vaginal examination should be repeated 2 hours later.

25.5 When delay is diagnosed in the **nulliparous** patient, advice from the obstetric registrar or consultant should be sought with regards to the use of syntocinon®) and all findings should be documented in the health care records contemporaneously by the responsible health care professional. (Refer to 'Guideline for the Augmentation of Labour'. Register number 04270)

25.6 When delay is diagnosed in the **multiparous** patient, the obstetric registrar or consultant will need to make a full assessment, including abdominal palpation and vaginal examination before deciding if syntocinon®) is to be used and again all findings should be documented in the health care records contemporaneously by the responsible health care professional.

25.7 Patients should be offered the use of an epidural before syntocinon®) commences. They will need to be informed that it will increase the strength and the intensity of their contractions. (Refer to 'Guideline for the Augmentation of Labour'. Register number 04270)

25.8 A vaginal examination should be performed **4 hours** after commencing syntocinon®) in established labour. If the cervix has dilated less than **2cm after 4 hours** of syntocinon®) further obstetric review must be sought. (Refer to Appendix C).

25.9 Continuous cardiotocograph (CTG) monitoring must be used throughout a syntocinon®) infusion.

26.0 The Second Stage

26.1 Definition of the second stage of labour is when the cervix is fully dilated until complete expulsion of the baby. It is defined in two stages.

26.2 **Active second stage of labour** :

- The baby is visible
- Persistent involuntary 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

26.3 **Passive second stage of labour** is defined as full dilatation of the cervix prior to or in the absence of persistent (occurring with every contraction) involuntary expulsive contractions. This would be expected to last for no more than **1 hour** in both nulliparous and multiparous patients.

26.4 The duration of the second stage of labour in a nulliparous patient; the birth would be expected to take place within **3 hours** of the start of the active second stage.

26.5 In a parous patient the birth would be expected to take place within **2 hours** of the start of the active second stage. (Refer to Appendix D)

27.0 Delay in the Second Stage of Labour

(Refer to Appendix D)

27.1 In a **nulliparous** patient delay is diagnosed when the active second stage has reached **2 hours,** at this point the patient should be referred to the obstetric registrar unless the birth is imminent. All findings should be documented in the health care records contemporaneously by the responsible health care professional.

27.2 CTG monitoring will need to commence after **2 hours** of active pushing.

27.3 In a **multiparous** patient delay is diagnosed when the second stage has lasted **I hour,** at this point the patient should be referred to the obstetric registrar unless the birth is imminent. All findings should be documented in the health care records contemporaneously by the responsible health care professional.

27.4 CTG monitoring will need to commence after 1 **hour** of active pushing

27.5 For patients **without** an epidural who have a fully dilated cervix and who do not have an urge to push, a vaginal assessment should be undertaken **1 hour** after full dilatation.

28.0 Observations in the Second Stage of Labour

28.1 Observations during the second stage of labour should be recorded in the healthcare records by the midwife. (Refer to 'Guideline for completion of the partogram in pregnancy'. Register number 09064)

- Hourly blood pressure and pulse
- 4 hourly temperature
- Vaginal examination should be offered **hourly** in the active second stage or as the patient wishes, acknowledging the fetal position and station at the onset of the second stage.
- Abdominal palpation (with reference to the presentation and position of the baby) prior to vaginal examination
- Half-hourly documentation on the frequency and strength of contractions
- Ensure bladder emptied at least 4 hourly and a urinalysis performed
- Observation on the colour and the amount of the liquor if membranes ruptured

28.2 Consideration should be given to the patient's emotional and psychological needs, including her desire for pain relief and this should be available throughout her labour

28.3 Assessment of progress should include maternal behaviour, effectiveness of pushing and fetal wellbeing, taking into account fetal position and station at the onset of the second

stage and the subsequent descent of the presenting part. These factors will assist in deciding the timing of further vaginal examination and the need for obstetric review.

28.4 Document the effectiveness of pushing, the patient's position, behaviour and how she feels she is managing her labour.

