University Hospitals of North Midlands NHS
NHS Trust

Achieving Sustainable Quality in Maternity Services

ASQUAM

Guideline for the Care of Healthy Women in Labour

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Ratified by:	Maternity Forum Sub-Group Obstetric Guideline Group
Reviewed by:	Midwife Birth Centre Manager

VERSION CONTROL SCHEDULE

Version	Date	Author	Comments
1	2009 (August)		
2	2010 (July)		
3	2010 (November)		
4	2011 (June)		
5	2011 (December)		
6	2012 (March)		
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8	2012 (September)		
9	2013 (July)		
10	2014 (September)		
11	2017 (January)	Reviewed by E Pearson/ E Hubball Lead Midwives for Development and Education N King, Inpatient Matron Obstetrics	Full review undertaken in NICE gap analysis
12	2018	Reviewed by S Bailey and E Hubball, Lead Midwives for Education and Development N King Inpatient Matron Obstetrics	Recommendations on water birth included Addition made to include Skin to skin-Women should be encouraged to have skin-to-skin contact with their babies as soon as possible after the birth for at least one hour or until after the first feed In addition included that for 2nd stage - nulliparous women - the baby should be delivered within 4 hours following confirmation of second stage of labour In addition included that for 2nd stage – multigravida - the baby should be delivered within 3 hours following confirmation of second stage of labour Reference included for NICE – 2017 Documentation updated to include K2
13	2020 - November	Reviewed by J Hulse MBC Manager	Minor changes: Recommendations include Manual protection of the perineum (MPP) “Hands on” for second stage of labour. In addition it is more important to carry out an episiotomy when indicated (especially for instrumental births); with epi-scissors when available. Reference included for: OASI Care Bundle Project, manual protection of the perineum, 2018 The Management of Third and Fourth Degree Perineal Tears. RCOG (2015)

Contents Page

This guideline should be read in conjunction with the most up to date versions of:

- ASQUAM Guideline for Continuous and intermittent Electronic Fetal Monitoring (EFM) and Fetal Blood Sampling (FBS)
- ASQUAM Guideline for Management and Repair Perineal Trauma
- Guideline for the Repair of 3rd and 4th Degree Tears
- ASQUAM Neonatal Guidelines Immediate Care of the Newborn
- ASQUAM Guideline for Home Birth

1. INTRODUCTION

Giving birth is a life changing event. 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. Good communication, support and compassion from staff and having her wishes respected, can help her feel in control of what is happening and contribute to making birth a positive experience for the woman and her companions.

This guideline relates to women in all care settings, including high risk Delivery Suite, Midwife Birth Centre, Free Standing Birth Unit (FMBU) or Home Birth for women who go into labour at term, from 37^{+0} to 41^{+6} weeks gestation.

It is important that the woman is given information and advice about all available settings when she is deciding where to have her baby, so that she is able to make a fully informed decision. This includes information about outcomes for the different settings. It is also vital to recognise when transfer of care from midwifery-led care to obstetric-led care is indicated because of increased risk to the woman and/or her baby resulting from complications that have developed during labour.

Women should be offered the opportunity to birth in all care settings. Low-risk multiparous women should be advised that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit[2].

Advise low-risk nulliparous women that planning to give birth in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different

compared with an obstetric unit[2]. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby.

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 this guideline is to demonstrate the following:

- That the UHNM Maternity services have approved documentation for the care of women in labour at term in all care settings (as detailed above) including observations that must be undertaken in each identified stage of labour.
- That UHNM Maternity services have accepted methods of auscultation of the fetal heart in labour allowing identification of those fetuses who may be at risk of compromise with the appropriate and timely intervention.
- UHNM Maternity services 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[3].

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. When performing an initial assessment of a woman in labour, the midwife will listen to her story and take into account her preferences and

her emotional and psychological needs. The midwife will carry out an initial assessment to determine if midwifery-led care in any setting is suitable for the woman, irrespective of any previous plan.

Observations of the woman

On admission the midwife will:

- Review the antenatal records including all screening results and discuss these with the woman.
- Ask her about the length strength and frequency of contractions
- Ask her about any pain she is experiencing and discuss her options for pain relief.
- Record her observations and calculate her modified early obstetric warning sign (MEOWS) score and carry out urinalysis.
- Record if she has any vaginal loss.

Observations of the unborn baby:
On admission the midwife will:

- Ask the woman about the baby's movements in the last 24 hours.
- Perform an abdominal palpation identifying her fundal height, lie, presentation, position and engagement of the presenting part.
- Auscultate the fetal heart rate for a minimum of 1 minute immediately after a contraction. Palpate the woman's pulse to differentiate between the heart rates of the woman and baby.
- If there is uncertainty about whether the woman is in established labour, a vaginal examination 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
- All findings will be discussed and documented.

