University Hospital of North Staffordshire NHS Trust

Achieving Sustainable Quality in Maternity Services

ASQUAM Guideline for

1. Care of healthy Women in Labour
2. Auscultation of the Fetal Heart
3. Clinical Risk Assessment in Labour

Date of Ratification:	September 2012
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Ratified by:	Labour Ward Forum Sub-Group Obstetric Guideline Group
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This guideline should be read in conjunction with:

- **Perineal Repair Guideline**
- **3rd and 4th Degree Tear Guideline**
- **Immediate Care of the Newborn Guideline**
- **Continuous and Intermittent Electronic Fetal Monitoring**
- **Homebirth Guideline**

1. INTRODUCTION

The University Hospital of North Staffordshire (UHNS) has nationally accepted systems relating to care of women in labour, auscultation of the fetal heart rate in labour and Clinical Risk Assessment around commencement of labour. These guidelines relate to women in all care settings, including high risk Delivery Suite, Midwife Birth Centre or Home Birth.

Care during Labour should always be aimed towards achieving the best possible physical, emotional and psychological outcome for the Woman and Baby (NICE 2007) irrespective of the woman's risk status.

The aim of the guideline is to demonstrate that the UHNS Maternity services have approved documentation for the care of women in labour at term in all care settings (as mentioned above) including observations that must be undertaken in each identified stage of labour. That the service has accepted methods of auscultation of the fetal heart in labour allowing identification of those fetuses who may be at risk of compromise and allowing appropriate and timely intervention (ASQUAM 2011). That the service follows an agreed process of clinical risk assessment for when labour commences, which is implemented and monitored.

Record keeping is an integral part of the care of women in labour and this guideline will demonstrate how documentation aids the provision of safe and effective care (NMC 2009)

2. ADMISSION OBSERVATIONS

On admission to the woman's preferred choice of care setting she should be met by a Midwife who will introduce herself and explain what her role is in the woman's care. The Midwife and/or any other care giver should establish a rapport with the woman and offer her explanations and reassurance throughout her care. She should be cared for with respect and the Midwife must always endeavour to meet the woman's individual needs.

A number of observations will be carried out on both the woman and the fetus. The purpose of these observations is to assess Maternal and Fetal health, to determine the stage of labour and to assess the woman's health needs.

- A history from the WMPI Pregnancy Notes/Health record will be reviewed,
- Physical observations – Temperature, pulse, blood pressure, urinalysis, length, strength, regularity and frequency of contractions
- Abdominal palpation – fundal height, lie, presentation, position and palpability of presenting part
- Vaginal Loss – Show, Liquor, Blood etc.
- If the woman does not appear to be in established labour after a period of assessment a Vaginal Examination (VE) may be offered. However if the woman appears to be in established labour then a V.E should be offered (NICE 2007)
- Assessment of pain and requirements for pain relief as per the woman's needs and wishes
- All findings will be documented in the West Midlands Perinatal Institute (WMPI) Intrapartum Care Records (Birth Notes).
- The woman and her partner or support person will be informed of the findings

Healthcare professionals who conduct vaginal examinations should:

- Be sure that the vaginal examination is really necessary and will add important information to the decision-making process be aware that for many women who may already be in pain, highly anxious and in an unfamiliar environment, vaginal examinations can be very distressing
- Ensure the woman's consent, privacy, dignity and comfort and offer the option of a chaperone.
- Explain the reason for the examination and what will be involved, and explain the findings and their impact sensitively to the woman.
- Some women have pain without cervical change. Although these women are described as not being in labour, they may well consider themselves 'in labour' by their own definition. Women who seek advice or attend hospital with painful contractions but who are not in established labour should be offered individualised support and occasionally analgesia, and encouraged to remain at or return home.
- The use of admission cardiotocography (CTG) in ***low-risk*** pregnancy is not recommended in any birth setting.

3. AUSCULTATION OF FETAL HEART ON ADMISSION USING A PINARDS, DOPPLER ULTRASOUND OR CARDIOTOGRAPH

Initial auscultation of the fetal heart rate (FHR) is recommended at first contact. The FHR should be auscultated for a minimum of 1 minute (NICE 2007) immediately after a contraction; this will therefore be recorded as 'Beats per Minute' (BPM). The Maternal pulse should be measured prior to auscultating the fetal heart to differentiate between Maternal and FHR.

