Intrapartum Care: Healthy Women and their Babies.

University Hospitals of Leicester NHS
NHS Trust

Scope:

This guideline is for all Maternity Unit staff caring for healthy women in normal labour. This includes antenatal assessment for place of birth.

Legal Liability (standard UHL statement):

Guidelines issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible health professional' it is fully appropriate and justifiable – such decision to be fully recorded in the patient's notes.

Background:

This document replaces UHL Guidelines for Midwifery Led Care in Labour following publication of NICE Clinical Guideline 55 ***Intrapartum Care: Care of healthy women and their babies during childbirth***. This guideline has been extensively reviewed within the Maternity Unit prior to implementation to ensure local requirements are reflected within this slightly amended document. Please contact the Clinical Governance Manager for details.

Related UHL documents:

Consent to examination or treatment

Mental capacity act – UHL Policy

Patient identification band policy

Maternity records documentation policy

Privacy and dignity in maternity

Fetal heart rate monitoring in labour

Augmentation of labour

Operative vaginal delivery

Management of epidural analgesia and accidental dural puncture

Thermal Protection of the Newborn (UHL)

Resuscitation of the newborn infant at birth

Initial assessment of the newborn

Breast Feeding. Guideline for Supporting Successful Feeding in Healthy Term Babies

Bottle Feeding. Guideline for Supporting Successful Feeding in Healthy Term Babies

Breastfeeding Strategy

Identification and repair of perineal or genital trauma following childbirth

Obstetric emergencies

Severe pre-eclampsia and eclampsia: guidelines for management

Management of severe sepsis

Intrapartum Care Labour & Birth

Normal Labour & Birth:

Intrapartum risk assessment is to be performed on all women in all care settings when labour has been diagnosed (cervical dilation of 4 cm or more with regular contractions), to ensure care is being provided in the appropriate care settings. The identification of new (or previously undisclosed) risk factors may necessitate a change in the planned place of birth or type of care provided. The documentation of this in the notes is the responsibility of the midwife completing the intrapartum risk assessment (see form at the end of this document). Women who are identified as high risk should be referred for Obstetrician led care and a management plan should be documented in the woman's notes.

Refer to combined care

Disease Area	Medical Condition	Factor	Additional Information
Cardiovascular	Confirmed Cardiac Disease	Previous complications	Unexplained stillbirth/Neonatal death or previous death related to Intrapartum difficulty
	Hypertensive Disorders		
Respiratory	Asthma requiring an increase in treatment or Hospital Treatment		Previous baby with neonatal encephalopathy
Haematological	Haemoglobinopathies - Sickle-Cell Disease, beta-thalassaemia major		Previous anaesthetic complications
			Previous severe pre-eclampsia
	History of thromboembolic disorders		Placental abruption with adverse outcome
	Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100,000		Eclampsia
			Uterine rupture
	Von Willebrand's Disease		Primary postpartum haemorrhage requiring additional treatment or blood transfusion
	Bleeding Disorder in the women or unborn baby		
	Atypical antibodies which carry a risk of haemolytic disease of the Newborn		Retained placenta requiring manual removal in theatre
			Caesarean Section
			Shoulder Dystocia
Infective	Risk Factors associated with Group B Streptococcus whereby antibiotics in Labour would be recommended	Current Pregnancy	Multiple Birth
			Placenta Praevia
			Pre-eclampsia or pregnancy- induced hypertension
	Hepatitis B/C with abnormal liver function tests		Preterm labour or preterm prelabour rupture of membranes
	Carrier of/infected with HIV		Placental abruption
	Toxoplasmosis - women receiving treatment		Anaemia - haemoglobin <8.5g/dl at onset of labour
	Current active infection of chickenpox/rubella/genital herpes on the woman or baby		Confirmed intrauterine death
			Induction of labour
			Substance misuse
	Tuberculosis under treatment		Alcohol dependency requiring assessment or treatment
Immune	Systemic Lupus erythematosus		
	Scleroderma		Onset of gestational diabetes
Endocrine	Hyperthyroidism		Malpresentation - breech or transverse lie
	Diabetes		
Renal	Abnormal renal function		BMI at booking of >35kg/m2
	Renal disease requiring supervision by a renal specialist		Recurrent ante partum haemorrhage
Neurological	Epilepsy	Fetal Indications	Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound)
	Myasthenia gravis		
	Previous cerebrovascular accident		
Gastrointestinal	Liver disease associated with current abnormal liver function tests		Abnormal fetal heart rate (FHR)/ Doppler studies
			Ultrasound diagnosis of oligo-polyhydramnios
Psychiatric	Psychiatric disorder requiring current inpatient care		
		Previous Gynaecological History	Myomectomy/hysterotomy