Healthcare professionals who conduct vaginal examinations should be certain that:

- The vaginal examination is really necessary and the findings 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 has been sought, maintain privacy, dignity and comfort and offer the option of a chaperone (if a chaperone is declined then this should be clearly documented in the birth record).
- The reason for the examination should be explained along with 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.

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 with the woman in labour and at each further assessment. The FHR should be auscultated for a minimum of 1 minute, immediately after a contraction and record this as a single rate of beats per minute (bpm). The maternal pulse should be palpated prior to auscultating the fetal heart to

differentiate between Maternal and FHR.[1] Accelerations and decelerations should be recorded if heard.

Both maternal pulse and FHR must be documented on the initial assessment and on the partogram throughout the 1st and 2nd stage of labour, as well as in their care records. If concerns arise the maternal pulse should be taken to differentiate between the fetal heart and maternal pulse.

The use of admission cardiotocography (CTG) in **low-risk** pregnancy is not recommended in any birth setting.

During Intermittent auscultation record all accelerations and decelerations.

3.1 Equipment to be used

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

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 liquor, 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.
- Suspected chorioamnionitis or sepsis.
- Severe hypertension (160/110 mmHg or above)
- Vaginal bleeding
- Oxytocin use for augmentation of labour
- Maternal request
- Epidural analgesia
- Maternal pyrexia ($\geq 38^0$ on one occasion and $>37.5^0$-37.9^0) on 2 occasions 2 hours apart
- Delay in the first and second stage of labour

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. 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.

The opportunity to labour in water is recommended for pain relief.

Transcutaneous electrical nerve stimulation (TENS) should not be offered to women in established labour[1].

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.

Opioids such as Pethidine by Intra Muscular Injection are available in all hospital 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 opioids may interfere with breastfeeding. If an intravenous or intramuscular opioid is used, it should be administered with an antiemetic.

EPIDURAL

Before choosing epidural analgesia, women should be informed about the risks and benefits, and the implications for their labour. Please refer to ASQUAM Epidural Guideline for further information

6. FIRST STAGE OF LABOUR OBSERVATIONS

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

- A pictorial record of labour (partogram). This should be used once labour is established.
- 4 hourly temperature and blood pressure
- Half-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 immediately after a contraction should occur for at least 1 minute, at least every 15 minutes. The rate should recorded as a figure of beats counted in that minute The maternal pulse should be palpated if an FHR abnormality is detected to differentiate between the two. Documentation of the fetal and maternal pulse must be recorded on the partogram in the electronic K2 birth records.

- 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.

6.2 Recommendations on pre-labour rupture of membranes at Term

There is no reason to carry out a speculum examination with a confirmed 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 approximately 24 hours after rupture of the membranes is appropriate. Management until the induction is commenced, or if expectant management beyond 24 hours is chosen by the woman, should include:

  Women should be advised to record their temperature every 4 hours during waking hours to detect any infection that may be developing, if the temperature is 37.5°c or above, or any change in the colour or smell of their vaginal loss; they should immediately inform the unit.

  Informing the woman that bathing or showering are not associated with an increase in infection, but that having sexual intercourse may be;
  Any decrease or change in fetal movements should be reported.

Fetal movements and heart rate should be assessed at initial contact and then every 24 hours after rupture of the membranes while the woman is not in labour.

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 at RSUH and advised to stay in hospital for at least 12 hours following the birth.

- Lower vaginal swabs and maternal C-reactive protein should not be offered.

- Women with pre-labour 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. The midwives will carry out neonatal observations in the first 12 hours of the birth with women who have had ruptured membranes for over twenty four hours.

- 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 for 48 hours, and consideration made for orally antibiotics for the remainder of the course. A neonatal review required and guidance for sepsis in neonates under 72 hours would be followed.

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[2]

The second stage of labour is defined as passive or active[1]:

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

WAIT FOR 1 HOUR FOR DESCENT PRIOR TO ACTIVE PUSHING.

Active second stage – The vertex is visible, or there are expulsive contractions with full dilatation of cervix and active maternal effort.

Suspected Delay in the second Stage.

For a nulliparous woman, 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. Contact medical staff for review and document an individualised management plan. If at home or on the Freestanding Midwife Birth Unit (FMBU) initiate transfer to the delivery suite and inform the co-ordinator.

For multigravida- if there is a delay of progress (in the terms of rotation or descent of the presenting part) after 30 minutes of active second stage. Offer vaginal examination and amniotomy if membranes intact. Review by medical staff to formalise an individualised management plan if undelivered in a further 30 minutes. If at home or on the Freestanding Midwife Birth Unit (FMBU) initiate transfer to the delivery suite and inform the co-ordinator.

