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Originated / Modified By:	Glenys Fell and Val Clare / Esme Booth and Kylie Watson
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1 Introduction

Giving birth is a life-changing event, and the care that a woman receives during labour has the potential to affect her – both physically and emotionally in the short and longer term – and the health of her baby (NICE, 2014).

Providers, senior staff and all healthcare professionals should ensure that in all birth settings there is a culture of respect for each woman as an individual undergoing a significant and emotionally intense life experience, so that the woman is in control, is listened to and is cared for with compassion, and that appropriate informed consent is sought. (NICE, 2014).

Senior staff should demonstrate, through their own words and behaviour, appropriate ways of relating to and talking about women and their birth companion(s), and of talking about birth and the choices to be made when giving birth (NICE 2014).

2 Communication with women and families

2.1 Treat all women in labour with respect. Ensure that the woman is in control of and involved in what is happening to her and recognise that the way in which care is given is key to this. To facilitate this, establish a rapport with the woman, ask her about her wants and expectations for labour, and be aware of the importance of tone and demeanour, and of the actual words used. Use this information to support and guide her through her labour. (NICE, 2014).

2.2 To establish communication with the woman (NICE, 2014).

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

- Encourage the woman to have support from birth companion(s) of her choice.
- Provide one –to- one care in established labour for all women.
- If the woman is on the consultant-led unit ensure that the woman is informed about the purpose of ward rounds, who will be present and timings of the ward rounds. Also inform her that there may be a need to ask doctors and other midwives to attend the room and discuss different aspects of her care.

3 Place of Birth

3.1 Depending on individualised risk assessment and discussion in the antenatal period, woman may choose to birth at home, Ingleside Stand Alone Midwifery Led Unit, The Manchester Birth Centre (Saint Mary's Wythenshawe), The Bluebell Birth Centre (Saint Mary's North Manchester), Midwifery-Led Birth Rooms (Saint Mary's Oxford Road Campus), or the Consultant/Obstetric Led Units at Saint Mary's (all sites).

3.2 Please see *Appendix 2* for

- Medical conditions indicating increased risk suggesting planned birth at an obstetric unit.
- Other factors indicating increased risk suggesting planned birth at an obstetric unit.
- Medical conditions indicating individual risk assessment when planning place of birth.
- Other factors indicating individual risk assessment when planning place of birth**.**

3.3 Please see *Appendix 3* for

- Admission criteria for the Manchester Birth Centre at Saint Mary's
- Wythenshawe, Midwifery-led birth rooms at Saint Mary's Oxford Road Campus and the Bluebell Birth Centre at North Manchester.

3.4 Please see the *Homebirth Guideline* and *Ingleside Guideline* for criteria for these places of birth.

4 Advice for women who telephone in suspected labour.

See also the *Maternity Triage Guideline / Home Birth Guideline*

4.1 Women in suspected labour may telephone directly for advice. The midwife should assess whether a telephone interpreter is required and employ the use of this service if needed.

4.2 Take a detailed history of the women, including enquiring about any maternal or fetal risk factors. Ask the woman about any previous telephone calls and admissions. Ask the woman how she is, and about her wishes, expectations and concerns. Ensure that kindness and compassion is evident when speaking to women. Ask the woman about:

- Fetal movements, including any changes.
- Contractions – commencement, frequency, and duration
- Vaginal loss – including presence of show, any blood loss or rupture of membranes (including colour).
- Any complications of pregnancy/ medical conditions

- Any other factors felt relevant to clinical scenario.

4.3 Agree a plan of care with the woman depending on the information gathered from the telephone call.

- Women **without complications**, who are assessed as in the latent phase of labour, may remain at home following discussion and advice and provided the woman is happy to do so. Women should be given clear information about when to make further contact. For example, if they experience spontaneous rupture of membranes, any fresh bleeding, increasing contractions or decreased fetal movements or any concerns.
- Practical suggestions to support the woman at home should include:
  - Encouraging everyday activity within their home environment .
  - Massage
  - Breathing and relaxation techniques
  - Simple oral analgesia e.g., paracetamol
  - The use of Transcutaneous Electrical Nerve Stimulation (TENS)
  - The use of water - warm bath or shower
  - Women should be advised to eat and drink as normal, ensuring they remain adequately hydrated.
  - Information regarding how to contact a midwife and/or returning to hospital.
  - Attempt to pass urine at least every 4 hours.
- Consideration for inviting into maternity triage should be given for women who have called more than once in the latent phase of labour.
- The midwife should consider requesting an obstetric review for women who have repeated attendances during the latent phase. On the third or subsequent admission obstetric review is required.
- For women **with complications or any risk factors**, an individual risk assessment should be made, and the woman invited to attend if necessary.
- The midwife should seek further advice from a senior midwife or doctor (ST 3 or above) if there is any uncertainty about whether admission for an assessment is required.

5 Initial face-to-face assessment at the onset of labour

5.1 The initial risk assessment by a midwife may take place at home or in hospital. Listen to the woman's story. Consider her emotional/psychological needs and her wishes, and concerns including reading any birth plan that the woman has made.

- An initial assessment of risk must be undertaken during the woman's admission for suspected labour and documented on the Triage Assessment Card (TAC) for Suspected Labour. For women choosing a home birth or birth at Ingleside, the midwife will perform a risk assessment and ensure that the woman continues to meet the criteria for the chosen setting. See *Home Birth Guideline* and *Ingleside Operational Guideline*.

- The midwife should undertake a clinical assessment, as outlined on page 1 of the TAC, and review the antenatal notes (including all antenatal screening results) to identify any risk factors and/or special instructions for labour. This includes:
- Medical conditions, including anaesthetic history and specialist clinic care plans.
- Previous obstetric history
- Social and lifestyle factors
- Risk assessment for appropriate place of birth
- Antenatal VTE assessment
- Review the current pregnancy and note any new risks that have arisen since the booking assessment.
- Ensure all previous vaginal swab and urine culture results are reviewed, with a particular attention to GBS status.
- If the woman is in constant severe pain not wholly attributable to labour or assessed as a RED priority from the suspected labour TAC, then the woman must be admitted directly to the consultant-led unit.