28.5 Intermittent auscultation of the fetal heart rate should occur after a contraction for at least 1 minute, every 5 minutes; to commence during the active phase of labour. The fetal heart rate should be recorded in the Labour Care Record and following delivery the partogram should be completed to include the following:

- The time and mode of delivery

(Refer to the 'Guideline for fetal monitoring in pregnancy. Register number 04265)

28.6 If an abnormality is detected in the FHR simultaneously palpate the maternal pulse

28.7 If unclear of the normality of the FHR-the CTG monitoring must commence.

28.8 Ensure that the patient is well hydrated.

28.9 Patients should be discouraged from the supine and semi-supine positions. Employ the use of different positions and birthing aids to maximise descent of the fetus and comfort for the patient.

28.10 Patients should be informed that in second stage they should be guided by their own urge to push.

29.0 Management of a Delay in the Second Stage of Labour

29.1 In a **nulliparous** patient, if after 1 hour of active second stage progress is inadequate, delay is suspected. Amniotomy should be performed for intact membranes.

29.2 In **multiparous** patient, if after ½ an hour of active second stage progress is inadequate, delay is suspected. Amniotomy should be performed where the membranes are intact.

29.3 Syntocinon infusion should be considered in **nulliparous patient** if the contractions are inadequate at the **onset** of the second stage. **NICE do not recommend the use of oxytocin in parous patients.**

29.4 Patients with confirmed **delay in** the second stage should be assessed by an obstetric registrar or consultant. **Oxytocin should not be started**. (Refer to Appendix D Permissible time limits in normal labour-based on cervical dilatation of 2cm in 4 hours)

30.0 Intrapartum Intervention to Reduce Perineal Trauma during the Second Stage

30.1 Perineal massage should not be performed.

30.2 'Hands on' (guarding the perineum and flexing the baby's head) or the 'hands poised' (with hands off but in readiness) techniques can be used.

30.3 For episiotomy technique: (Refer to 'Guideline for Episiotomy'. Register number 07045)

- Only perform for clinical need:
- Suspected fetal compromise

- To perform an operative delivery

30.4 An episiotomy should not be routinely offered at vaginal birth following previous third or fourth degree trauma.

30.5 In order for the patient to make an informed choice, discussion regarding her future mode of birth should encompass:

- Current urgency or incontinence symptoms (urine, faeces and flatus)
- The degree of the previous trauma
- Risk of recurrence
- The success of the repair undertaken
- Psychological effects
- Management of her labour

30.6 Patients with infibulated genital mutilation should be informed of the risks and difficulties with vaginal examination, catheterisation and application of fetal scalp electrodes. There is also a risk in delay in the second stage, spontaneous laceration, the need for an anterior episiotomy and the need for difibulation in labour. (Refer to the 'Guideline for female genital mutilation. Register number 08040)

31.0 The Third Stage

31.1 The third stage is defined from the birth of the baby to the expulsion of the membranes and placenta. Two methods of delivery of the placenta and membranes can be employed depending upon clinical circumstances and the mother's request.

31.2 **Physiological management** as follows:

- Uterotonic (syntocinon or syntometrine®) drugs are not used
- The cord is not clamped until the pulsations have ceased
- The placenta is delivered by maternal effort

31.3 **Active management** as follows:

- Use of uterotonic drugs (1ml of syntometrine®) intramuscularly or 5 units of syntocinon given intravenously in the presence of hypertension and maternal cardiac problems);
- Early clamping and cutting of the cord
- Controlled cord traction
- Guarding of the uterus

31.4 Patients should be informed that active management shortens the third stage and reduces the risk of maternal haemorrhage.

