Bedfordshire Hospitals NHS Foundation Trust

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	CG140 Obstetric Anaesthetic Guidelines Including Epidural and Dural Tap CG142 Managing Intravenous Remifentanyl Patient Controlled Analgesia (PCA) for Women in the Delivery Suite CG209 Guidelines for the Management of Postpartum Haemorrhage including the Management of Retained Placenta CG440 Latent Phase of Labour SOP: BLMK LMNS Approach in Improving Outcomes for Black, Asian & Ethnic Minority Pregnant Women - Based on Recent Covid-19 Pandemic Experience CG563L Intrapartum Physiological Fetal Monitoring Guideline
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Care of the Woman in Labour Guideline

Introduction

Birth is a life changing event and the care given to women has the potential to affect them both physically and emotionally for the rest of their life.

The Department of Health recommend all maternity services should facilitate normal childbirth wherever possible, with medical interventions recommended only when they are of benefit to the woman and/or her baby.

This guideline covers the care of healthy women in labour at term (37 - 41+6 weeks of gestation). These guidelines are intended to support midwives and obstetricians care for these women and their families.

Women have the right to a quality, personalised service and should be able to make decisions about the support they need during birth and where they would prefer to give birth, after a full discussion of the benefits and risks associated with each option. Respect for personal space, dignity and privacy are of equal importance.

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

For women presenting with symptoms of Covid-19 please also refer to SOP: BLMK MSNS Approach in Improving Outcomes for Black, Asian & Ethnic Minority Pregnant Women.

Labour; Definitions

Normal Labour **–** The World Health Organisation (WHO) continue to use their 1996 definition of normal labour; "Spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition."

Latent phase first stage of Labour – a period of time, not necessary continuous, when there are painful contractions and there is some cervical change, including cervical effacement and dilatation up to 4cm.

Established first stage of labour – regular painful contractions and progressive cervical dilatation from 4cm dilated, along with changes in a woman's behaviour as the endorphin levels rise.

Second stage of labour – from full dilatation of the cervix (10cms) until the birth of the infant.

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

Active second stage of labour - is one or more of the following:

- the presenting part is visible
- expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix
- encouragement of active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions.

Third stage of labour – is the time from the birth of the infant to the expulsion of the placenta and membranes.

Aims and objectives of the guideline

To support midwives and obstetricians in promoting normal labour and birth:

 providing safe, effective women centred care

- avoid unnecessary admissions in the latent phase of labour by offering careful assessment and support
- a woman in established labour should receive one-to-one care by a midwife and the support of her chosen birth partner(s)
- undertaking observations of the labouring women; make continuous risk assessments of women in labour and identify any deviations from normal during labour or birth
- assessment and monitoring the fetal condition during labour and the condition of the infant after birth.
- making appropriate and timely referral to an obstetrician if any deviations from normal are identified during labour or birth.
- encourage mobilisation during labour and support the use of nonpharmacological methods of coping with contractions such as hydrotherapy

Education

As part of all women's education and early assessment they should be given information about:

•what to expect in the latent first stage of labour

•how to work with any pain they experience

•how to contact the labour ward if they suspect they are in labour or have any concerns during their pregnancy and what to do in an emergency

Risk assessments in labour

- Social considerations: consideration of any on-going social issues which may impact on the safety of the mother, baby and health professionals attending.
- A thorough risk assessment must be undertaken on admission to the maternity Unit and to inform the appropriate pathway of care and place of birth.
- Transfer from Midwife led care to Consultant led care: following recognition of any deviation from the normal pathway.

Initial labour assessment

For the majority of women the initial labour assessment begins when they contact the maternity unit via the triage telephone. The telephone triage assessment communication tool must be completed detailing advice given and filed in the woman's hospital notes. If the woman/partner is contacting the maternity unit on the SECOND or subsequent occasion, she should be reassured and invited in for assessment.

Women who are assessed as low risk and are not considered to be in established labour should be encouraged to stay at home, with a plan in place to maintain good communication with the hospital staff to ensure that further progress can be monitored and support offered.

If this initial assessment is normal remind the woman what to expect and when to call back/come into delivery suite, MLBU or need community midwives to attend in the case of planned homebirth.

If there are any concerns raised in this initial assessment the women should be given the appropriate advice in relation to the concerns raised. (Refer to CG310 Maternity Care Pathways and Risk assessments and CG393 Midwifery Led Rapid Assessment Guideline)

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 either return home with appropriate advice on the basis of an overall risk assessment or allowed to stay (with support on the Antenatal Ward/Ward 32).