5.2 The midwife should perform and document an assessment of maternal and fetal wellbeing according to page 1 of the TAC for suspected labour. This should include:

- A full set of clinical observations with calculated MEOWS score as indicated – See *Modified Early Obstetric Warning Score Guideline*
- Urinalysis
- Ask her about any pain she is experiencing and discuss her options for pain relief.
- Assessment of contractions length, strength and frequency
- Asking the woman about her recent bladder and bowel function.
- Abdominal palpation including symphysis fundal height (SFH) if applicable, the baby's lie, presentation, position and engagement of the presenting part.
- Recording of liquor/ vaginal loss
- Ask about the baby's movements in the last 24 hours.
- Recording the fetal heart rate (FHR):
  - On admission auscultation of the fetal heart must be performed with a Pinard stethoscope and/or hand-held Doppler for 1 minute immediately after a contraction. Palpate the woman's pulse to differentiate between the heart rates of the woman and the baby.
  - Record the FHR as a single rate.
  - Note any accelerations during fetal movements.
  - For women with risk factors, electronic fetal monitoring (CTG) should be performed (See *Fetal Monitoring in Labour Guideline*).
  - The use of admission CTG in low-risk pregnancy is not recommended in any birth setting.
  - If there is uncertainty about whether the woman is in established labour a vaginal examination (see 7.4) 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.

    - The midwife should discuss the findings of the assessment with the woman and subsequent management plan.
- Any woman not booked at the place of admission in labour will require a group & antibody screen and full blood count taken on admission. A further group and antibody screen should be taken as soon as practicable.
- Women who remain low risk following assessment can receive midwifery led care in their setting of choice. For women who wish to labour and birth on the **Manchester Birth Centre (Saint Mary's** Wythenshawe), or Bluebell Birth Centre (Saint Mary's North Manchester) or continuity rooms Oxford Road Campus see Appendix 2 for admission criteria. Please see *Ingleside Operational Guideline* and *Homebirth guideline* for the admission criteria for these settings.

6 Latent phase of labour

6.1 Definitions

For the purposes 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 dilatation up to 4 cm.
- Established first stage of labour – when:
    - There are regular painful contractions **and**
    - There is progressive cervical dilatation from 4 cm.
- It is important to utilise all midwifery skills and expertise when diagnosing labour and a repeat vaginal examination may not be necessary to diagnose established labour.

6.2 Factors for midwives to consider when diagnosing labour:

- Uterine activity – changes, increasing in frequency and strength – be mindful that some women may experience infrequent irregular contractions and still be making progress. Contractions should be assessed by listening to the woman's history, abdominal palpation and continuous observation of contractions over a period of at least 10 minutes.
- Cervical dilation- changes in effacement and dilatation
- Maternal behaviour – altered, need for analgesia, increased vocalisation.
- Descent and rotation of the foetus
- Increasing pain
- Request for further analgesia
- Rupture of membranes
- Increase in show.
- Increased need for support
- Midwives should be mindful of the effects of opiates on women's behaviour and uterine activity and that the sedative effects of opiates may mask other signs of established labour.

The diagnosis of labour is important as the frequency and timing of fetal and maternal monitoring depends on this factor to ensure the safety and wellbeing of the foetus and mother.

6.3 Care planning for women in the latent phase:

If a woman seeks advice or attends with painful contractions but is not in established labour the midwife should:

- Demonstrate care, compassion and consider language used, avoiding words or phrases which may be discouraging.
- Recognise that a woman may experience painful contractions without cervical change, and although she 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.
- Make an individualised care plan which takes into consideration all risk factors and the woman's preferences. Options may include: returning home to await events or admission for further support.
- Consider requesting an obstetric review for women who have repeated attendances during the latent phase. On the third or subsequent admission obstetric review is required.
- Document the guidance that she gives to the woman.
- If under consultant led, or shared, care refer for an obstetric review regarding a management plan for the latent phase. Any deviations from the standard monitoring, as per 6.4, must be documented.

6.4 Monitoring in the latent stage

- The fetal heart rate should be assessed at the first contact with the woman in early labour and at each further assessment to determine whether labour has become established (NICE, 2014).
- If remaining as an inpatient, in the latent phase of labour, undertake the following as a minimum - 4 hourly observations of:
  - maternal observations including calculation of MEOWS.
  - fetal heart rate auscultation
  - abdominal palpation
  - monitoring of frequency, length and strength of contractions and any change in the woman's behaviour including a request for analgesia.

If the woman is asleep then undertake observations once awake.

Increase frequency of observations in response to the clinical situation and any change in risk factors, such as SROM, reduced FM, increase in abdominal contractions/pain, or PV Loss.

- If oral analgesia is provided, its effectiveness must be reviewed in a timely manner and further analgesia requirements taken into consideration when deciding on continuing place of care. Seek advice from shift coordinator or maternity bleep holder if required.

7 Care in Established first Stage of Labour

7.1 General care throughout labour

Inform women that, the first stage of labour lasts on average 8 hours and is unlikely to last over 18 hours. Second and subsequent labours last on average 5 hours and are unlikely to last over 12 hours (NICE, 2014).

Clinical intervention

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

Mobilisation

Encourage and help the woman to move and adopt whatever positions she finds most comfortable throughout labour. This may include use of birthing balls, mats, adapting the bed position, and use of telemetry when having continuous monitoring of the fetal heart.

Hygiene

Routine hygiene measures must be taken by staff caring for women in labour, including standard hand hygiene and use of alcohol gel. Single-use non-sterile gloves, and an apron, are appropriate to reduce cross-contamination between women, babies and healthcare professionals.

Personal Protective Equipment

Selection of personal protective equipment (PPE) must be based on an assessment of the risk of transmission of microorganisms to the woman, and the risk of contamination of the healthcare worker's clothing and skin by women's blood, body fluids, secretions or excretions (NICE 2014). Please always refer to current Trust guidance on PPE and the Infection, Prevention and Control guidelines.

- All women should have one-to-one midwifery care in established labour (NICE 2014)
- Do not leave a woman in established labour on her own except for short periods or at the woman’s request.

7.2 Vaginal Examinations

7.2.1 Communication and consent:

- Be sure that the examination is necessary and will add important information to the decision-making process. Recognise that a vaginal examination can be very distressing for a woman, especially if she is already in pain, highly anxious and in an unfamiliar environment.