Both Maternal Pulse and FHR must be documented on the Initial Assessment page (page 3) and the Partogram throughout the 1st and second stage (page 10-11) of the WMPI Intrapartum Care Records.

3.1 Equipment to be used

Intermittent auscultation can be undertaken by either a Pinards stethoscope or a Doppler Ultrasound.

The use of admission Cardiotography in a low risk pregnancy is not recommended in any birth setting.

4. CHANGING FROM INTERMITTENT TO CONTINUOUS AUSCULTATION

In order to **change from intermittent auscultation to continuous Electronic** Fetal Monitoring (EFM) in a Low risk woman there must be a significant indication and currently this change would be advised for the following reasons:

- Significant Meconium stained liquor (dark green/black amniotic fluid which is thick and tenacious)
- In light Meconium stained liquour, consider depending on risk assessment which should include as a minimum their stage of labour, volume of liquour, parity and the fetal heart and where applicable the transfer pathway (e.g. community to hospital)

- Abnormal FHR detected by intermittent auscultation i.e. <110 beats per minute (bpm), >160 bpm or any late deceleration.
- Maternal Pyrexia (≥38^{o}C on one occasion and 37.5^{o} - 37.9^{o}C on two occasions 2 hours apart).
- Vaginal bleeding
- Oxytocin use for augmentation of labour
- Maternal request
- Epidural analgesia (see below)

If any of the above risk factors were to develop while in labour, then EFM would be considered and discussed.

5. PAIN RELIEF

Women who choose to use breathing and relaxation techniques in labour should be supported in their choice.

Women who choose to use massage techniques in labour that have been taught to birth partners should be supported in their choice
The opportunity to labour in water is recommended for pain relief.

For women labouring in water, the temperature of the woman and the water should be monitored hourly to ensure that the woman is comfortable and not becoming pyrexial. The temperature of the water should not be above 37.5 °C. Any bath or birthing pool should be kept clean using a protocol agreed with the microbiology department and, in the case of birthing pools, in accordance with the manufacturer's guidelines.

Acupuncture, acupressure and hypnosis should not be provided, but women who wish to use these techniques should not be prevented from doing so. The playing of music of the woman's choice in the labour ward should be supported.

Transcutaneous electrical nerve stimulation (TENS) should not be offered to women in established labour.

Inhalation analgesia and Opioids

Entonox (a 50:50 mixture of oxygen and nitrous oxide) should be available in all birth settings as it may reduce pain in labour, but women should be informed that it may make them feel nauseous and light-headed.

Pethidine, diamorphine or other opioids should be available in all birth settings. Women should be informed that these will provide limited pain relief during labour and may have significant side effects for both the woman (drowsiness, nausea and vomiting) and her baby (short-term respiratory depression and drowsiness which may last several days).

Women should be informed that pethidine, diamorphine or other opioids may interfere with breastfeeding. If an intravenous or intramuscular opioid is used, it should be administered with an antiemetic.

Women should not enter water (a birthing pool or bath) within 2 hours of opioid administration or if they feel drowsy**.**

Before choosing epidural

Before choosing epidural analgesia, women should be informed about the risks and benefits, and the implications for their labour. Information about choosing epidural analgesia should include the following:

- It is only available in obstetric units.
- It provides more effective pain relief than opioids.
- It is associated with a longer second stage of labour and an increased chance of vaginal instrumental birth.
- It is not associated with long-term backache.
- It is not associated with a longer first stage of labour or an increased chance of caesarean birth.
- It will be accompanied by a more intensive level of monitoring and intravenous access.
- Modern epidural solutions contain opioids and, whatever the route of administration, all opioids cross the placenta and in larger doses (greater than 100 micrograms in total) may cause short-term respiratory depression in the baby and make the baby drowsy.

Intravenous access should always be secured prior to commencing regional analgesia.

Preloading and maintenance fluid infusion need not be administered routinely before establishing low-dose epidural analgesia and combined spinal–epidural analgesia.

The following additional observations should be undertaken for women with regional analgesia:

- During establishment of regional analgesia or after further boluses (10 ml or more of low dose
  solutions) blood pressure should be measured every 5 minutes for 15 minutes.
- If the woman is not pain free 30 minutes after each administration of local anaesthetic/opioid solution, the anaesthetist should be recalled.
- Hourly assessment of the level of the sensory block should be undertaken.