31.5 Changing from physiological management to active management is indicated as follows:

- Excessive bleeding of haemorrhage occurs
- Failure to deliver the placenta within one hour
- The patient's desire to shorten the third stage

32.0 Observations in the Third Stage of Labour

32.1 Observations by a midwife of a patient in the third stage of labour should be documented in the health care records and should include:

- Estimating the amount of vaginal blood loss
- Assessing the general condition of the mother i.e. her respirations, colour and her own report of how she feels
- In addition, where haemorrhage, retained placenta or maternal collapse diagnosed, observations of the mother's pulse, respiration rate, blood pressure and oxygen saturation levels are required, to assess the need for resuscitation, ensuring all findings are documented in the health care records. (Refer to the 'Guideline for the management of the severely ill pregnant patient'. Register number 09095)

33.0 Delay in the Third Stage of Labour

33.1 Delay is diagnosed if not completed within:

- **60 minutes** of physiological management
- **30 minutes** of active management (Refer to Appendix D)

33.2 Ensure intravenous access is obtained; take bloods for group and save and a full blood count.

33.3 In a patient where a delay in the third stage has been identified, referral to an obstetric registrar or consultant should ensue. All findings should be documented in the health care records contemporaneously by the responsible health care professional.

33.4 Ensure adequate analgesia/anaesthesia is maintained and transfer into the Consultant-led Unit.

33.5 For the **management of a retained placenta** refer to the 'Guideline for the management of retained placenta'. Register number 04245)

34.0 Care of the Patient Immediately following Delivery

34.1 Initial assessment of the mother:

- Mother's psychological wellbeing
- Observations of blood pressure, pulse, respirations and temperature
- Ensure that the uterus is contracted; observe any further loss per vaginum.
- Examination of the placenta and membranes-assessment of their condition, structure, cord vessels and completeness. Ensure correct disposal.

- In terms of bladder care, the time and volume of the first void should be recorded in the health care records

- Re-inspect the perineum, if the mother complains of continued discomfort.

35.0 Inspection of the Perineum

35.1 Repair of the perineum should be undertaken as soon as possible to minimise the risk of infection and blood loss.

35.2 Patients should be advised of the following:

- First degree trauma, that the wound should be sutured to improve healing, unless the skin edges are well opposed.

- Second degree trauma, that the muscle should be sutured to improve healing.

- If the skin is well opposed following suturing of the muscle, there is no need to suture it.

(Refer to guideline for 'Perineal repair'. Register number 07066)

36.0 Care of the Baby Immediately after Birth

(Refer to the 'Guidelines for the Examination of the Newborn' Register number 04225)

36.1 Record the APGAR score at 1 and 5 minutes (if born in a poor condition; at 1, 3, 5 and 10 minutes or until the baby's condition is stable).

36.2 If there are any concerns regarding the babies wellbeing or for an operative delivery, double clamp the cord 10cm apart immediately after delivery to allow paired blood gases to be obtained.

36.3 Skin-to-skin bonding should be initiated immediately after delivery, covering the baby with a warm dry towel and a hat.

36.4 Initiate breast-feeding, ideally within one hour of birth.

36.5 Avoid separation of the baby from the mother within the first hour after birth for routine procedures (weighing, checking and labelling) unless the mother requests it or the baby's condition is concerning.

36.6 An initial examination of the newborn is to be undertaken with parental consent, to detect any abnormalities and to identify any problems that may require referral.

36.7 Take measurements of the head circumference, weight (undressed) in kilograms, axilla temperature, apply two identity ankle bracelets writing on each the mother's name and the baby's date of birth and sex, (include the baby's hospital number if referral to the NNU is required). (Refer to 'Guideline for the attachment and detachment of identification labels for the newborn. Register number 04216)

36.8 Administer vitamin K 1 mg intramuscularly with prior parental consent. (Refer to 'Guideline for the administration vitamin K'. Register number 08095)

37.0 Staffing and Training

37.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.

37.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

38.0 Infection Prevention

38.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively ‘decontaminate their hands’ before and after each procedure.

38.2 Normal warm tap water is to be used for cleansing prior to vaginal examination. Normal infection prevention and control measures are to be taken in compliance with Trust guidelines.