- Explain the reason for the examination and what will be involved.
- Ensure the woman's informed consent, privacy, dignity and comfort. Minimise the number of people present in the room. A documented discussion should be had with the woman around her preferences with regards to people present in the room during intimate examinations (for example presence of a chaperone may be preferred or necessary).
- Explain sensitively the findings of the examination and any impact on the birth plan to the woman and her birth companion(s) (NICE, 2014).
- In the presence of ruptured membranes, the frequency of vaginal examinations should be kept to a minimum unless clinically indicated, so as to reduce the risk of infection.
- Document all examinations accurately using the documentation tool specific to your area, the electronic system or the Partogram depending on place of birth.

7.2.2 When undertaking a vaginal examination:

- An abdominal palpation must be undertaken prior to any vaginal examination.
- Observe strict adherence to Hand Hygiene Policy and PPE Policy (See 3.3)
- A sterile vaginal examination pack and sterile gloves should be used for all vaginal examinations. Please refer to the *Swab, Instrument and Needle Count Policy*.
- Warm tap water can be used to cleanse prior to the vaginal examination.

7.3 Bladder care in labour - see *Oliguria in Labour guideline.*

- All women in labour are to be encouraged to pass urine 4 hourly.
- The timing and volume of the void should be documented along with a plan of care if urine output is reduced. If a woman is unable to void spontaneously an intermittent catheter should be used to empty the bladder.
- Oliguria is defined as measured urine output of less than 80mls in 4 hours and can complicate labour. If oliguria is diagnosed see *Oliguria in Labour guideline* for management plan.
- Prior to the active second stage of labour an indwelling catheter must be fully removed and documented on the labour records.
- If there is any delay in descent during either the passive or the active 2nd stage or any indication that the woman has not been able to fully empty her bladder an in/out catheter should be passed using aseptic non touch technique (ANTT).

7.4 Hydration and nutrition

- Inform the woman if she is low risk that she may drink during established labour and that isotonic drinks may be more beneficial than water (NICE, 2014).
- Inform the woman if she is low risk that she may eat a light diet in established labour unless she has received opioid analgesia **or** she develops risk factors that make a general anaesthetic more likely. All women on the consultant-led delivery units who receive opioids or have risk factors for a general anaesthetic should receive antacid prophylaxis. See *Antacid Prophylaxis and aspiration risk on the Consultant Led Delivery Unit* guideline.

- In the event there is clinical evidence of dehydration an intravenous infusion of Hartmann's solution may be prescribed, and a fluid balance chart commenced. The woman should be closely observing signs for fluid overload particularly if IV syntocinon is also in progress. Ketonuria does not need correction by intravenous fluids if the mother is healthy, not dehydrated, progressing in labour and the fetal heart is normal.

7.5 Observations during first stage of labour

- All observations should be documented in the electronic maternal records depending on place of birth.
- All care and observations should be conducted and recorded in the delivery room.
- Maternal wellbeing and assessment of progress in labour, including as a minimum.
  - 4 hourly temperature and blood pressure
  - Hourly pulse rate (although this should be monitored simultaneously with intermittent fetal heart auscultation in order to differentiate)
  - Every 30 minutes: frequency, duration and strength of contractions ○ The frequency of bladder voiding. It is vital to ensure the woman voids her bladder on a regular basis and she should be encouraged to do this at least every 4 hours. Urinalysis should be performed following each void.
  - Offer a vaginal examination (including abdominal palpation prior to VE) four-hourly during the first stage of labour, or if there is concern about progress or in response to the woman's wishes. If, however, the cervix is 9cm dilated a reassessment should take place between 2 – 3 hours depending on clinical judgement.
  - Observation of the woman's behaviour
  - Holistic assessment and support of the woman's coping strategies including discussion of options for pain relief.
- Fetal wellbeing according to Fetal Monitoring in Labour guideline
- In women whose most recent haemoglobin measurement is less than 100g/L, take full blood count (FBC) and group and antibody screen. Consider intravenous cannulation.

8 Pain Relief in Labour

- Healthcare professionals should think about how their own values and beliefs inform their attitude to coping with pain in labour and ensure their care supports the woman's choice.
- Encourage the woman to communicate her need for analgesia at any point during labour.
- Support women in their choice to: ○ use breathing and relaxation techniques.
  - use massage techniques that have been taught to birth companions.
  - the playing of their choice of music
- If appropriate offer the woman, the opportunity to labour in water for pain relief (See *Birthing Pool for Labour and Birth Guideline*)
- Do not offer acupuncture, acupressure or hypnosis, but do not prevent women who wish to use these techniques from doing so.

- Do not offer transcutaneous electrical nerve stimulation (TENS) to women in established labour but support the woman if she wishes to use her own.
- Ensure that Entonox (a 50:50 mixture of oxygen and nitrous oxide) is available in all birth settings but inform the woman that it may make her feel nauseous and light-headed.
- Ensure that diamorphine hydrochloride or other opioids are available. Inform the woman that these will provide limited pain relief during labour and may have significant side effects for both her (drowsiness, nausea and vomiting) and her baby (short-term respiratory depression and drowsiness which may last several days and may interfere with breastfeeding). If required in the latent phase, consider transfer to the labour ward.
- Up to 10 mg of diamorphine hydrochloride or 100mg of pethidine can be administered intramuscularly every 4 hours if required when in established labour. This is covered on the *Administration of Medicines without a Prescription Policy.* The woman should not enter a bath or birthing pool within 2 hours of opioid administration. If an intravenous or intramuscular opioid are used, also administer an antiemetic. Prochlorperazine (Stemetil) 12.5mg/1mL solution given 8 hourly by intramuscular injection is covered in the *Administration of Medicines without a Prescription Policy.*
- If the woman asks for regional analgesia or patient controlled intravenous opioid analgesia, she will need transferring to consultant-led care. Transfer the woman according to 9.3 or 9.4 below. Contact the duty anaesthetists to inform them of the woman's request. If a woman in labour asks for regional analgesia, comply with her request. This includes women in severe pain in the latent first stage of labour following a review by an obstetrician and /or anaesthetist.
- Bear in mind that remifentanil PCA cannot be started within 4 hours of administration of diamorphine.
- See guidelines for *Epidural Analgesia in Obstetrics, Neuraxial Opioid Analgesia during and after Operative Delivery,* and *Remifentanil Patient Controlled Analgesia for Women in Labour.*

9 On-going assessment and indications for transfer to obstetric led care

If, at any point, any of the following are observed, an urgent referral to an obstetrician (ST3 or above) and transfer to obstetric led care is necessary (this may mean a change in location for some low-risk women).