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 rate monitoring every 15 minutes.
- 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 encourage the woman to mobilise to the toilet and if unsuccessful 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.

Both the woman and her partner will be informed of all findings. The above observations will 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 commences 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 immediately after a contraction for at least 1 minute, at least every 5 minutes. The maternal pulse should be palpated every 15 minutes to differentiate between the two heart rates. If there is suspected fetal bradycardia or any other FHR anomaly this also helps the midwife or obstetrician 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 record.

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 clinician's hand position at delivery

Manual protection of the perineum (MPP) "Hands on" technique is best practice if the birth position permits it. (guarding the perineum and flexing the baby's head) technique should be used to facilitate spontaneous birth.

Recommendations on episiotomy

A routine episiotomy should not be carried out during spontaneous vaginal birth. However, it is more important to carry out an episiotomy when indicated (especially for instrumental births). Epi-scissors should be used, in order to prevent obstetric anal sphincter injuries as used properly they ensure the correct angle is adopted and reduce the potential for unnecessary long term outcomes from incorrect angles of incision. Where epi-scissors are unavailable, 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 performed at 60 degrees.

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

Women who have experienced previous third or fourth degree perineal trauma should have attended the perineal care clinic at UHNM to enable informed choice about mode of delivery. Discussions will focus on:

- The current urgency or incontinence symptoms
- The degree of previous trauma
- The risk of reoccurrence
- The success of the repair undertaken
- The psychological effect of the previous trauma
- Management of her labour.
- Conducting an endoanal scan in order to formulate a management plan.

Recommendations for woman with infibulated genital mutilation

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. Water birth should be provided as an option to all pregnant women who are suitable for low risk care in labour.

Preparation and cleaning of the pool should follow local infection control measures and manufacturers instruction.

Women entering the pool should be in established labour and should not enter the pool within 2 hours of opioid administration or if feeling or appearing to be drowsy. Once a woman is in-situ in the pool she should not be left unaccompanied.

Intermittent auscultation of the fetal heart should be performed with a non-electrical waterproof sonic aid.

It is recommended that nitrous oxide is the only suitable analgesic for women labouring in water.

The pool should be filled to cover the maternal abdomen. The maternal temperature should be monitored hourly in order to ensure that the woman is not becoming pyrexial. The use of the pool should be discontinued if there is a rise of 1^{o}C or above in maternal temperature. In a warm humid environment oral fluid intake should be encouraged in order to prevent maternal dehydration.

Pool water temperature should be monitored hourly in order to maintain a temperature that is comfortable for the woman but does not exceed 37.5^{o}C at any time. The pool should be kept clear of debris.

Two Midwives should attend a water birth. Delivery in the pool should be a mainly "hands off" procedure. Following delivery of the head the trunk should be expelled with the next contraction, if the trunk fails to deliver the woman should be encouraged to stand up and deliver the baby in air. If the baby is delivered in air do not allow the mother to re-enter the water.

Perineal suturing if required should not be performed within 1 hour of the woman leaving the pool in order to allow tissue oedema to reduce. Suturing should be completed within 2 hours of delivery.

In the event that removal from the pool is required local evacuation policy should be followed.

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.

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

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 is administered, no early cord clamping and delivery is by maternal effort only, do not pull the umbilical cord or palpate the uterus.

Active - Can take up to ½ hour; administer Oxytocin (syntometrine unless hypertensive), delay cord clamping and cutting for at least 1 minute after the birth unless there is concerns about the integrity of the cord or the baby has a heart rate <60bpm. The cord should be double-clamped to allow paired cord blood gases to be taken if indicated. Clamp the cord before 5 minutes in order to perform controlled cord traction. If the woman requests that the cord is clamped and cut later than 5 minutes, support her in her choice. Advise her that this reduces her risk of haemorrhage and shortens her 3rd stage. If at home or on FMBU then urgent transfer to Delivery Suite at RSUH should be initiated.

Recommendation on observations in the third stage of labour

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

- Observing the woman's 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 MEOWS observations to assess the need for resuscitation are required.

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

- Active management of third stage of labour is recommended to prevent the risk of postpartum haemorrhage (PPH)[2]. At UHNM the following drugs should be used.

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

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

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

Inspection of the perineum should be carried out in line with the perineal repair guideline – Please see ASQUAM guideline **for Management and Repair Perineal trauma.**

9. POSTNATAL OBSERVATIONS MOTHER AND BABY

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

- Maternal observation – temperature, pulse, blood pressure, respirations, saturation (except homebirths), uterine contraction, lochia.

- Swabs should be counted before and following delivery by two members of staff, one of which must be a registered practitioner, they should both complete the relevant record to ensure that all swabs are accounted for.

- All women who have had a vaginal delivery at UHNM will have one set of MEOWS observations recorded following delivery and on admission to a post natal area or before transfer home, unless the score suggests that further observations are required.