38.2 All staff should ensure that they follow Trust guidelines on infection prevention. All invasive devices must be inserted and cared for using High Impact Intervention guidelines to reduce the risk of infection and deliver safe care. This care should be recorded in the Saving Lives High Impact Intervention Monitoring Tool Paperwork (Medical Devices).

39.0 Supervisor of Midwives

39.1 The supervision of midwives is a statutory responsibility that provides a mechanism for support and guidance to every midwife practising in the UK. The purpose of supervision is to protect women and babies, while supporting midwives to be fit for practice'. This role is carried out on our behalf by local supervising authorities. Advice should be sought from the supervisors of midwives are experienced practising midwives who have undertaken further education in order to supervise midwifery services. A 24 hour on call rota operates to ensure that a Supervisor of Midwives is available to advise and support midwives and women in their care choices.

40.0 Audit and Monitoring

41.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy, the Maternity annual audit work plan and the NHSLA/CNST requirements. The Audit Lead in liaison with the Risk Management Group will identify a lead for the audit.

41.2 As a minimum the following specific requirements will be monitored:

- Maternal observations to be carried out on admission
- Maternal observations to be carried out during established first stage of labour
- Maternal observations to be carried out during second stage of labour
- Maternal observations to be carried out during third stage of labour
- Documentation of all of the above maternal observations
- Guidance on duration of all stages of labour
- Guidance on referral to obstetric care
- Process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans

41.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 41.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

41.4 The findings of the audit will be reported to and approved by the Maternity Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

41.5 The audit report will be reported to the monthly Maternity Directorate Governance Meeting (MDGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

41.6 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

41.7 Key findings and learning points will be disseminated to relevant staff.

42.0 Guideline Management

42.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

42.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

42.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

42.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

43.0 Communication

43.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

43.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

43.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

43.4 Regular memos are posted on the guideline notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

44.0 References

C Barnett, V Hundley, H Cheyne, F Kane (2008). Not in Labour: Impact of sending women home in the Latent Phase. British Journal of Midwifery,16 (3), p144 – 153.

Department of Health: Maternity Matters: Maternity matters: choice, access and continuity of care in a safe service (2007). London.

Department of Health: National Services Framework for Children, Young People and Maternity Services (2004).London

National Childbirth Trust, Royal College of Midwives, Royal College of Obstetricians: Making Normal Birth a Reality (2007)
National Institute for Health and Clinical Excellence: Induction of Labour Guidelines (2008). London.

http://www.nice.org.uk/nicemedia/pdf/CG070FullGuideline.pdf

National Institute for Health and Clinical Excellence, Intrapartum care care of healthy women and their babies during childbirth (2007) London.

http://www.nice.org.uk/nicemedia/pdf/CG55FullGuideline.pdf (accessed 6th December 2007.

Appendix A

Indications for a Consultant Led Unit Booking

Maternal indications

Respiratory

Asthma requiring a 'step-up' in treatment of hospital treatment within the last year

Cystic fibrosis

Cardiovascular

Cardiac disease

Hypertensive disorders

Renal

Renal disease requiring supervision by a renal specialist

Abnormal renal function

Recurrent infection

Gastro-intestinal

Liver disease

Crohn's disease

Ulcerative colitis

Infective

TB-under treatment

HIV-carrier and infected

Sexually transmitted disease

Hepatitis B/C with abnormal liver function tests

Toxoplasmosis if occurs when pregnant

Chicken pox if occurs when pregnant

Rubella-if pregnant

Genital herpes if pregnant

Group B streptococcus

Haematological

Haemoglobinopathies such as beta Thalassaemia major, sickle-cell disease

Family history of previous thrombo-embolism

Evidence of or suspected thromboembolitic disorders

Suspected thrombocytopaenia, a platelet count below 100,000 or abnormal platelet formation

Von Willibrand's disease

Bleeding disorders in the woman or the unborn baby

Immune

Rheumatoid arthritis

SLE (systemic lupus erethromatosis)

APS (antiphosphoid antibody syndrome)

Scleroderma

Other connective tissue disease.