Women with regional analgesia should be encouraged to move and adopt whatever upright positions they find comfortable throughout labour.

Once established, regional analgesia should be continued until after completion of the third stage of labour and any necessary perineal repair.

Upon confirmation of full cervical dilatation in women with regional analgesia, unless the woman has an urge to push or the baby's head is visible, pushing should be delayed for at least 1 hour and longer if the woman wishes, after which pushing during contractions should be actively encouraged.

Following the diagnosis of full dilatation in a woman with regional analgesia, a plan should be agreed with the woman in order to ensure that birth will have occurred within 4 hours regardless of parity.

Oxytocin should not be used as a matter of routine in the second stage of labour for women with regional analgesia.

Continuous EFM is recommended for at least 30 minutes during establishment of regional analgesia and after administration of each further bolus of 10 ml or more.

6. FIRST STAGE OF LABOUR OBSERVATIONS

Recommendations on observations during the established first stage of labour include:

- A pictorial record of labour (partogram) should be used once labour is established.
- 4 hourly temperature and blood pressure
- Hourly pulse
- Half-hourly documentation of frequency of contractions
- Frequency of emptying the bladder on a 3-4 hourly basis
- Vaginal examination offered 4 hourly, or where there is concern about progress or in response to the woman's wishes

In addition:

- Intermittent auscultation of the fetal heart after a contraction should occur for at least 1 minute, at least every 15 minutes, and the rate should be recorded as an average. The maternal pulse should be palpated if an FHR abnormality is detected to differentiate the two. Documentation of the fetal and maternal pulse must be recorded on the Partogram (page 10 and 11 of the Birth Notes).

- Ongoing consideration should be given to the woman's emotional and psychological needs, including her desire for pain relief.

- Women should be encouraged to communicate their need for analgesia at any point during labour.

Recommendations on prelabour rupture of membranes at Term

There is no reason to carry out a speculum examination with a certain history of rupture of the membranes at term.

Women with an uncertain history of prelabour rupture of the membranes should be offered a speculum examination to determine whether their membranes have ruptured. Digital vaginal examination in the absence of contractions should be avoided.

Women presenting with prelabour rupture of the membranes at term should be advised that:

The risk of serious neonatal infection is 1% rather than 0.5% for women with intact membranes.

- 60% of women with prelabour rupture of the membranes will go into labour within 24 hours
- Induction of labour is appropriate approximately 24 hours after rupture of the membranes. Until the induction is commenced or if expectant management beyond 24 hours is chosen by the woman:
    - Lower vaginal swabs and maternal C-reactive protein should not be offered
    - To detect any infection that may be developing women should be advised to record their temperature every 4 hours during waking hours and to report immediately any change in the colour or smell of their vaginal loss

- Women should be informed that bathing or showering are not associated with an increase in infection, but that having sexual intercourse may be.
- Fetal movement and heart rate should be assessed at initial contact and then every 24 hours following rupture of the membranes while the woman is not in labour, and the woman should be advised to report immediately any decrease in fetal movements.
- If labour has not started 24 hours after rupture of the membranes, women should be advised to give birth where there is access to neonatal services and advised to stay in hospital for at least 12 hours following the birth.
- If there are no signs of infection in the woman, antibiotics should not be given to either the woman or the baby, even if the membranes have been ruptured for over 24 hours.
- If there is evidence of infection in the woman, a full course of broad-spectrum intravenous antibiotics should be prescribed.
- Women with prelabour rupture of the membranes should be asked to inform their healthcare professionals immediately of any concerns they have about their baby's wellbeing in the first 5 days following birth, particularly in the first 12 hours when the risk of infection is greatest.

7. SECOND STAGE OF LABOUR OBSERVATIONS

Definition of the stages of labour need to be clear in order to ensure that women and staff providing their care have an accurate and shared understanding of the concepts involved (NICE 2007)

NICE define the second stage of labour as :

- Passive second stage – The finding of full dilatation of the cervix prior to or in the absence of involuntary expulsive contractions.