Initial labour assessment Includes:

- risk assessment for the most appropriate area for this care episode
- listening to her story, considering her emotional and psychological needs, and reviewing her maternity records, including all antenatal screening results
- birth plans should be read and discussed with the woman and her birth partner
- establish the woman's language needs and ensure that interpreters are arranged or telephone translation services are used as required
- ideally the environment should be homely and the woman encouraged to adapt to her current environment to meet her individual needs
- physical observation – weight/BMI, temperature, pulse, blood pressure, respirations and urinalysis
- length, strength and frequency of contractions
- abdominal palpation – fundal height, lie, presentation, position and station vaginal loss – description of vaginal loss including show, liquor, blood assessment of the woman's pain, including her wishes for coping with labour along with the range of options for pain relief
- a history of fetal movements in the last 24 hours
- ensure all observations and assessments are documented in the Intrapartum booklet and the OEWS chart

All women admitted to the maternity Unit, even for assessment, must have a OEWS chart started, charting their observations.

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

In addition:

- the fetal heart (FH) should be auscultated for a minimum of 1 minute immediately after a contraction and recorded as a single rate. Record any accelerations or decelerations heard and the equipment used to auscultate.
- during the initial labour assessment the FH should be auscultated as above on admission, then if established labour is confirmed the FH must be auscultated every 15mins in the first stage, or every 5 minutes or after every contraction (if this is sooner than 5 minutes) in the second stage.
- the maternal pulse should be palpated to differentiate between maternal and fetal heart rates
- if a woman appears to be in labour it may be beneficial to perform a vaginal examination with consent.

When a vaginal examination is undertaken:

- 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
- explain the reason for the examination, what will be involved and sensitively explain the findings and any impact on the birth plan to the woman
- document the findings and make a management plan with the woman

Offer continuous CTG in the presence of identified risk factors and explain why this is recommended.

Offer CTG if intermittent auscultation indicates possible fetal heart rate abnormalities. **Remove the CTG if the trace is normal after 20 minutes**.

Any woman who is very anxious and reluctant to go home when advised to do so may stay in the maternity unit with a full re-assessment of labour 4 hours from admission.
If labour is not established she should be encouraged to return home, with a plan in place to maintain good communication with the hospital staff to ensure that further progress can be monitored and support offered.

Transfer to consultant led care in labour

If a deviation from normal arises during labour the woman's care should be transferred to Consultant led care. If contemplating transfer of care

- talk with the woman and her birth companion(s) about the reasons for this and what they can expect, including the time needed for transfer.
- address any concerns she has and try to allay her anxiety

- ensure that her wishes are respected and her informed consent is obtained
- ensure the woman is made to feel as comfortable as possible during transfer

In the event of a need to transfer when birth is imminent, an assessment is required to determine if birth in the current location is preferable to transferring. This should be discussed with the co-ordinating midwife. The woman will be allocated the Consultant on take as her named Consultant. The Senior Midwife and Obstetric Registrar on duty must be informed of the reason for transfer to Consultant led care. The reason for transfer to Consultant led care must be documented in the woman's hospital maternity record at the time of transfer. (CG151 Mother and Baby transfer of care guidelines for health professionals and CG287 Midwifery Led Birthing Unit operational policy).

Communication with women and their birth companions

All women in labour should be treated with respect and should be in control of and involved in what is happening to them, and the way in which care is given is key to this. To facilitate this, healthcare professionals and other caregivers should establish a rapport with the labouring woman, asking her about her wants and expectations for labour, being aware of the importance of tone and demeanour, and of the actual words they use. This information should be used to support and guide her through her labour.

To establish good communication with the labouring woman, healthcare professionals should:

- Greet the woman with a smile and a personal welcome, establish her language needs, introduce themselves and explain their role in her care.
- Maintain a calm and confident approach so that their demeanour reassures the woman that all is going well.
- Knock and wait before entering the woman's room, respecting it as her personal space, and ask others to do the same.
- Ask how the woman is feeling and whether there is anything in particular she is worried about.
- If the woman has a written birth plan, read and discuss it with her and document the discussion in the woman's maternity records.
- Assess the woman's knowledge of strategies for coping with pain and provide balanced information to find out which available approaches are acceptable to her.
- Encourage the woman to adapt the environment to meet her individual needs.
- Ask her permission before all procedures and observations, focusing on the woman rather than the technology or the documentation.
- Show the woman and her birth partner how to summon help and reassure her that she may do so whenever and as often as she needs to.

- When leaving the room, healthcare professionals should let her know when they will return.
- Involve the woman in any handover of care to another professional, either when additional expertise has been brought in or at the end of a shift.

Hygiene during labour

Routine hygiene measures taken by staff caring for women in labour, including standard hand hygiene and single-use non-sterile gloves, are appropriate to reduce cross-contamination between women, babies and healthcare professionals.

Selection of personal protective equipment must be based on an assessment of the risk of transmission of micro-organisms to the woman, and the risk of contamination of the healthcare practitioner's clothing and skin by women's blood, body fluids, secretions or excretions.

Tap water may be used if cleansing is required prior to vaginal examination.