Endocrine

Thyroid disorders

Diabetes or previous history of gestational diabetes or current gestational diabetes

Other significant disorders e.g. Cushing's disease

Neurological

Psychiatric disease

Epilepsy

Myasthenia gravis

Spinal abnormalities

Previous cerebrovascular accident

Neurological defects

Substance misuse

Alcohol dependency requiring assessment or treatment.

Body Mass Index greater than 35 at booking

Disorders requiring current inpatient care.

Anaesthesia risk

Known airway problems

History of drug

Latex allergy

Spinal abnormalities

Surgical

Myomectomy

Hysterectomy

Spinal surgery

Vascular surgery

Previous fractured pelvis

Obstetric problems

Previous complications

Previous still birth/neonatal death

Previous baby with neonatal encephalopathy

Pre-eclampsia requiring pre-term delivery

Eclampsia/HELLP syndrome

Uterine rupture

Placental abruption with adverse outcomes

Primary postpartum haemorrhage requiring additional treatment or blood transfusion.

Retained placenta requiring manual removal in theatre

Caesarean section

Obstetric cholestasis

Babies >4.5 kg

Shoulder dystocia

Fetal indications

Rhesus disease

Atypical antibodies

Confirmed uterine death

Obstetric problems

Current pregnancy

Multiple pregnancy

Unstable lie

Malpresentation

Placenta praevia

Recurrent antepartum haemorrhage

Placental abruption

Pre-term (less than 37 weeks gestation)

Pre-eclampsia or pregnancy induced hypertension BP >140/90 or 15mmhg above booking diastolic or 30mmhg above booking systolic.

Proteinuria >+1on dipstick (30mg of protein)