If the birth is imminent, transfer may not be possible and direct communication with a senior obstetrician and the delivery unit coordinator must take place. Where transfer cannot be facilitated this should be immediately escalated to the site maternity bleep holder to facilitate prompt obstetric review and transfer.

9.1 Maternal Observations (NICE, 2014):

- Pulse over 120 beats/minute on 2 occasions 30 minutes apart
- A single reading of either raised diastolic blood pressure of 110 mmHg or more or raised systolic blood pressure of 160 mmHg or more.

- Either raised diastolic blood pressure of 90 mmHg or more or raised systolic blood pressure of 140 mmHg or more on 2 consecutive readings taken 30 minutes apart.
- A reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (90 mmHg or more) or raised systolic blood pressure (140 mmHg or more).
- Temperature of 38°C or above on a single reading, or 37.5°C or above on 2 consecutive occasions 1 hour apart.
- Any vaginal blood loss other than a show.
- Rupture of membranes more than 24 hours before the onset of established labour.
- Pain reported by the woman that differs from the pain normally associated with contractions.
- Confirmed delay in the first or second stage of labour.
- Request by the woman for additional pain relief using regional analgesia.
- Any risk factor recorded in the woman's notes that indicates the need for obstetrician led care.
- Obstetric emergency – including antepartum haemorrhage, cord prolapse, postpartum haemorrhage, maternal seizure or collapse, or a need for advanced neonatal resuscitation.
- Retained placenta.
- Third-degree or fourth-degree tear or other complicated perineal trauma that needs suturing.

9.2 Fetal Observations:

- Any abnormal presentation, including cord presentation, transverse or oblique lie.
- High (4/5–5/5 palpable) or free-floating head in a nulliparous woman
- Suspected fetal growth restriction or macrosomia.
- Suspected oligohydramnios or polyhydramnios
- Fetal heart rate abnormalities on intermittent auscultation, for example –
  - fetal heart rate below 110 or above 160 beats/minute or any concerns in the FHR that require continuous EFM.
  - decelerations in fetal heart rate heard on intermittent auscultation, or any other concerns such as a rising baseline rate.
- The presence of **significant** meconium. This is defined as dark green or black amniotic fluid that is thick or tenacious, or any meconium-stained amniotic fluid containing lumps of meconium.
- Prolonged period since rupture of membranes (24 hours or more) in the presence of non-significant meconium.
- Presence of risk factors requiring electronic fetal monitoring – *See Fetal monitoring in labour guideline* for specific criteria.

The band 7 labour ward coordinator must attend and review all women within 30 minutes of their arrival to the delivery unit. This must be documented in the labour record.

Women admitted to the consultant-led unit who are un-booked will be admitted under the on-call Consultant and should not be considered low risk.

9.3 Transferring a woman from the Manchester or North Manchester Birth Centre

- Talk with the woman and her birth companion about the reasons for this and what they can expect and alleviate her anxiety.
- Inform the labour ward co-ordinator of the need for transfer. An SBAR style handover should be communicated. Communication should include the urgency of the transfer. If there are any delays with transfer inform the site maternity bleep holder. See Appendix 4 for indications and transfer times.
- The Labour ward coordinator and/ or midwife caring for the woman should then liaise with duty obstetricians and/or anaesthetists as appropriate.
- If appropriate, complete the transfer details in the electronic patient records to enable the collection of intrapartum transfer audit data from midwifery led care to obstetrician led care.
- The woman can be transferred to delivery suite on a wheelchair, delivery bed or transfer trolley depending on the woman's circumstances her stage of labour and the urgency of the transfer.
- Assistance should be sought from the team to provide support with manual handling and the opening of doors, use of lift and transfer of the bed/chair/trolley.
- Where possible, to support continuity, the midwife should continue to care for the woman. There should be a clear SBAR handover from midwife caring for the woman to the consultant-led unit midwife if care is to be handed over.
- If there is any delay in transfer, inform the maternity bleep holder to support a prompt transfer. It may be necessary for an obstetrician to review the woman on the Manchester Birth Centre, Bluebell Birth Centre or midwifery led rooms at ORC whilst awaiting transfer.
- Within 30 minutes of arrival, if not sooner depending on clinical picture, the labour ward coordinator should perform a full review.

9.4 Transfer from midwifery-led care on the consultant-led units

- If the woman is receiving midwifery led care on the consultant-led unit inform the woman regarding the need to transfer her lead carer to the consultant. Talk with the woman and her birth companion about the reasons for this, and what they can expect and alleviate her anxiety. Inform the labour ward coordinator and document in the maternal records that care is no longer midwifery led.
- The Labour ward coordinator and/or midwife caring for the woman should then liaise with duty obstetricians and/or anaesthetists as appropriate.

10 Suspected delay in the 1st stage of labour

- If delay in the established first stage of labour is suspected, assess all aspects of progress in labour when diagnosing delay including:
  - cervical dilatation of less than 2cm in 4 hours for first labours

    - cervical dilatation of less than 2cm in 4 hours or a slowing in the progress of labour for second or subsequent labours
    - descent and rotation of the baby's head
    - changes in the strength and frequency of uterine contractions
- Take the following into account during assessment:
    - parity
    - cervical dilation
    - uterine contractions
    - station and position of presenting part
    - the woman's emotional state
- referral to the most appropriate health professional (NICE, 2014)
- Irrespective of the birth setting, ensure the delivery unit coordinator is aware of suspected delay in first stage of labour, and a management plan has been discussed and clearly documented.
- If delay in the established first stage of labour is suspected amniotomy should be considered for all women with intact membranes after explanation of the procedure, explain that this is likely to shorten labour by approximately an hour, and will increase contraction strength and frequency (NICE, 2014).
- Advise all women with suspected delay to have a vaginal examination 2 hours later and diagnose delay if progress is less than 1cm (NICE 2014).
- For all women with confirmed delay in the established first stage of labour, transfer the woman to consultant-led care for an obstetric review and a decision about management options, including the use of oxytocin. Explain to her that using oxytocin after spontaneous or artificial rupture of the membranes will bring forward the time of birth but will not influence the mode of birth or other outcomes. Inform that continuous fetal monitoring is recommended whilst intravenous oxytocin is in use.
- See also *Induction of Labour guideline* (ORC and Wythenshawe)
- Offer all woman with confirmed delay in the first stage of labour adequate analgesia and emotional support (NICE 2014).
- Ensure oral hydration and fluid balance is maintained and conduct regular urinalysis to assess for ketonuria.