- Active second stage

    - Vertex is visible
    - Expulsive contractions with full dilatation of cervix
    - Active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions

NICE RECOMMENDS WAITING 1 HOUR FOR DESCENT PRIOR TO ACTIVE PUSHING

Women should be informed that in the second stage of labour they should be guided by their own urge to push, but that change of position, support, emptying of the bladder and encouragement may all be used as strategies to assist birth.

For many women, the physical demands of labour are increased during the second stage of labour; this necessitates increased surveillance of both maternal and fetal condition

Recommendations for observations to be undertaken by the Midwife during the second stage of labour are:

- Observation of Maternal behaviour, effectiveness of pushing, fetal wellbeing, fetal position including the station of the fetal presenting part
- Ongoing consideration of both the physical and emotional wellbeing of the woman
- Hourly Blood Pressure and Pulse

- 4 hourly Temperature

- Half hourly documentation of the frequency of contractions

- In the second stage of labour ensure that the labouring woman has passed urine in the past 3 hours and if not encourage voiding. If descent of the head or delivery is delayed consider catheterization.
  Remember that a full bladder is a major cause of delayed delivery and that delivery with a full bladder can lead to long term damage of the bladder.

- Vaginal Examination should be offered hourly in the active second stage or in response to the woman's wishes, but always perform an abdominal palpation prior to the vaginal examination. All findings from observations must be documented both on the partogram and in the WMPI Intrapartum Care Records

- Both the Woman and her partner will be informed of all findings

All findings from the above observations alert the Midwife to any deviations from normal and will also assist in determining the timing of further vaginal examinations and the need, if any, for obstetric review.

* In the case of passive 2nd stage commence 2nd stage observations once active or physiological pushing comments or maternal or fetal condition dictates.

7.1 Auscultation of the Fetal Heart during the Second Stage of Labour

Intermittent auscultation of the fetal heart should occur after a contraction for at least 1 minute, at least every 5 minutes. The maternal pulse should be palpated if there is suspected fetal bradycardia or any other FHR anomaly to differentiate the two heart rates.

N.B. In second stage of labour the fetal heart is to be plotted on the partogram every 15 minutes and documented every 5 minutes within the birth notes.

Recommendation on position in the second stage of labour

Women should be discouraged from lying supine or semi-supine in the second stage of labour and should be encouraged to adopt any other position that they find most comfortable.

Recommendations on pushing in the second stage of labour

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

If pushing is ineffective or if requested by the woman, strategies to assist birth can be used, such as support, change of position, emptying of the bladder and encouragement.

Recommendation on hand position

Either the 'hands on' (guarding the perineum and flexing the baby's head) or the 'hands poised' (with hands off the perineum and baby's head but in readiness) technique can be used to facilitate spontaneous birth.

Recommendations on episiotomy

A routine episiotomy should not be carried out during spontaneous vaginal birth. Where an episiotomy is performed, the recommended technique is a mediolateral episiotomy originating at the vaginal fourchette and usually directed to the right side. The angle to the vertical axis should be between 45 and 60 degrees at the time of the episiotomy.

An episiotomy should be performed if there is a clinical need such as instrumental birth or suspected fetal compromise.

Tested effective analgesia should be provided prior to carrying out an episiotomy, except in an emergency due to acute fetal compromise.

Recommendations on vaginal birth following previous third- or fourth-degree perineal trauma

In order for a woman who has had previous third- or fourth-degree trauma to make an informed choice, discussion with her about the future mode of birth would take place in the Perineal Repair Clinic and should encompass:

- Current urgency or incontinence symptoms
- The degree of previous trauma
- Risk of recurrence
- The success of the repair undertaken
- The psychological effect of the previous trauma
- Management of her labour.
- May be offered and endoanal scan in order to formulate a management plan

Women with infibulated genital mutilation should be informed of the risks of difficulty with vaginal examination, catheterisation and application of fetal scalp electrodes. They should also be informed of the risks of delay in the second stage and spontaneous laceration together with the need for an anterior episiotomy and the possible need for defibulation in labour.

Recommendation on water birth

Women should be informed that there is insufficient high-quality evidence to either support or discourage giving birth in water.

8. THIRD STAGE OF LABOUR OBSERVATIONS

The Third Stage of Labour is the time from the birth of the baby to the expulsion of the Placenta, Cord and Membranes.

