Western Health and Social Care Trust

Midwifery Care
Care of Low Risk Women in Labour
April 2010

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Western Health and Social Care Trust

WOMEN AND CHILDREN'S DIRECTORATE

PROFESSIONAL CARE FOR LOW RISK WOMEN IN LABOUR

1.0 Introduction

1.1 This guideline provides direction for all health care professionals involved in the care of low risk childbearing women based on current recommendations from the NICE guidelines.

1.2 Women opting to come into hospital to give birth should be given the choice of planning birth in Midwifery Led Unit or the Labour Ward (obstetric unit).

1.3 Childbearing women and their babies are the focus of care and should be offered evidence based information at all stages of their pregnancy to support and help them make informed decisions to manage their labour.

1.4 Women should be informed:

- That giving birth is generally safe for both mother and baby
- That the evidence suggests that there is a higher likelihood of normal birth with less intervention for women who give birth in a midwifery led unit with lesser use of pharmacological pain relief and increased satisfaction for the woman (Hodnett et al 2005)
- Of the possibility of the need to transfer to the Labour Ward
- That if she has a pre-existing medical condition or previous complicated birth or develops complications in this pregnancy she should be advised to give birth in the Labour Ward.

2.0 Professional Roles

2.1 Good rapport between the woman, her family and the midwife should be established. Where possible, care should be provided by a midwife known to the woman. Welcoming of the mother and her birth partner to the Midwifery Care Unit is an important aspect of care and helps to establish effective communication.

2.2 Continuity of care through pregnancy and labour should be provided by the same professional wherever possible as this model of care has been shown to result in less need for induction of labour, pharmacological pain relief, neonatal resuscitation and increased satisfaction in the birth experience for women (Simkin, 1991) If possible the midwife attending her antenatally should be informed of her admission.

2.3 On going assessment of the woman in labour will enable the midwife to respond to any risk factors, which may arise. The majority of women will proceed in labour without the need of further assistance.

2.4 On presenting in spontaneous labour the midwife is responsible for assessing maternal and fetal condition and suitability for the Midwifery Care Unit and recording in the Midwifery notes.

2.5 Current evidence does not support the use of admission CTG in Low risk pregnancy.

2.6 The midwives role is to watch, listen and interpret cues. Monitoring progress in labour will require more than routine assessment of contractions and cervical dilatation. The midwife must use her skills in abdominal palpation as well as her intuition and knowledge of the women's behaviour in the different stages of labour.

3.0 First Stage of Labour.

3.1 If women meet the criteria and are in active labour they should be admitted to the Midwifery Care Unit.

3.2 If not in active labour the woman should be encouraged to return home to wait events. Studies have shown that women admitted in the latent phase of labour have higher rates of intervention than those who await onset of labour (Bailit 1t al, 2005)

3.3 Clinical intervention should not be offered or advised where labour is progressing normally and the woman and baby are well, within the agreed limits of low risk care.

3.4 The partogram should be commenced once labour is established.

3.5 Observations by a midwife during the first stage of labour include

- 4hrly temp, blood pressure

- Hourly pulse
- ½ hrly documentation of frequency of contractions
- Frequency of emptying of the bladder and urinalysis
- Vaginal examination offered 4hrly once one to one care has commenced or where there is concern regarding progress in labour
- Abdominal palpation and assessment of vaginal loss should always precede vaginal examination
- Intermittent auscultation of the fetal heart after a contraction should occur for at least 1 minute, and be recorded at least every 15 minutes, and following vaginal examination. (In the first stage of labour)

3.6 The opportunity to labour in water should be offered for pain relief. The woman's temperature should be monitored and recorded hourly to ensure the woman is not becoming pyrexial. (Refer to guideline (65) 2006 Labour and Delivery in Water.)

3.7 Women may drink in established labour (isotonic drinks may be more beneficial than water).

3.8 Women may eat a light diet in established labour unless they have had opioids.

3.9 Antacids should not be given routinely to low risk women in labour.

4.0 SECOND STAGE OF LABOUR

4.1 Second stage is the phase between full dilatation of the cervix to the birth of the baby. There is typically a latent or passive phase prior to the involuntary expulsive contractions. Women should be supported while awaiting the urge to push.