11 Care in the second stage of labour

Once full dilatation has been confirmed for women receiving consultant-led care the midwife caring for the woman should request a senior midwife (Band 7 or above) or senior obstetric (ST3 or above) bedside review. This should include a full review of the woman, her pregnancy, her fetus and her labour thus far. A management plan should be discussed with the woman and the midwife caring for her and documented.

11.1 Passive second stage of labour

- Full dilatation of the cervix prior to or in the absence of involuntary expulsive contractions.

- For women receiving midwifery-led care, if full dilatation of the cervix has been confirmed but she does not get an urge to push carry out a further assessment after 1 hour and commence active second stage.
- For women with an epidural an individualised care plan should be documented by the obstetrician (ST3 or above) in relation to the timing of commencing the **active** second stage. The passive stage would usually between 1-2 hours, depending on the whole clinical assessment of the woman and fetus.

11.2 Active second stage of labour

- there is active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions.
- the woman is experiencing expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix.
- the baby is visible.
- (NICE, 2014)

11.3 Observations in the passive and active 2nd stage

- All observations should be documented in the electronic maternal records.
- The midwife should assess maternal and fetal wellbeing, including as a minimum (See also: *Fetal Monitoring in Labour guideline*):
  - Half hourly documentation of the frequency of contractions
  - Maternal pulse every 15 minutes
  - Half hourly blood pressure
  - Continued 4 hourly temperature.
  - Frequency of passing urine - if there is any delay in descent during either the passive or the active 2nd stage or any indication that the woman has not been able to fully empty her bladder an in/out catheter should be passed using ANTT.
  - Offer a VE hourly in the active 2nd stage or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss)

Assess the baby's wellbeing See also: *Fetal Monitoring in Labour guideline*):

Assessment should also include:

- Baby's position and station at the onset of the 2nd stage
- Maternal behaviour
- Effectiveness of pushing

These factors will assist in deciding the timing of further vaginal examination and any need for obstetric review.

11.4 Woman's position and pushing

- Ongoing consideration should be given to the woman's position, hydration, coping strategies and pain relief throughout the second stage.

- Discourage the woman from lying supine or semi-supine in the second stage of labour and encourage her to adopt any other position that she finds most comfortable.
- Inform the woman that in the second stage she should be guided by her own urge to push.
- If pushing is ineffective or if requested by the woman, offer strategies to assist birth, such as support, change of position, emptying of the bladder and encouragement. Routine use of the Valsalva manoeuvre (holding the breath with a closed glottis and pushing down) should not be used.
- Routine use of lithotomy is **not** advocated for women in the second stage.
- Manual stretching of the perineum and vaginal wall should not take place as this can cause pain, distress and trauma to the woman.

11.5 Management of the perineum

- Management of the perineum should be discussed and documented as part of the woman's birth plan and again at the onset of labour.
- Use the OASI care bundle principles:
  - Inform the woman about OASI and what steps can be taken to minimise her risk.
  - Documented use of manual perineal protection (MPP)
- For spontaneous births, MPP should be used unless the woman's position doesn't allow MPP, or she objects.
- For assisted births, MPP should be used.
- If an episiotomy is to be undertaken, it should be performed mediolaterally at a 60-degree angle at crowning
- Following the birth, the perineum should be examined, and any tears graded according to RCOG guidance. The examination should include a per rectum (PR) check even when the perineum appears intact, and this should be documented in the case notes.
- Consider use of a warm compress held on the perineum towards the end of the second stage as evidence suggests this can reduce the incidence of OASI by nearly 50%

For further information please see the *Perineal Repair Guideline*

For women with female genital mutilation see *Female Genital Mutilation FGM in maternity guideline*

11.6 Delay in the second stage of labour

Nulliparous women:

- **Suspect** delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 1 hour of active second stage. Offer vaginal examination and then offer amniotomy if the membranes are intact.
- **Diagnose** delay in the active second stage when it has lasted 2 hours. If birth is not imminent, inform the shift coordinator, and refer the woman to an obstetrician. If the woman is in a midwifery-led setting arrange transfer to the delivery unit.
- Assess if assisted vaginal delivery is indicated after 3 hours in primiparous women with epidural or 2 hours in primiparous women without epidural.

Multiparous women:

- **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.
- **Diagnose** delay in the active second stage when it has lasted 1 hour. If birth is not imminent, inform the shift coordinator, refer the woman to an obstetrician. If the woman is in a midwifery-led setting arrange transfer to the delivery unit.
- Assess if assisted vaginal delivery is indicated after 2 hours in multiparous women with epidural or 1 hour in multiparous women without epidural.

See also local Assisted Vaginal Birth Guidelines, Fetal Monitoring in Labour guideline and Caesarean Section Guideline for further indications for Operative Vaginal Delivery or Caesarean Section

See also Home Birth Guideline and Transfer of Obstetric/Neonatal Emergencies from Saint Mary's Community and Antenatal Services to Saint Mary's Hospital including the process for born before arrival (ORC and Wythenshawe only).

- If there is delay in the second stage of labour, or if the woman is excessively distressed, support and sensitive encouragement and the woman's need for analgesia/anaesthesia are particularly important (NICE, 2014)
- Where delay is suspected, ensure the woman remains hydrated and continue to assess contraction frequency, duration and strength (NICE, 2014)
- After initial obstetric assessment of a woman with delay in the second stage, maintain ongoing obstetric review every 15–30minutes (NICE, 2014)
- If there is confirmed delay in the second stage of labour an obstetrician should assess the woman before starting intravenous oxytocin (IVO). If such delay occurs in a multiparous woman, delivery will almost always be favoured over the use of IVO – use of IVO should only be authorised by a Consultant Obstetrician. See also *Induction of Labour guideline.*

12 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 (NICE, 2014).