There are 2 main methods of management of the third stage of labour:

Physiological - Can take up to 1 hour suitable for low risk women – no Oxytocin, no early cord clamping; Delivery by Maternal effort Do not pull core or palpate uterus.

Active - Can take up to ½ hour; Oxytocin, early cord clamping and cutting and deliver placenta by CCT- Advise that this reduces risk of haemorrhage and shortens 3rd stage.

The Midwife should discuss the options for mode of management with the woman and subsequently gain consent for the appropriate and/or chosen method of management.

Recommendation on observations in the third stage of labour

Observations by a midwife of a woman in the third stage of labour include:

- Her general physical condition, as shown by her colour, respiration and her own report of how she feels
- Vaginal blood loss

In addition, in the presence of haemorrhage, retained placenta or maternal collapse, frequent observations to assess the need for resuscitation are required.

Recommendations on physiological and active management of the third stage of labour

- NICE recommends active management of third stage of labour to prevent the risk of postpartum haemorrhage (PPH). This includes early clamping and cutting of the cord and controlled cord traction. At UHNS the following drugs should be used.

    1. Women with no contraindications to ergomotrine, who are normotensive, should have syntometrine 1 ml (5 international units oxytocin and 0.5 mgs of ergometrine maleate) intramuscular

    2. Women who have had hypertension should not receive syntometrine, but should be given syntocinon (oxytocin – 10 international units) intramuscular.

    3. Women who are admitted and delivery very quickly, where the blood pressure has not been checked in labour, should receive syntocinon (oxytocin – 10 international unit) intramuscular

Women should be informed that active management of the third stage reduces the risk of maternal haemorrhage and shortens the third stage.
Women at low risk of postpartum haemorrhage who request physiological management of the third stage should be supported in their choice.

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

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

Pulling the cord or palpating the uterus should only be carried out after administration of syntometrine as part of active management.

In the third stage of labour neither umbilical Oxytocin infusion nor prostaglandin should be used routinely.

9. POSTNATAL OBSERVATIONS MOTHER AND BABY

Maternal Observations taken following the birth of the baby should include:

- Maternal observation – temperature, pulse, blood pressure, uterine contraction, lochia
- All women who have had a vaginal delivery at UHNS will have one set of MEOWS observations recorded following delivery and on admission to the post natal area, unless the score suggests that further observations are required.

- Women who have had a Caesarean Section at UHNS will have 4 MEOWS assessments within a 24 hour period following delivery recorded on the MEOWS chart, unless the score suggests that further observations are required.
- Examination of placenta and membranes – assessment of their condition, structure, cord vessels and completeness
- Early assessment of maternal emotional/psychological condition in response to labour and birth
- Time and volume of first void of urine. Successful voiding of the woman's bladder within 4 hours of delivery to be documented in line with Guideline for the Prevention of Urinary Problems.

Neonatal Observations include:

The Apgar score at 1 and 5 minutes should be recorded routinely for all births. If the baby is born in poor condition (the Apgar score at 1 minute is 5 or less), then the time to the onset of regular respirations should be recorded and the cord double-clamped to allow paired cord blood gases to be taken. The Apgar score should continue to be recorded until the baby's condition is stable.
Women should be encouraged to have skin-to-skin contact with their babies as soon as possible after the birth.

In order to keep the baby warm, he or she should be dried and covered with a warm, dry blanket or towel while maintaining skin-to-skin contact with the woman.

Separation of a woman and her baby within the first hour of the birth for routine postnatal procedures, for example weighing, measuring and bathing, should be avoided unless these measures are requested by the woman, or are necessary for the immediate care of the baby.*

Initiation of breastfeeding should be encouraged as soon as possible after the birth, ideally within 1 hour.*
Head circumference, body temperature and birth weight should be recorded soon after the first hour following birth.

An initial examination should be undertaken by a healthcare professional to detect any major physical abnormality and to identify any problems that require referral.

Any examination or treatment of the baby should be undertaken with the consent and in the presence of the parents or, if this is not possible, with their knowledge.

10. DOCUMENTATION

Good documentation is an integral part of Midwifery Practice and is essential to the provision of safe and effective care (NMC 2009). All Midwives and medical staff have a duty to communicate via documentation with their colleagues, ensuring that they are fully informed about the women in their care. The manner in which information is documented and therefore communicated is crucial to care provision.