Refer for review of suitability for low risk care

Disease Area	Medical Condition	Factor	Additional Information
Cardiovascular	Cardiac disease without intrapartum implications	Previous Pregnancy Complications	Unexplained stillbirth/ neonatal death or previous death related to intrapartum difficulty
	Hypertensive disorders		
Haematological	Atypical antibodies not putting the baby at risk of haemolytic disease		Previous baby with neonatal encephalopathy
	Sickle-cell trait		Previous severe Pre-eclampsia
	Thalassaemia trait		Placental abruption with adverse outcome
	Anaemia-haemoglobin 8.5-10.5g/dl at onset of labour		Eclampsia
Infective	Hepatitis B/C with normal liver function tests		Uterine Rupture
Immune	Non-specific connective tissue disorders		Primary postpartum haemorrhage requiring additional treatment or blood transfusion
Endocrine	Unstable hypothyroidism such that a change in treatment is required		Retained placenta requiring manual removal in theatre
Skeletal/neurological	Spinal abnormalities		Caesarean Section
	Previous fractured pelvis		Shoulder Dystocia
	Neurological deficits	Current Pregnancy	Antepartum bleeding of unknown origin (single episode after 24wks gestation)
Gastrointestinal	Liver disease without current abnormal liver function		Blood pressure of 140 mmHg Systolic or 90 mmHg diastolic on 2 occasions
	Ulcerative colitis		Clinical or Ultrasound suspicion of Macrosomia
			Para 6 or more
			Recreational drug use
			Under current outpatient psychiatric care
			Age over 40 at booking
		Fetal Indications	Fetal abnormality
		Previous Gynaecological History	Major gynaecological surgery
			Cone biopsy or large loop excision of the transformation zone (LLETZ)
			Fibroids

Refer to combined care

Intrapartum Concerns	Postpartum Concerns
Fetal Heart Rate concerns	Haemorrhage
Delay in the first or second stage	Retained Placenta, Maternal collapse
Meconium Stained Liqour (unless light staining & delivery imminent)	Perineal trauma requiring medical review
Maternal request for epidural pain relief	Inverted uterus
Haemorrhage	**ANY** concerns about maternal or neonatal wellbeing
Cord presentation or prolapse	
Maternal pyrexia (38ºC once, or 37.5ºC on two occasions, 2 hours apart)	
Undiagnosed malpresentation	
Maternal hypertension (either raised diastolic BP >90mmHg or raised systolic BP >140mmHg on 2 consecutive readings taken 30 minutes apart)	
Need for advance Neonatal resuscitation	
ANY concerns about maternal or neonatal wellbeing	

Intrapartum Care Labour & Birth

KEY:
OB – seek obstetric advice (transfer to obstetric unit if appropriate)
HT – healthcare professional trained in operative vaginal birth

Normal Labour & Birth:

Care throughout the Labour	Vaginal Exam
Ask the woman about her wants & expectations for labour	Tap water may be used for cleansing prior to exam
Don't intervene if labour is progressing normally	Ensure exam is really necessary
Tell the woman that the first labour last on average 8 hrs & second labour lasts on average 5 hrs	Ensure consent, privacy, dignity & comfort
	Explain the reason for the exam & what is involved
Ensure supportive 1:1 care	Explain findings sensitively
Discuss pain relief option available to patient	Documentation of this will be by the midwife discussing the woman's individualised birth plan in the community / on admission / on initial assessment. This will be documented in the woman's handheld notes. Maternal and fetal observations throughout labour should be documented in the health record (documentation should be on the partogram once in established labour where possible)
Encourage involvement of birth partner(s)	
Encourage the woman to mobilise & adopt comfortable positions	
Take routing hygiene measures	
Do not give H2-receptor antagonists or antacids routinely to low risk women	