Recognise that this time immediately following the birth is when a woman and partner are meeting their baby for the first time and ensure that any care or interventions are sensitive to this and minimise disruption and separation of the mother and baby (NICE 2014).

Advise the woman to have an active management of the third stage as it is associated with lower risk of postpartum haemorrhage. Low risk women requesting physiological management should be supported in their choice. Ensure this discussion and the agreed management is documented within the intrapartum documentation.

12.1 Maternal well-being during the third stage of labour.

Assessment of maternal well-being should include:

- General physical condition as shown by colour, respiration and how she feels.
- Vaginal blood loss (See also *Postpartum Haemorrhage and Major Obstetric Haemorrhage (including uterine inversion)* guideline.
- Transfer to obstetric unit where concerns around the woman's wellbeing arise.

12.2 Neonatal well-being during the third stage of labour and immediate postnatal period

- Assessment of neonatal well-being consideration of risk factors for Sudden Unexplained Postnatal Collapse (SUPC) should include:
- Evaluate the physical condition of the baby using the APGAR score. See also *Resuscitation of Newborn Infants Policy* for babies requiring resuscitation.
- Record the time from birth to the onset of regular respirations and the APGAR score.
- Facilitate skin to skin with maternal consent if it is safe to do so. Keep the baby warm and dry and cover him or her with a warm dry blanket or towel whilst maintaining skin-to-skin contact with the woman.
- Vigilant observation of the mother and baby should continue, with prompt removal of the baby if the health of either gives concern.
- Mothers should be encouraged to be in a semi-recumbent (half lying, half sitting) position to hold and feed their baby, ensuring the mother can see the baby's face.
- Care should be taken to ensure that the baby's position is such that their airway remains clear and does not become obstructed.
- Staff should have a conversation with the mother and her companion about recognising any changes in the baby's condition.
- Always listen to parents and respond immediately to any concerns raised.
- Medicines given to the mother should be considered when discussing skin-to-skin contact. Pain relief given to mothers can affect their ability to observe and care for their baby.
- Additional risk factors should be considered. The level of risk for Sudden Unexplained Postnatal Collapse when a baby is in skin-to-skin contact can increase with, for example, increased maternal body mass index, antenatal use of opiate medication, sedation, and staffs' focus on other tasks.
- Babies should not be in skin-to-skin contact with their mothers when the mothers are receiving Entonox or other analgesics (painkillers) that effect their consciousness and awareness of the baby's position. This includes epidural analgesia, and the level of the sensory block should be assessed.
- If the mother is unable to provide skin-to-skin care, it is possible that the birth partner can undertake this in the initial post-birth period. Close observation of the baby should still continue. If the birth partner is not present a baby can be placed under a warm resuscitaire close to a mother and in her line of sight.

12.3 Active Management of the 3rd Stage

Active management includes:

- Routine use of uterotonic drugs:
- 10 units Syntocinon™ **or** 1 ampoule of Syntometrine™ via intramuscular injection with the birth of the anterior shoulder or immediately after birth and before the cord is clamped and cut.
- Women who have individualised care plans for medical reasons (for example, women with cardiac conditions) may require a modified third stage. Midwives should refer to the individualised care plan for guidance.
- Deferred clamping and cutting of the cord: Refer to *Deferred Cord*
- *Clamping in Newborns* guideline
- **Do not** clamp the cord earlier than one minute from birth of the baby unless there is concern about the integrity of the cord or the baby has a heartbeat below 60beats/minute that is not getting faster (NICE, 2014).
- Controlled cord traction should only be used after administration of uterotonic and signs of separation of the placenta:
- Unless the woman requests otherwise, clamp and cut the cord before 5 minutes to facilitate controlled cord traction. Record the timing of cord clamping (NICE, 2014).

Women should be informed Syntometrine™ is associated with an increased risk of nausea and vomiting in the immediate postpartum period.

12.4 Physiological Management of the 3rd Stage

- Physiological management includes (NICE, 2014)
  - No routine use of uterotonic drugs
  - No clamping of the cord until pulsation has stopped. Record the timing of cord clamping.
  - Delivery of placenta by maternal effort
- Advise changing to active management if:
  - the placenta is not delivered within 1 hour of the birth of the baby.
  - the woman is haemorrhaging.
  - the woman wants to shorten the third stage.

12.5 Retained Placenta

Diagnose a prolonged third stage if the placenta is not delivered with 30 minutes of the birth with active management or within 60 minutes of the birth with physiological management (NICE, 2014). Refer to the local *Retained Placenta and Manual Removal of Placenta* Guideline.

12.6 Cord blood

- For indication and guidance on when to take paired cord blood gas samples post-delivery see the *Fetal monitoring in labour guideline*
- Take cord blood samples for –

- Rhesus negative women and women with known maternal antibodies. See also *Care of the Rhesus D Negative Woman in pregnancy and the puerperium.*
- Maternal Thrombocytopenia. See local guideline for *Thrombocytopaenia management during Pregnancy, Labour, Delivery and Postpartum*
- Maternal Hyperthyroidism - to check TFTs. See local guideline for *Thyroid disease in pregnancy*.

12.7 Following delivery of the Placenta and Membranes

- Assess the woman's condition; MEOWS, uterine contraction and vaginal bleeding within the first 30 minutes and subsequently as indicated by her condition.
- Assess the perineum in accordance with the local *Perineal Repair Guideline*
- Check the placental vessels and completeness of the placenta and membranes.

12.8 Indications for referral of placentas for pathological examination

Referral of the placenta is essential for:

- Stillbirth (antepartum or intrapartum)
- Late miscarriage (> 16 weeks)
- Unexpected admission to NICU
- Prematurity (less than 34 weeks gestation)
- Intrauterine growth restriction (birthweight below the 3rd centile)
- Fetal hydrops
- Placental abruption
- Severe maternal sepsis
- Maternal death
- Abnormal placental appearance/adhesion
- Previous Chronic Histiocytic Intervillositis (CHI)
- Fetal congenital abnormalities

Multiple pregnancy – same sex MCDA/DCDA twins or selective IUGR

A placental swab should be taken and sent for microbiological investigation in the event of:

- Pre-term delivery
- Intrauterine infection (suspected and confirmed cases)
- Unknown causes of stillbirth, neonatal death, non-viable pregnancies
- Evidence of sepsis in labour

12.9 Further considerations following birth.

- It is essential that two baby identification labels are printed, checked with the woman and/or her partner and then one placed around each of the baby's ankles. Refer to the *Patient Identification Policy.*
- Encourage skin-to-skin contact and breastfeeding as soon as possible after birth. See the *Infant feeding including collection and storage of expressed breastmilk (EBM).*

Please refer to 12.2 Neonatal well-being during the third stage of labour and immediate postnatal period.