All observations during the woman's labour are documented in the WMPI Intrapartum Care Records. These are clearly identified as Initial Assessment, First/Second stage, Third Stage and Immediate Postnatal Observations Once it has been identified that Labour is established, then formal charting of both Maternal observations (Temperature, Pulse, Blood Pressure, Urinalysis) and fetal observations (FHR) **are made on the Partogram**, which is a pictorial

record of labour, integrated within the WMPI Intrapartum Care Records, pages 10 – 11.

It is integral to everyone's practice to ensure that the required elements are documented within the WMPI records:

- Equipment used.
- Fetal Heart rate
- Length of auscultation.
- When auscultated i.e. following a contraction.
- The palpation of the maternal pulse when indicated.
- Reasons for transfer from intermitted to continuous fetal monitoring.

11. GUIDANCE ON DURATION OF ALL STAGES OF LABOUR

The UHNS, in accordance with the NICE Guidelines (2007) uses locally adapted guidelines to give guidance on acceptable duration for each stage of labour.

Women should be informed that duration of the first stage of labour for a first labour lasts, on average, between 8 hours and 18 hours. Subsequent labours last, on average, between 5 hours and 12 hours. Women should be informed that these are guidelines and that the length of the first stage of labour varies between women.

Recommendations of acceptable duration of the Second Stage of Labour for a Nulliparous woman delivery would be expected to take place within 3 hours of commencement of the active second stage and within 2 hours for a Multiparous woman.

Recommendations on duration of the Third Stage of Labour are dependant upon either Active Management or Physiological Management. Typically, as

recommended by NICE (2007) the Third Stage, active management, should be completed within 30 minutes and physiological management, within 60 minutes.

12. GUIDANCE ON REFERRAL TO OBSTETRIC CARE

If the Midwife detects a deviation from normal during the process of labour, she has a responsibility to summon Obstetric assistance. Midwives Rule 6 states "Your responsibility and those of other Health Professionals are inter-related and complementary. Each practitioner is responsible for their own practice" (Midwives Rules 2004) As stated in Safer Childbirth (2007) "A Midwives expertise lies in the care of normal childbirth and in their diagnostic skills to identify deviations from the normal and to refer when indicated"

The following list as suggested by NICE (2007) is not exhaustive, but may be used to identify women who would need referral to Obstetric Care during the Intrapartum period:

- Delay in 1st or 2nd stage
- Thick meconium
- Retained placenta
- Complicated perineal repair
- Pain relief i.e. epidural
- Intrapartum Haemorrhage
- Placental Abruption
- Ruptured Uterus
- Suspected Amniotic Fluid Embolus
- Suspected Pulmonary Embolus
- Eclampsia and severe Pre-Eclampsia

- Cord Prolapse
- Shoulder Dystocia
- Massive Obstetric Haemorrhage
- Maternal Collapse
- Monitoring suggesting Fetal compromise
- Undiagnosed Breech
- Maternal Pyrexia in labour (≥38^{o}C on one occasion and 37.5^{o} - 37.9^{o}C on two occasions 2 hours apart).

Specific to women giving birth in out of hospital settings, i.e. Home Birth, if a woman needs referral for Obstetric review, the UHNS follows the recommended transfer arrangements set out in the CESDI 5th report, specifically that transfers should be arranged at the earliest indication of deviations from normal (see UHNS Transfer Guidelines).

13. CLINICAL RISK ASSESSMENT – LABOUR

When labour commences, the midwife **will review the Pregnancy Notes to identify any of the following**

- Medical Conditions to be considered listed on Page 3, including anaesthetic history

- Relevant factors from previous pregnancies listed on Page 5

- Lifestyle history to be considered listed on Page 2/3

- Risk Assessment for the appropriate place of birth, Special Features and Management Plan

A risk assessment will be completed as a result of reviewing the information set out above and will be recorded in the Birth Notes 'Significant Risk Factors' – where these have been identified.

Where appropriate, an action plan will be developed in response to this assessment and will be documented in the 'Management Plan' and summarised in the 'Intrapartum Action Plan' or the 'Birth Action Plan'.

During the intrapartum period, the midwife in conjunction with the Obstetrician where appropriate, will continually assess the mother and baby's condition and the progress of labour to identify emerging risks. Where risks are identified, this will be recorded in the Birth Notes, and a plan of care will be set out.