Initial Assessment	Women not established in labour
Listen to the woman, taking into account her emotional and psychological needs	If initial assessment normal, offer individual support. If in the community, encourage to remain at home, if in maternity unit then encourage to return home Discuss pain relief options. To reassure and offer guidance on when to call the community team, birth centre or Maternity Assessment Centre (MAC). The responsibility for this assessment and documentation in the maternity records is with the attending midwife.
ask about vaginal loss documenting show, blood loss or SRM & contractions and pain	
Review Clinical Records	
Check temperature, pulse, BP, urinalysis	
Observe contractions length, frequency & strength, monitor fetal heart rate (FHR)	
Palpate abdomen, fundal height, lie, presentation, position and station	
Offer vaginal exam	

First stage of labour	Concerns OB
Use a partogram once labour is established	Indications for electronic fetal monitoring (EFM) in low risk women, e.g. significant meconium stained liqour, abnormal FHR, maternal pyrexia, fresh bleeding;
If a partogram action line is used, this should be a 4hr action line	
Every 15 mins after a contraction: Check FHR	
Every 30 mins: document frequency of contractions	
Every Hour: check pulse (check MP against fetal heart if fetal heart rate abnormality detected) The interval should not exceed 90 minutes and should only exceed 60 minutes where dictated by clinical circumstances.	↑ diastolic BP (over 90 mmHg) or
Every 4 hrs: check BP, temperature and offer a vaginal examination. The interval should not exceed 5 hours and should only exceed 4 hours where dictated by clinical circumstances.	↑ systolic BP (over 140 mmHg) twice, 30mins apart
Every 4 hrs: offer VE after abdominal palpation and assessment of vaginal loss	
Regularly: check frequency of bladder emptying	Uncertainty about the presence of a fetal heartbeat
Consider the woman's emotional & psychological needs Where there is deviation from the recommended intervals, the reason for any delay should be documented in the notes.	Suspected delay
	Nulliparous: <2cm dilation in 4hrs
	Parous: <2cm dilation in 4hrs or slowing in process
	The responsibility for this assessment and documentation in the intrapartum records is with the attending midwife.

Second stage of labour	Concerns OB
Every 5 min after a contraction: check FHR for at least 1 minute following contraction	Indications for EFM in low-risk women, e.g. meconium stained liqour, abnormal FHR, maternal pyrexia, fresh bleeding, oxytocin for augmentation
Every 30 min: document frequency of contractions	
Every hour: check BP, offer vaginal exam	
Every hour: check pulse (check MP against fetal heart if fetal heart rate abnormality detected)	
Every hour: offer vaginal examination to assess progress after abdominal palpation and assessment of vaginal loss	
Every 4 hrs: check temperature	Nulliparous: consider oxytocin, with offer of regional analgesia, if contractions inadequate at onset of second stage.
Regularly: check frequency of bladder emptying Where there is deviation from the recommended intervals, the reason for any delay should be documented in the notes.	
Assess progress, including fetal position & station	
If woman has full dilation but no urge to push, assess after 1 hr	Delay
Discourage woman from lying supine/semi-supine	Nulliparous: active second stage 2 hours, parous 1 hour
Consider the woman's position, hydration & pain-relief needs, provide support and consider psychological needs	Concerns about fetal position, presentation and station

Assess maternal behaviour, effectiveness of pushing taking into account fetal well being	Documentation on the partogram by the attending midwife.