- Record the first two urine voids in accordance with the guideline *Postpartum urinary retention (bladder care)*
- Undertake an initial full examination of the baby in the presence of the parents to detect any major physical abnormality and identify any problems that might require referral. This should be done in a manner that does not disrupt skin to skin. It should include a top to toe examination of eyes, ears, mouth, palate, fingers, toes, genitals, the base of the spine and the fontanelles. The baby's temperature should also be recorded within the first hour of life and documented (on both K2 if appropriate and within the yellow neonatal record). Refer to *Hypoglycaemia and Thermoregulation following birth* guideline.
- Avoid prolonged 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, 2014).
- Following skin to skin the baby should be weighed and vitamin K should be discussed and administered with maternal consent. Administration should be clearly documented in the notes. See also the guideline for *Vitamin K for Newborn Babies.*

13 Communication and Documentation

All women with learning disabilities, visual or hearing impairments or those whose first language is not English must be offered assistance with interpretation where applicable, and where appropriate a telephone interpreter must be used. It is paramount that clear channels of communication are maintained at all times between all staff, the women and their families. Once any decisions have been made/agreed, comprehensive and clear details must be given to the woman thereby confirming the wishes of the women and their families.'

The contents of any leaflet issued must be explained in full at the time it is issued. All communication difficulties (including learning difficulties) and language barriers must be addressed as outlined in the previous paragraph at the time the leaflet is issued.

Ensure the provision and discussion of information of the risks and benefits with women during the antenatal, intrapartum and postnatal periods.

All details surrounding discussion of the risks and benefits together with explicit details of proposed management must be documented contemporaneously in the maternal records.

14 Equality, Diversity and Human Rights Impact Assessment

This document has been equality impact assessed using the Trust's Equality Impact Assessment (EqIA) framework. The EqIA score fell into low priority (0-9); no significant issues in relation to equality, diversity, gender, colour, race or religion are identified as raising a concern.

15 Consultation, Approval and Ratification Process

During development this guideline has been reviewed by senior midwives, obstetricians and anaesthetists from both across Saint Mary's MCS. It has been ratified by the Site Obstetric Quality and Safety Committee.

It will be formally reviewed 3 years following its ratification or sooner if there are significant changes in evidence-based practice.

16 Monitoring Compliance

This guideline will be audited in accordance with the Obstetric Directorate audit plan. The findings of the audit report will be presented to staff and where appropriate an action plan will be developed and monitored.

17 References

National Institute for Health and Clinical Excellence CG190 (2014). Intrapartum care: Care of healthy women and their babies during childbirth. London: NICE.

Appendix 1 Ward Rounds on Delivery Units

1. The obstetric consultant should be present on all delivery unit ward rounds. This should be normal practice and the only exceptions should be if the consultant is occupied elsewhere clinically (for example if the consultant is in theatre) or if the ward round has been appropriately delegated (see below point 2 to 4 for details).

2. The consultant should lead the ward round or in the absence of the obstetric consultant the senior registrar (ST6 equivalent or above but not a locum) should conduct the ward round. However, if some of the more senior trainees wish to develop their skills by conducting a ward round with **indirect supervision**, they are expected to use mini-cex work-place based assessments to be deemed competent first for direct supervision and then for indirect supervision on leading delivery unit ward round. The trainee and the consultant on duty at the time will need to establish the trainee's competencies at the start of the shift.

   Directly or indirectly supervised ward rounds should only occur once the consultant and trainee have conducted at least one ward round together on the shift in question. The ward round remains the responsibility of the consultant and therefore the consultant needs to be confident that the clinical ability of the trainee is sufficient considering the complexity and number of the women on the delivery unit at the time. This should also be in agreement with the band 7 coordinating midwife.

3. In exceptional circumstances if the consultant is occupied indefinitely e.g. in theatre, then a senior registrar who has not been assessed as competent for indirect supervision may be asked to lead the ward round – as that may be deemed a safer option than delaying until the consultant is free. A discussion about the clinical status of all the patients seen should occur with the consultant as soon as they are available. This should be conducted at the patient status at a glance (PSAG) board.

4. If the consultant is not present on the ward round secondary to the trainee conducting an indirectly supervised ward round, the consultant should be given an update (using the PSAG board) immediately after the ward round.

5. It is recognised that occasionally, during the ward round, it may be necessary to the delegate junior doctor to see individual patients. In this case, the junior doctor should feedback to the consultant immediately after reviewing the patient.

6. At all times the consultant remains the leader of the team working on the shift and needs to know what is happening as well as checking nothing has been missed. Any changes to plans made by the trainee on the ward round must be communicated to the consultant, together with any other clinical concerns.

7. The number of staff (including any students) entering a room on the ward rounds should be kept to a minimum.

8. Ward round frequency and purpose should be discussed with the woman and her support person, and this conversation documented in the notes. Consent should be gained from women prior to the ward round team entering the room.

9. The midwife providing care for the women should provide a SBAR handover to the ward round team to prompt discussion and care planning.

10. Any decisions taken on the ward round should be made in partnership with the woman and documented accordingly.

Appendix 2

- Medical conditions indicating increased risk suggesting planned birth at an obstetric unit,
- Other factors indicating increased risk suggesting planned birth at an obstetric unit.
- Medical conditions indicating individual assessment when planning place of birth.
- Other factors indicating individual assessment when planning place of birth.

Table 1: Medical conditions indicating increased risk suggesting planned birth at an obstetric unit.