13.1 Development and documentation of a Management Plan

When risks have been identified during the labour period an individual management plan must be clearly documented in the intra-partum record. This will be discussed and agreed with the woman at the time.

The Management Plan will be updated as necessary in discussion with the woman.

13.2 Referral Arrangements

Where risk factors are identified during the intrapartum period, this will be recorded in the intra-partum records and referral arrangements made.

It is the responsibility of the midwife to

- Request a review of the woman and record the details of the request and the reason for the request in the birth notes.

- Ensure that all observations are up-to-date and recorded in the birth notes and on the partogram

- The obstetrician will record the outcome of the review in the birth notes and will agree a plan of care with the woman and the midwife. The plan will be recorded in the birth notes.

Where the woman is already under consultant care, and risk factors other than an obstetric risk is identified, a member of the medical obstetric team will request review by the appropriate specialist team/clinician.

14. WOMEN WHO WILL REFUSE BLOOD OR BLOOD PRODUCTS

Women who have declined blood or blood products will have been identified during the antenatal period and a copy of the directive (Management Plan) will be secured in the Pregnancy Notes/Health Record.

This will ensure the identification of women who will refuse blood or blood products. When admitted in labour a discussion will take place with the mother regarding any changes in the management plan for labour. A senior obstetrician should be involved in this discussion and any changes documented in the intra-partum record.

15. RECOMMENDATIONS ON PLANNING PLACE OF BIRTH

Women should be offered the choice of planning birth at home, in a midwife-led unit or in an obstetric unit. Women should be informed:

- That giving birth is generally very safe for both the woman and her baby.

- That the available information on planning place of birth is not of good quality, but suggests that among women who plan to give birth at home or in a midwife-led unit there is a higher likelihood of a normal birth, with less intervention. We do not have enough information about the possible risks to either the woman or her baby relating to planned place of birth.

- That the obstetric unit provides direct access to obstetricians, anaesthetists, neonatologists and other specialist care including epidural analgesia.

- Of locally available services, the likelihood of being transferred into the obstetric unit and the time this may take.

- That if something does go unexpectedly seriously wrong during labour at home or in a midwife-led unit, the outcome for the woman and baby could be worse than if they were in the obstetric unit with access to specialised care.

- That if she has a pre-existing medical condition or has had a previous complicated birth that makes her at higher risk of developing complications during her next birth, she should be advised to give birth in an obstetric unit.

15.1 Clinical governance structures should be implemented in all places of birth

- Multidisciplinary clinical governance structures, of which the Labour Ward Forum is an example, should be in place to enable the oversight of all places of birth. These structures should include, as a minimum, midwifery (ideally a supervisor of midwives), obstetric, anaesthetic and neonatal expertise, and adequately supported user representation.

- Rotating staff between obstetric and midwife-led units should be encouraged in order to maintain equivalent competency and experience.

- Clear referral pathways should be in place to enable midwives to inform or seek advice from a supervisor of midwives when caring for a woman who may have risk factors but does not wish to labour in an obstetric unit.

- If an obstetric opinion is sought by either the midwife or the woman on the appropriate place of birth, this should be obtained from a consultant obstetrician or Registrar.

- All healthcare professionals should document discussions with the woman about her chosen place of birth and the discussion of risks/benefits, in the hand-held maternity notes.

- In all places of birth, risk assessment in the antenatal period and when labour commences should be subject to continuous audit.

- Monthly figures of numbers of women booked for, being admitted to, being transferred from and giving birth in each place of birth should be audited. This should include maternal and neonatal outcomes.

- The clinical governance group should be responsible for detailed root-cause analysis of any serious maternal or neonatal adverse outcomes (for example, intrapartum-related perinatal death or seizures in the neonatal period) and consider any 'near misses' identified through risk management systems.

- The Confidential Enquiry into Maternal and Child Health (CEMACH) and the National Patient Safety Agency (NPSA)'s 'Seven steps to patient safety' provide a framework for meeting clinical governance and risk-management targets.

- Data must be submitted to the national registries for either intrapartum-related perinatal mortality or neonatal encephalopathy once these are in existence.

- Clear pathways and guidelines on the indications for, and the process of transfer to, an obstetric unit should be established. There should be no barriers to rapid transfer in an emergency.