BIRTH

Episiotomy OB HT
Carry out episiotomy only when there is: clinical need such as instrumental birth or suspected fetal compromise
Do not offer routinely following previous third or fourth degree trauma
Use mediolateral technique (between 45º and 60º to right side, originating at vaginal fourchette)

Use tested effective analgesia

Third stage of labour	Concerns OB
Observe physical health (colour, resps and how the woman feels) Check vaginal loss (EBL) **Active Management:** Syntometrine (1ml), early cord clamping/cutting & controlled cord traction; advise that this reduces risk of haemorrhage and shortens third stage. Where Syntometrine is contraindicated Syntocinon 10iu im should be offered **Physiological Management**: if requested by low risk woman. No syntocinon/no early cord clamping; delivery by maternal effort. Do not pull cord or palpate uterus	**Retained Palcenta:** Active Management: >30 mins Physiological Management: >1 hour PPH / maternal collapse Documentation should be within the intrapartum notes and it is the responsibility of the attending midwife / obstetrician

Care after birth	Concerns OB
Woman: Observe general physical condition, colour, respiration, how she feels; check temperature, pulse, BP, uterine contractions, lochia, bladder voiding Examine cord, placenta & membranes Assess maternal emotional/psychological condition and pain	Suspected postpartum haemorrhage: take emergency action Basic resuscitation of newborn babies should be started with air Documentation is the responsibility of the attending midwife to be completed within the intrapartum records / paediatric records
Baby: Record APGAR score at 1 & 5 mins; keep warm Encourage skin to skin contact between woman & baby as soon as possible Don't separate the woman & the baby in the first hour unless necessary due to maternal or fetal condition or maternal choice Initiate breastfeeding within the first hour After 30 minutes, record body temperature	

Perineal Care	Concerns OB
Carry out systematic assessment of any trauma, including a rectal examination, sensitively. Explain assessment to the woman and confirm analgesia is effective. Document extent & findings	Refer if uncertain of nature/extent of trauma Third or fourth degree trauma Documentation is the responsibility of the attending midwife / obstetrician undertaking the perineal assessment / repair
Lithotomy, if required, only to be used for assessment & repair	
First degree trauma: Suture skin unless well opposed	
Second degree trauma: suture vaginal wall and muscle for all second degree tears. Suture skin unless well opposed	
Use continuous non-locked technique for suturing vaginal wall & muscle	
Use continuous subcuticular technique for suturing skin	
Offer rectal NSAIDs following perineal repair	

Regional Analgesia:

Regional Analgesia is only available in Obstetric Units, administered by an anaesthetist
Provide for all women who request regional analgesia after discussion

Secure IV access
Preloading/maintenance fluid infusion not needed routinely

Establishment/after each bolus: measure BP, maternal pulse, and FH every 5 min for 15 min; provide continuous EFM for 30 min
After 30 min: call anaesthetist if the woman is still in pain
Every hour: check pain intensity score
No routine use of Oxytocin in the second stage
Encourage & help the woman to adopt any comfortable position
Epidural or combined spinal-epidural analgesia is recommended
Use low concentration anaesthetic & opoid for establishing & maintaining epidural
Do not use high concentrations of local anaesthetics routinely
Use combined spinal-epidural analgesia (bupivicaine & fentanyl) for rapid relief
Continue epidural until after completion of the third stage and any perineal repair

Fully dilated: delay pushing for at least 1 hour unless the baby's head is visible or the woman has the urge to push
Birth should take place within 4 hours (for nulliparous women) 3 hours for Multiparous women)

KEY:
OB – seek obstetric advice (transfer to obstetric unit if appropriate)
HT – healthcare professional trained in operative vaginal birth

Complications:

Delay in the first stage

Definition of delay in the first stage

Nulliparous:
<2 cm dilatation in 4hrs

Consider also:
- Descent & rotation of the fetal head
- Changes in strength, duration & frequency of uterine contractions
- Station & position of presenting part
- Woman's emotional state

Parous:
<2 cm dilatation in 4hrs or a slowing in progress

Delay suspected: consider amniotomy if membranes intact
Whether membranes ruptured or intact, advise vaginal exam 2 hours later

Progress > 1cm:
Return to first stage

Progress < 1cm:
- Diagnose delay **OB**
- Offer support & effective pain relief
- Offer continuous EFM