Disease area	**Medical condition**
Cardiovascular	Confirmed cardiac disease Hypertensive disorders
Respiratory	Asthma requiring an increase in treatment or hospital treatment Cystic fibrosis
Haematological	Haemoglobinopathies – sickle cell disease, beta thalassaemia major History of thromboembolic disorders Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100×10^9/litre Von Willebrand's disease Bleeding disorder in the woman or unborn baby Atypical antibodies which carry a risk of haemolytic disease of the newborn
Endocrine	Hyperthyroidism Diabetes
Infective	Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended Hepatitis B/C with abnormal liver function tests. Carrier of/infected with HIV (place of birth dependent on viral load) Toxoplasmosis – women receiving treatment. Current active infection of chicken pox/rubella/genital herpes in the woman or baby Tuberculosis under treatment
Immune	Systemic lupus erythematosus Scleroderma
Renal	Abnormal renal function Renal disease requiring supervision by a renal specialist
Neurological	Epilepsy Myasthenia gravis Previous cerebrovascular accident
Gastrointestinal	Liver disease associated with current abnormal liver function tests
Psychiatric	Psychiatric disorder requiring current inpatient care

Table 2: Other factors indicating increased risk suggesting planned birth at an obstetric unit.

Factor	**Additional information**
Previous complications	Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty. Previous baby with neonatal encephalopathy Pre-eclampsia requiring preterm birth. Placental abruption with adverse outcome Eclampsia Uterine rupture Primary postpartum haemorrhage requiring additional treatment or blood transfusion. Retained placenta requiring manual removal in theatre. Caesarean section Shoulder dystocia
Current pregnancy	Multiple birth Placenta praevia Pre-eclampsia or pregnancy induced hypertension. Preterm labour or preterm prelabour rupture of membranes Placental abruption Anaemia – haemoglobin less than 90 g/litre at onset of labour Confirmed intrauterine death. Induction of labour Substance misuse Alcohol dependency requiring assessment or treatment. Onset of gestational diabetes Malpresentation – breech or transverse lie BMI at booking of greater than 35 kg/m^2 Recurrent antepartum haemorrhage Small for gestational age in this pregnancy (less than 10th centile or reduced growth velocity on ultrasound) Abnormal fetal heart rate / doppler studies Ultrasound diagnosis of oligo/polyhydramnios
Previous gynaecological history	Myomectomy Hysterotomy

Table 3: Medical conditions indicating individual assessment when planning place of birth.

Disease area	**Medical condition**
Cardiovascular	Cardiac disease without intrapartum implications
Haematological	Atypical antibodies not putting the baby at risk of haemolytic disease. Sickle cell trait Thalassaemia trait Anaemia – haemoglobin 85–105 g/litre at onset of labour
Infective	Hepatitis B/C with normal liver function tests
Immune	Nonspecific connective tissue disorders
Endocrine	Unstable hypothyroidism such that a change in treatment is required
Skeletal/neurological	Spinal abnormalities Previous fractured pelvis Neurological deficits
Gastrointestinal	Liver disease without current abnormal liver function Crohn's disease Ulcerative colitis

Table 4: Other factors indicating individual assessment when planning place of birth.

Factor	**Additional information**
Previous complications	Stillbirth/neonatal death with a known nonrecurrent cause Pre-eclampsia developing at term. Placental abruption with good outcome History of previous baby more than 4.5 kg Extensive vaginal, cervical, or third - or fourth-degree perineal trauma Previous term baby with jaundice requiring exchange transfusion
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation) BMI at booking of 30–35 kg/m^2 Blood pressure of 140 mmHg systolic or 90 mmHg diastolic or more on 2 occasions Clinical or ultrasound suspicion of macrosomia Para 4 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 Fibroids

Appendix 3

Admission criteria for the Manchester Birth Centre, Bluebell Birth Centre and Midwifery-led rooms at Saint Mary's Oxford Road Campus

- Low risk woman of <5 parity
- Women in spontaneous labour
- Women in established labour following induction of labour for post maturity (up to term plus 14) with the exception of women with prolonged rupture of membranes.
- (>24hours) that have received prostaglandins for induction/acceleration of labour. *See also Outpatient Induction of labour guideline.*
- Women who have had consultant led antenatal care but who are suitable for intrapartum midwifery led care with an agreed appropriate intrapartum care plan.
- Women who would usually be excluded from the birth centre but have had a full documented birth options discussion regarding use of the birth centre in labour.
- Low risk woman who are post mature (up to term plus 14) awaiting IOL for ARM (women requiring acceleration following ARM should be for immediate transfer to delivery unit).
- Women who are HIV positive but low risk in labour with an undetectable viral load at 36 weeks' gestation onwards
- Women with Group B Strep
- Women with rupture of membranes <24hrs in the absence of meconium
- Women in labour with thinly stained meconium
- Women with a BMI < 40 at booking
- Women with Hb ≥ 90g/l on admission
- Women with a platelet count of >80x109/l on admission (in the absence of HELLP syndrome or platelet dysfunction)
- GDM diet controlled.
- Women who have had a blood loss of < 750mls in their last birth, not requiring additional treatment or blood transfusion.
- IVF pregnancy in spontaneous labour
- Low PAPPA with normal USS scans (we are no longer inducing for low PAPPA)

Appendix 4 Indications and timing for transfer from alongside midwifery-led settings

RED TRANSFER Any Obstetric Emergency which is immediately life threatening with the exception of shoulder dystocia / maternal cardiac arrest / managed in situ. **Transfer time 7 minutes**	Any obstetric emergency including. • PPH • cord prolapse. • fetal bradycardia or audible late decelerations • APH • maternal collapse except cardiac arrest • seizure • malpresentation in labour	Emergency Bell Inform Coordinator Immediate transfer Verbal handover on arrival	Coordinator and Obstetric Review Immediate Inform anaesthetics / neonatal teams as appropriate.
AMBER TRANSFER **Transfer time 20 minutes**	• 3rd/4th degree tear • Retained placenta with no bleeding. • Indication for continuous fetal monitoring • Delay in 1st/2nd stage of labour • MEOWS >3, not corrected with simple measures. • Maternal pyrexia >38	Inform DS coordinator, full SBAR required to DS coordinator. Any delay inform Bleep Holder	Coordinator Review and Senior obstetrician >ST3 Within 10 minutes
YELLOW TRANSFER **Transfer time within 30 minutes.** Submit Red Flag for any delays >30 minutes	• Maternal request for further pain relief if birth not imminent	Inform DS coordinator, full SBAR required to DS coordinator. Any delay inform Maternity Bleep Holder	Coordinator Review within 30 minutes Inform anaesthetist