Epigastric pain

Pre-term rupture of the membranes

Pre-labour rupture of the membranes

Induction of labour

Anaemia Haemoglobin less than 8.5 g/dl at the onset of labour

Seizures

Maternal age of less than 16 or > 40

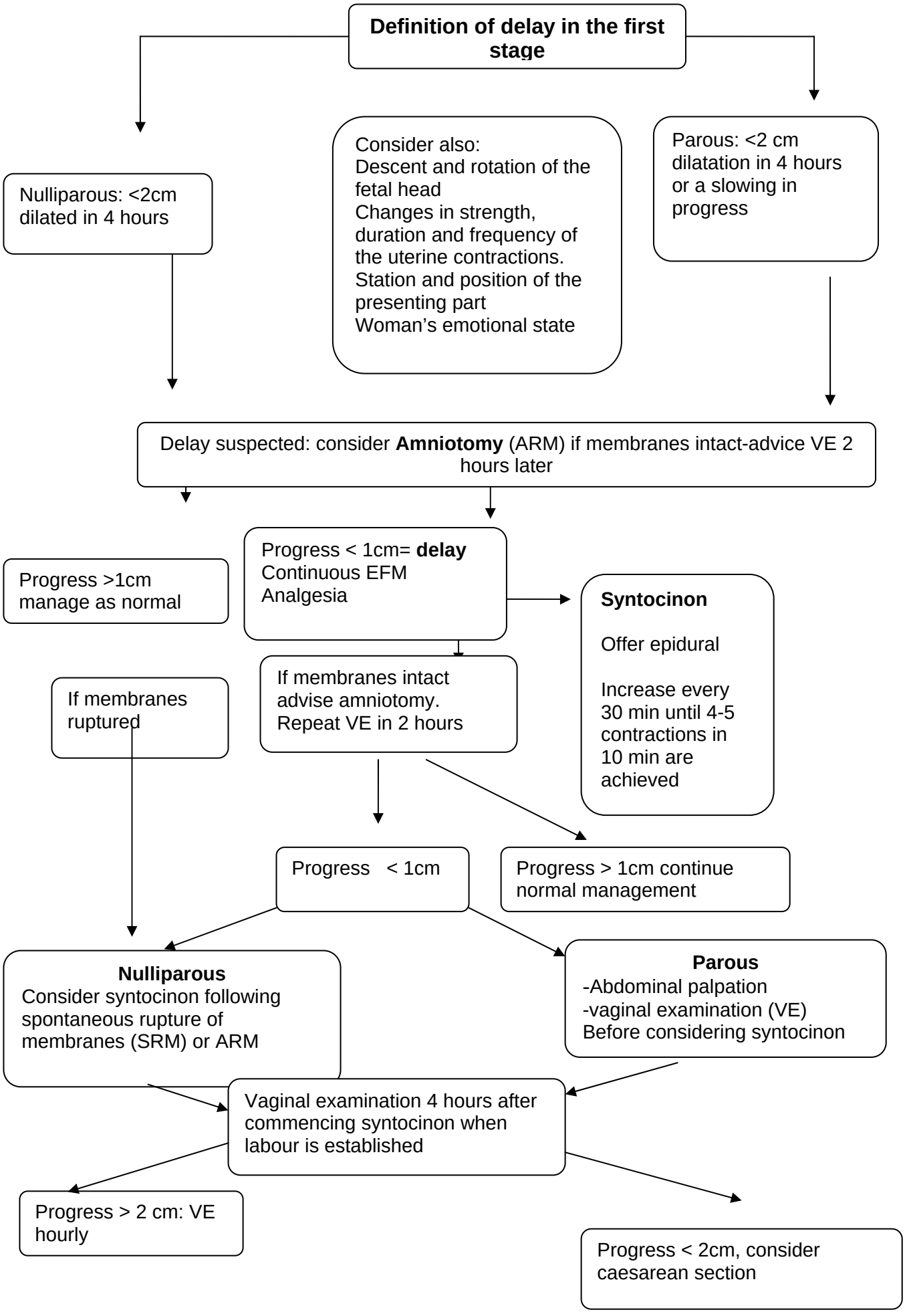
Appendix B

Considerations for a Consultant/Specialist Referral Regarding Individual Assessment

Disease area	Medical condition
Cardiovascular	Cardiac disease without intrapartum implications
Haematological	Atypical antibodies which are not putting the baby at risk of haemolytic disease
	Sickle cell trait
	Thalassaemia trait
	Anaemia-haemoglobin of 8.5-10.5 g/dl at onset of labour
Infective	Hepatitis B/C with normal liver function tests
Immune	Non-specific connective tissue disorders
Endocrine	Unstable hyperthyroidism such that a change in treatment is required
Skeletal/ neurosurgical	Spinal abnormalities
	Previous fractured pelvis
	Neurological deficits
Gastrointestinal	Liver disease without current abnormal liver function
	Crohn's disease
	Ulcerative colitis
Previous complications	Stillbirth/neonatal death with a known non-recurrent cause
	Pre-eclampsia developing at term
	Placental abruption with good outcome
	History of a previous baby more than 4.5kg
	Extensive vaginal, cervical,or third or fourth degree perineal trauma
	Previous term baby with jaundice requiring exchange transfusion.
Fetal indications	Fetal abnormality
Previous gynaelogical history	Major gynaelogical surgery
	Cone biopsy or large loop excision of the transformation zone
	Fibroids
Social reasons	Women who may need protection from domestic abuse
	Women whose babies need a child protection strategy plan
	Women who may require the services of an interpreter.