- Women who have had a Caesarean Section at UHNM 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 which includes an 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 ASQUAM Guideline for the Prevention of Urinary Problems.

Neonatal Observations and care include:

Recording the Apgar score at 1 and 5 minutes 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. The Apgar score should continue to be recorded until the baby's condition is stable.

Skin to skin-Women should be encouraged to have skin-to-skin contact with their babies as soon as possible after the birth for at least one hour.

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. Parents should be advised to observe babies colour, tone and breathing whilst having skin to skin and alert staff with any concerns.

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 birth. The baby should have identity bands secured on each ankle and an electronic ankle tag if the mothers consent is obtained.

An initial examination should be undertaken by a healthcare professional to detect any major physical abnormality and to identify any problems that require referral. See ASQUAM guideline for Immediate Care of the Newborn.

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 crucial to the provision of safe and effective care[3]. 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.

From October 2017 all maternity record keeping should be completed on the K2 electronic record keeping system

All observations during woman's are labour, inclusive of Initial Assessment, First/Second stage, Third Stage and Immediate Postnatal Observations should be documented in the guardian section of the K2 electronic records.

Once it has been identified that Labour is established, and then formal recording of both Maternal observations (temperature, pulse, respirations, blood pressure, urinalysis) and fetal observations (FHR) are also made on the partogram, which is a pictorial record of labour.

11. GUIDANCE ON DURATION OF ALL STAGES OF LABOUR

The UHNM adopts the following current NICE guidance in relation to the 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 are as follows for a Nulliparous woman delivery would be expected to take place within 3 hours of commencement of the active second stage.

For a multiparous woman delivery would be expected to take place within two hours of commencement of the active second stage.

Recommendations on duration of the third stage of labour are dependant upon either active management or physiological management. NICE recommended[1] that: 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 and Standards 2012) 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 is not exhaustive, but may be used to identify women who would need referral to Obstetric Care during the Intrapartum period:

- 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
- Delay in 1st or 2nd stage
- SROM over 24 hours and not in labour
- Significant meconium
- Retained placenta
- Complicated perineal repair
- Pain relief i.e. epidural
- Intrapartum Haemorrhage
- Placental Abruption
- Ruptured Uterus
- Pain reported by the woman that differs from that normally associated with labour.
- 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
- Abnormal presentation including Breech
- High free floating head
- Suspected growth restriction or macrosomia
- suspected an hydramnios or polyhydramnios

For women giving birth out of hospital settings, i.e. Home Birth, if a woman needs referral for Obstetric review, the UHNM follows the transfer arrangements recommended in the 5th CESDI report[4], specifically that transfers should be arranged at the earliest indication of deviations from normal.

13. CLINICAL RISK ASSESSMENT – LABOUR

When labour commences, the Midwife will review the pregnancy record to identify the need for any of the following to be notated in the birth record

- Medical Conditions including anaesthetic history
- Relevant factors from previous pregnancies
- Lifestyle history
- 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 intrapartum record '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 record, 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.

Where a woman presents on the Midwife Birth Centre outside the low risk guidelines 'supporting her birth choice' the Obstetricians should be informed of her admission.

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 record.

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

- It is the responsibility of the Obstetrician to record the outcome of the review in the birth record and will agree a plan of care with the woman and the midwife. The plan of care will be recorded in the birth record.

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

Please see ASQUAM Guideline for Patients Who Refuse Blood Products.[6]

15. 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.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and lead(s)	Change in practice and lessons to be shared
Guideline content	Guideline Co-ordinator	Guideline Review	Every three years	Maternity Ward Forum Subgroup: Guideline Meeting	Required changes to practice will be identified and actioned with the release of the updated guideline.	Required changes to practice will be identified and actioned with the release of the updated guideline.
Clinical standards within guideline	Directorate Clinical Auditor	Clinical Audit	As required in relation to other Directorate priorities	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.

16. REFERENCES

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

2. National Institute for Health and Care Excellence. (2017). Intrapartum care: Care of healthy women and their babies during childbirth. London: NICE

3. National Perinatal Epidemiology Unit, 2013. Birthplace National Study. Nursing and Midwifery Council (NMC) 2015. The Code: Professional Standards and Behaviour For Nurses and Midwives. London: **NMC**

4. Maternal and Child Health Research Consortium. Confidential Enquiry into Stillbirths and Deaths in Infancy: 5th Annual Report, 1 January–31 December 1996. London: Maternal and Child

5. ASQUAM Guideline for Patients Who Refuse Blood Products, April 2012

6. OASI Care Bundle Project, manual protection of the perineum, 2018

7. The Management of Third and Fourth-Degree Perineal Tears. Green Top Guideline No 29. RCOG (2015)