Amniotomy
Explain procedure & that it:
- Will shorten labour by about an hour
- May make contractions stronger & more painful

If membranes ruptured

If membranes intact:
- Advise amniotomy
- Advise repeat vaginal exam 2hrs later

Progress < 1cm

Progress > 1cm:
Return to the first stage

Oxytocin
- Explain that oxytocin will bring forward time of birth, but not influence mode of birth. Will increase frequency & strength of contractions and continuous EFM will be necessary
- Offer Epidural before starting oxytocin
- Oxytocin increments > every 30 min: increase until 3-4 contractions in 10 mins

Nulliparous: OB
- Consider oxytocin following spontaneous or artificial rupture of membranes
- If oxytocin used, advise continuous EFM

Parous: OB
- Before making decision about the use of oxytocin:
  - Abdominal palpation
  - Vaginal exam
- If oxytocin used, advise continuous EFM

Vaginal Exam 4 hours after starting oxytocin in established labour

Progress >2cm:
Vaginal exam 4 hourly

Progress <2cm OB:
Consider Caesarean Section

KEY:
OB – seek obstetric advice (transfer to obstetric unit if appropriate)
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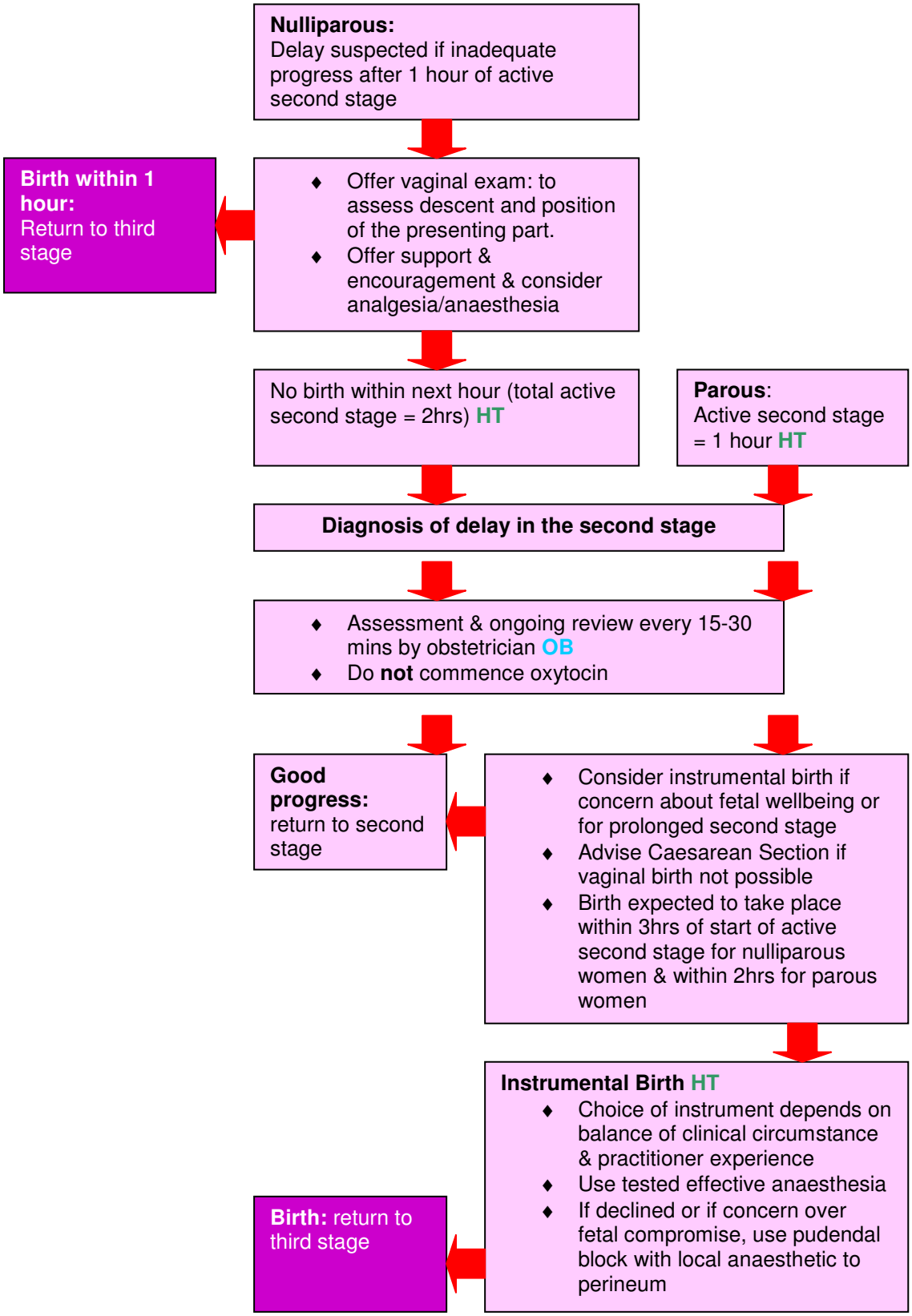
Complications:

Delay in the Second Stage

For nulliparous women at the onset of the second stage consideration should be given for amniotomy +/- the use of oxytocin, with the offer of regional analgesia if the contractions are inadequate.



Intrapartum transfer to Combined Care

Where the midwife is concerned about maternal, fetal or Neonatal wellbeing, the midwife will discuss the case with their midwifery, obstetric or neonatal colleague and transfer the woman to combined care, where necessary.

Transfer must be achieved in the safest and quickest means possible and will depend upon where the woman has chosen to labour.

Home Birth/St Mary's Birth Centre

- Planning for transfer and assessment of progress should always be made in consideration of the time taken for transfer to occur
- The midwife will contact the Delivery Suite and speak to the Co-ordinating Midwife and, if necessary, the Obstetric Registrar. Documentation of this will be recorded on the telephone assessment sheet.
- The clinical situation will be summarised and relayed stating the reason for referral. Women in labour must be transferred with a midwife in attendance (the midwife will need to take minimal equipment for the imminent birth and resuscitation of the baby during the journey). Care will then be handed over to a midwife working in the Combined Care Unit
- Transfer will be arranged by ambulance:

    - It is important to relay the degree of urgency when requesting the ambulance.
    - The decision to request a paramedic is made by the midwife in charge of the case and they should be aware that this request might significantly delay the arrival of the ambulance.

- **NON-URGENT: Call ambulance control and discuss the transfer needed, stating that there are no concerns about maternal or fetal wellbeing**.
- **URGENT – DIAL 999:** Ensure you say transfer is priority one critical to life of mother, fetus or baby.

Midwifery-led care within the hospital setting

- Midwife will contact the Delivery Suite and speak to the Co-ordinating Midwife and, if necessary, the Obstetric Registrar
- The clinical situation will be summarised and relayed, stating the reason for the referral. It is important to relay the degree of urgency of transfer
- Transfer to the Combined Care Unit should be undertaken in the most appropriate manner for the urgency of the situation. Women must be transferred with a midwife in attendance

In all cases, accurate and contemporaneous records must be kept by all involved in care.

Intrapartum risk assessment is to be performed on all women in all care settings when labour has been diagnosed (cervical dilatation of 4 centimetres or more with regular contractions). This will ensure care is being provided in the appropriate setting. The documentation of this is the responsibility of the midwife completing the intrapartum risk assessment proforma within the intrapartum notes.

Monitoring:

Process for monitoring:	Retrospective case note review
How often will monitoring take place:	Quarterly
Population:	0.5% of all health records of women who have delivered
Person responsible for monitoring:	Senior Midwives for Intrapartum and Inpatient Services
Auditable standards:	• A risk assessment has been made at the commencement of established labour and this is documented in the health record • Maternal observations (Temperature, blood pressure, pulse, respiration rate and oxygen saturations) are documented **on admission** in the patients' health records. • Maternal temperature is documented in the patients' health records every 4 hours **throughout** established labour • Maternal blood pressure is documented in the patients' health records every 4 hours in the established **first stage** of labour • Maternal pulse is documented in the patients' health records every hour in the established **first stage** of labour. • Maternal blood pressure and pulse are documented in the patients' health records every hour in the **second stage** of labour. • The frequency of contractions is documented in the patients' health records every 30 minutes in the established **first stage of labour and second stage of labour**. • Vaginal examination has been offered and documented in the patients' health records every 4 hours once **the first stage** of labour is established, and offered and documented in the patients health records every hour in **the active second stage** of labour • There is clear documentation in the patients' health records of the frequency of emptying the bladder during the established first stage of labour and the second stage of labour • Documentation in the patients' health records of the woman's general physical condition (colour, respirations and her report on how she feels) and vaginal blood loss during the **third stage** of labour • There is clear documentation of a care plan in the patients' health records if the duration of the stages of labour exceeds the timings set out in the maternity guideline 'Intrapartum Care; Healthy Women and Their Babies' • Referral to obstetric care is documented where appropriate in accordance to the maternity guideline 'Intrapartum Care; Healthy Women and Their Babies' Where there is deviation from the recommended observation intervals, a reason for any delay and further care plan management is documented in the patients medical notes
Results reported to:	Maternity Services Governance Group
Person responsible for producing action plan:	Senior Midwives for Intrapartum and Inpatient Services
Action plan signed off by:	Maternity Services Governance Group
Action plan to be monitored by:	Maternity Services Governance Group
How will learning take place: in one or more of the following fora	Audit meetings Delivery suite forums Band 7 meetings Team meetings Unit meetings Additionally, the following may be used where appropriate: • Face to face discussion where appropriate • Ward rounds • Newsletters • Communication boards/books • Posters • Emails.

Intrapartum Risk Assessment	University Hospitals of Leicester NHS NHS Trust
Please affix sticker	**This risk assessment is to be performed on all women admitted to labour ward or if anticipating a home birth <u>WHEN</u> labour has been diagnosed. (Cervical dilatation of 4cms or more with regular contractions).** **NB: Risk assessment is an ongoing process throughout labour and delivery.** Please file with Partogram once completed.
LOW RISK (Intermittent auscultation appropriate) ✓ Tick all that apply ☐ Pregnancy > 37 weeks gestation ☐ Presenting part Cephalic and in pelvis ☐ No history of medical diseases **Please refer to"Intrapartum Care: healthy women and their babies" guideline for full and comprehensive list.**	**HIGH RISK (assess need for continuous electronic fetal monitoring) ✓ Tick all that apply** **Antenatal Risk Factors (any tick here means high risk):** ☐ Previous caesarean section ☐ Previous stillbirth or neonatal death ☐ Previous gynaecological surgery – hysterotomy / myomectomy ☐ Previous baby with encephalopathy ☐ Maternal BMI >35 at booking ☐ Diabetes ☐ Current significant maternal infection/maternal pyrexia ☐ Maternal medical disease – e.g. epilepsy/hyperthyroidism/cardiac disease/cholestasis/hypertension ☐ Major maternal haemoglobinopathies ☐ Current maternal drug or alcohol abuse ☐ Other – please state **Intrapartum care plan:** ☐ Completed and present in case notes **Intrapartum Risk Factors (any tick here means high risk):** ☐ Augmentation of labour ☐ IUGR / fetal growth less than 3rd centile on ultrasound ☐ Pre eclampsia or pregnancy induced hypertension ☐ Placenta praevia – any grade ☐ SROM with meconium staining ☐ Pre term SROM or pre term labour less than 37 completed weeks gestation ☐ Antepartum haemorrhage ☐ Multiple pregnancy ☐ Breech presentation ☐ Meconium stained liquor and not in active labour ☐ Polyhydramnios / oligohydramnios ☐ Induction of labour ☐ Current or previous risk factors for PPH ☐ Other – please state This list is not exhaustive. If in doubt ask the labour ward coordinator for advice
☐ **LOW RISK**	☐ **HIGH RISK**
If risk assessment changes at any point during labour please document reason:	
Signature of person completing risk assessment:	**Print name:** **Designation:**