- Clear pathways and guidelines should also be developed for the continued care of women once they have transferred. These pathways should include arrangements for times when the nearest obstetric or neonatal unit is closed to admissions.

- If the emergency is such that transfer is not possible, open access must be given on-site for any appropriate staff to deal with whatever emergency has arisen.

- There should be continuous audit of the appropriateness of, the reason for and speed of transfer. Conversely, audit also needs to consider circumstances in which transfer was indicated but did not occur. Audit should include time taken to see an obstetrician or neonatologist and the time from admission to birth.

16. MULTIDISCIPLINARY AUDIT, REVIEW AND MONITORING

The need to monitor/audit the standards set out below will be considered alongside other Directorate requirements and prioritised accordingly. The Directorate Clinical Audit programme is drafted by the Directorate Clinical Auditor, in liaison with clinical staff, and approved by the Directorate.

Adverse incidents relating to the care of the woman in labour should be reported via the Trust Incident Reporting System (DATIX), Such incidents will be investigated and managed in accordance Trust Policy RM07 Incident Management including Serious Untoward Incidents.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
CARE OF WOMEN IN LABOUR						
maternal observations to be carried out on admission	Directorate Clinical Auditor	Rolling Audit Programme	Every three years	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
maternal observations to be carried out during established first stage of labour	Directorate Clinical Auditor	On-going CNST Audit	Reported annually	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
maternal observations to be carried out during second stage of labour	Directorate Clinical Auditor	Rolling Audit Programme	Every three years	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit

						action plan.
maternal observations to be carried out during third stage of labour	Directorate Clinical Auditor	Rolling Audit Programme	Every three years	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
documentation of all of the above maternal observations	Directorate Clinical Auditor	Rolling Audit Programme	Every three years	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
guidance on duration of all stages of labour	Directorate Clinical Auditor	Rolling Audit Programme	Every three years	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and,

					action plan.	in addition, lessons will be shared with relevant stakeholders as per audit action plan.
guidance on referral to obstetric care	Directorate Clinical Auditor	Rolling Audit Programme	Every three years	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
INTERMITTENT AUSCULTATION						
equipment that should be used	Directorate Clinical Auditor	Rolling Audit Programme	Every three years	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
when to palpate the maternal pulse	Directorate Clinical Auditor	On-going CNST Audit	Reported annually	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe	Required changes to practice will be identified and actioned within a specific timeframe as per

					as per the audit action plan.	the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
when to auscultate the fetal heart	Directorate Clinical Auditor	On-going CNST Audit	Reported annually	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
length of auscultation	Directorate Clinical Auditor	Rolling Audit Programme	Every three years	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
when to transfer from intermittent	Directorate Clinical Auditor	On-going CNST Audit	Reported annually	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe	Required changes to practice will be identified and actioned within a specific timeframe as per

auscultation to continuous electronic fetal monitoring					as per the audit action plan.	the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
documentation of all of the above	Directorate Clinical Auditor	Rolling Audit Programme	Every three years	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
CLINICAL RISK ASSESSMENT (LABOUR)						
timing of the clinical risk assessment in all care settings	Directorate Clinical Auditor	On-going CNST Audit	Reported annually	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant

						stakeholders as per audit action plan.
medical conditions to be considered, including anaesthetic history	Directorate Clinical Auditor	Rolling Audit Programme	Every three years	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
factors from previous pregnancies	Directorate Clinical Auditor	Rolling Audit Programme	Every three years	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
lifestyle history to be considered	Directorate Clinical Auditor	Rolling Audit Programme	Every three years	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant

						stakeholders as per audit action plan.
risk assessment for appropriate place of birth	Directorate Clinical Auditor	Rolling Audit Programme	Every three years	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
documentation of an individual management plan when risks are identified during the clinical risk assessment	Directorate Clinical Auditor	On-going CNST Audit	Reported annually	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.
process for referral of women when risks are identified during	Directorate Clinical Auditor	On-going CNST Audit	Reported annually	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will

the clinical risk assessment						be shared with relevant stakeholders as per audit action plan.
documentation of all the above, where clinically relevant	Directorate Clinical Auditor	On-going CNST Audit	Reported annually	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.

17. REFERENCES

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