4.2 Clear signs that can accompany the onset of active second stage of labour include:

- Changes in woman's behaviour voice and posture
- Changes in facial expression
- Overwhelming urge to bear down
- Anus dilates
- Vulva gapes
- Spontaneous rupture of waters
- Anal cleft line (Hobbs, 1998)
- Appearance of the rhombus of Michaela's
- Heavy show
- Appearance of the presenting part

4.3 Observations in second stage include

- Hourly blood pressure and pulse
- 4 hourly temperature
- hourly vaginal examination in the absence of visible progress
- ½ hourly record of frequency of contractions
- frequency of emptying of the bladder
- intermittent auscultation of the fetal heart for at least 1 minute, at least every 5 minutes, or more often at the midwives discretion.

4.4 Women should be discouraged from lying supine or semi supine.

4.5 Women should be guided by their own urge to push and should not require direction. If pushing is ineffective strategies such as change of position and emptying the bladder should be engaged.

4.6 Episiotomy if required, with consent and should not be carried out routinely in the second stage of labour.

5.0 THIRD STAGE OF LABOUR

5.1 The third stage of labour is the time from birth of the baby to expulsion of the placenta and membranes. Active management of the third stage involves all of the following components:

- Routine use of oxytocic drugs
- Early clamping of the cord
- Controlled cord contraction (in Altnagelvin Hospital midwives practice Modified Brandt Andrews where the Uterus is guarded by the other hand while performing CCT).

Physiological Management is where there is no prophylactic oxytocic drug, no cord clamping and no cord traction.

5.2 Physiological management is only appropriate for low risk women and then only if they have had a physiological labour and have not received an opioid for pain relief.

5.3 Women at low risk of postpartum haemorrhage who request physiological management of the third stage should be supported in their choice.

5.4 Physiological management must change to active management in the event of;

- Haemorrhage
- Woman's choice to shorten the third stage

Should be considered if the placenta is still retained after 1 hour.

5.5 A piecemeal approach to the third stage of labour, whereby elements of both methods are used e.g.: no oxytocic drug but cord clamping and CCT, should never be employed.

6.0 EXITING THE NORMAL BIRTH PATHWAY

6.1 If a deviation from normal progress in labour pathway is suggested at any stage, or a risk factor is identified, advice from a colleague should be sought immediately.

6.2 Transfer to Labour Ward should be discussed and arranged with the Labour Ward Sister and an obstetric referral should be made immediately.

6.3 All findings and care given should be documented clearly in the woman's obstetric notes.

6.4 The 'Transfer of Woman to Main Labour Ward Summary' in the care pathway should be completed.

6.5 The Obstetric Registrar on call for Labour Ward is responsible for reviewing the woman on transfer to Labour Ward and documenting a plan of care in the obstetric notes.

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Appendix 1

Midwifery Care EXCLUSION CRITERIA

These lists are not exhaustive and midwives must continually risk assess and refer the woman to obstetric care as appropriate.

TABLE 1.0

Maternal request	• Maternal request for consultant care • Maternal request for epidural
Maternal conditions	• Endocrine disorder e.g. Diabetes Mellitus or Thyroid disease • Cardiac disease • Essential Hypertension • Renal disease • Severe asthma • Haematological disease including auto immune disease, anaemia < 10.0g/dl thromboembic disease • Epilepsy • Malignant disease • BMI >40 or <18 • Psychiatric disorder or substance abuse • HIV Hepatitis B or C or syphilis
Complications of previous pregnancy	• Severe pre-eclampsia, HELLP syndrome or eclampsia • Rhesus-iso immunisation or other blood group antibodies • Previous Caesarean Section or uterine surgery • Retained placenta on 2 occasions • Significant antenatal or postpartum haemorrhage • Stillbirth or neonatal death or significant neonatal morbidity • Deep venous thrombosis • Puerperal psychosis • Previous 4th degree tear
Complications in this pregnancy	• Multiple pregnancy • Grand multiparity >5 • Malpresentation • Suspected or confirmed intrauterine growth retardation • Prematurity <37 complete weeks • Antepartum haemorrhage • Placenta Praevia • Prolonged rupture of membranes longer than 24 hours • Suspicious fetal heart rate on auscultation • Oligohydramnious/Polyhdramnious • Meconium stained liquor • Intrauterine death • Antibodies in this pregnancy

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REFERENCE LIST.

Hobbs L (1998) *Assessing cervical dilatation without Vaginal Examinations, Watching the purple line* Practicing Midwife 1(11) pp34-35

Hodnett ED, Downe S, Edwards N, Walsh D (2005) *Homelike versus Conventional Birth Settings*. (Cochrane review) In The Cochrane Library. Issue 4 Oxford

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

Simkin P (1991) *Just another Day in a Woman's Life* Birth 18 (4) pp203-210