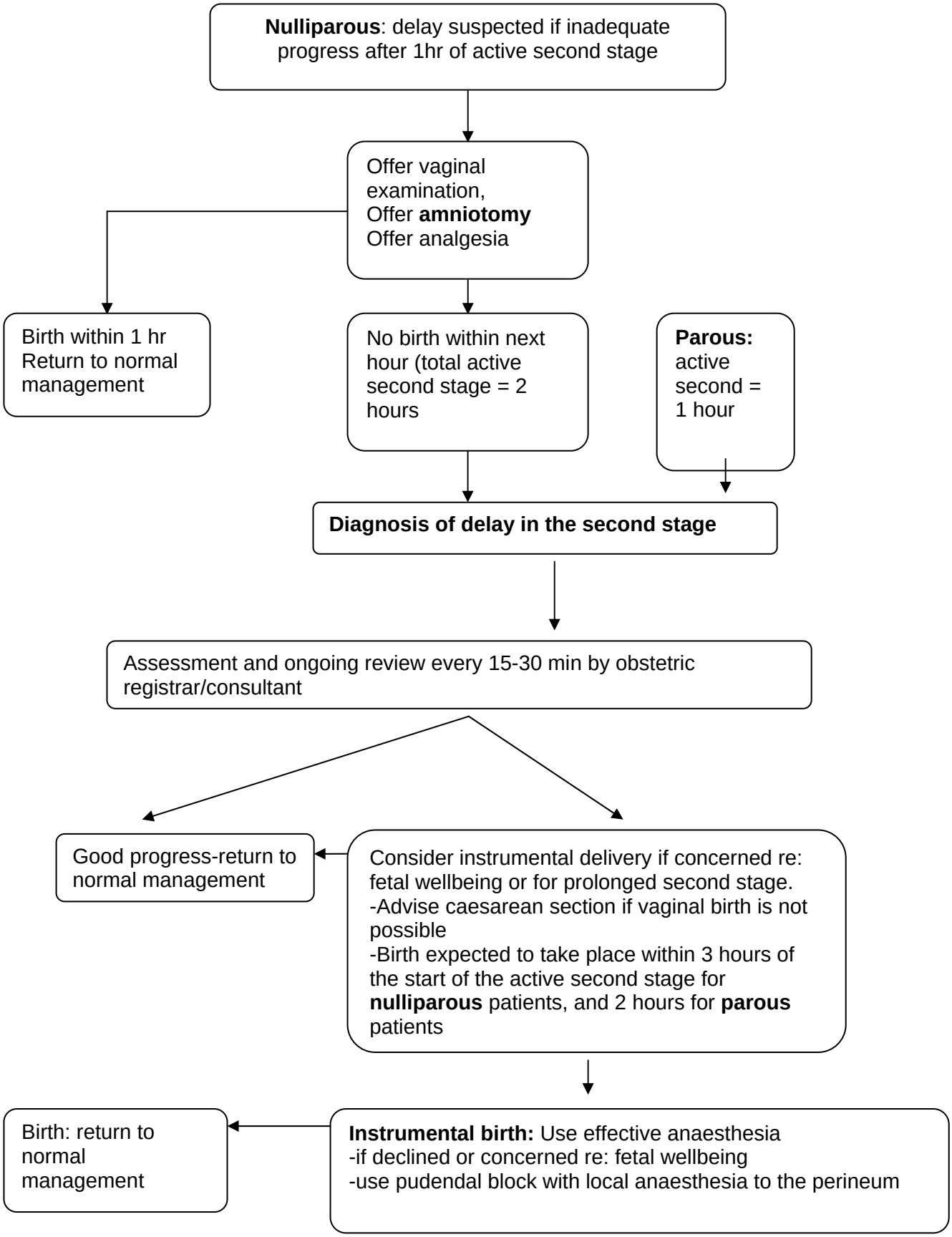
Delay in the first stage

Appendix C



Appendix D

Delay in the second stage



Appendix E

Permissible time limits in normal labour-based on cervical dilatation of 2cm in 4 hours

Labour	Nulliparous	Multiparous
First stage of labour	12 hours	12 hours
Second stage of labour		
Passive stage	1 hour	1 hour
Active stage	2 hours Amniotomy after 1 hour	1 hour Amniotomy after 30 minutes
Epidural	1 hour	1 hour
Third stage	I hour	1 hour
physiological	30 mins	30 mins
active		
Total	**17.30 hours**	**16.30 hours**