Eating and drinking in labour

There is insufficient evidence that denying food and drink to labouring women lessens gastric aspiration risks. Starving women in labour can cause dehydration and acidosis, these factors combined with fatigue can increase the risks of augmentation, instrumental delivery and PPH. Unless there are risk factors significantly increasing the need for a woman to go to theatre for procedures that may require a general anaesthetic all women in labour should be allowed to eat and drink as they wish. Women who choose not to eat or who are unable to eat, should be advised that still isotonic drinks may be beneficial as these have been shown to maintain calorie intake and blood sugars.

Controlling gastric acidity - Neither H2-receptor antagonists nor antacids should be given routinely to low-risk women. Either H2-receptor antagonists or antacids should be considered for women who have or develop risk factors that make a general anaesthetic more likely. Antacids should also be considered for women who have

opioids in labour as they appear to significantly delay stomach emptying. Omeprazole 40mg is prescribed by doctors as required.

Positions for labour and delivery

Midwives will support women's choices for positions in labour and enable women to be mobile birthing positions can have a psychological impact on the women's experience of labour and can influence her feeling of being in control.
The midwife should encourage and promote the woman to mobilise and adopt whatever positions she finds most comfortable throughout labour and should encourage an 'active birth'.

First stage of labour - Upright positions and walking in labour are associated with a reduction in the length of first stage of labour and the use of epidural analgesia.

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

Benefits of upright positions for the second stage of labour include:

- Shorter second stage
- Fewer instrumental births
- Fewer episiotomies

See RCM positions in labour poster Appendix 1

Normal labour

Labour and birth are normal physiological processes. Clinical intervention should not be offered or advised where labour is progressing normally and the woman and baby are well. In all stages of labour, women who have left the normal care pathway due to the development of complications can return to it if and/or when the complication is resolved.

Care of the woman in latent phase of labour - (See CG440 Guideline for Care of Women in Latent Phase of Labour).

Midwifery advice should be accessible by telephone to all women at home in latent phase of labour. When giving advice, the midwife should listen for any signs that the woman requires face to face midwifery assessment. Any advice or information given and a subsequent management plan should be documented on the telephone triage communication tool, which should then be filed in the woman's maternity records. (Refer to CG393 Midwifery Led Rapid Assessment Guideline).

Low risk women and their partners should be encouraged to experience the latent phase of labour at home and maintain normal everyday activities. Labour wards may not be the appropriate environment for women in latent phase.
Women should be encouraged to eat and drink as normal in latent phase of labour.

A mistaken diagnosis of active labour can lead to a subsequent diagnosis of labour dystocia and a consequent cascade of intervention.

Coping strategies and pain relief in labour

A woman's choice of, pain relief during labour are influenced by many factors, including her expectations, the complexity of her labour and the severity of her pain and for many women the pain of labour is significant and the majority require some form of pain relief. Extreme pain can result in psychological trauma for some women, while for others undesirable side effects of analgesia can be detrimental to the birth experience.

Women need to be in control of what is happening to them and continuing communication between the woman and the midwife during the progress of labour about her desire for analgesia is fundamental. The attitude and behaviour of the midwife is consistently seen to be the most obvious and powerful influence on women's satisfaction. Women are more satisfied with pain relief when their expectations of pain and how they choose to manage it are met.

Midwives should consider how their own values and beliefs inform their attitude to coping with pain in labour and ensure their care supports the woman's choice.

It is important to remember that relatively simple things can make a difference. Women appreciate having someone whom they know and trust with them in labour. Women should be able to play music of their own choice and drink and eat a light diet if they want to during labour. They can choose to walk, move around, find comfortable positions, sit, stand up, or lie down on their sides. However, if they lie on their backs, they are likely to feel the pain more intensely.

Below are the options for analgesia prioritised on the basis of the strength of the evidence of their effectiveness:

A woman in established labour should receive supportive one-to-one care and the support of her chosen birth partner(s) and should not be left on her own except for short periods or at the woman's request.

Breathing and relaxation - Women who choose to use breathing and relaxation techniques such as massage, aromatherapy, music and hypnotherapy should be supported with their choices.
(Midwives should provide support within their scope of practice)

Birth balls - Women may find the use of birthing balls beneficial in helping them to find a comfortable position.

Water - The evidence shows that immersion in water provides effective pain relief, so encouraging the woman to get into a warm bath or birthing pool will help reduce the pain of the first stage of labour, and mean they are less likely to need an epidural. The use of water as showers can also be considered where appropriate.
If there is a need for continuous CTG monitoring, Telemetry can be used to allow the use of water.
Refer to CG83 Waterbirth and Labour guideline.

Acupuncture and hypnosis - Women who choose to use acupuncture or hypnosis should be able to, although this is not offered by the maternity unit or clinical staff.

Transcutaneous electronic nerve stimulation (TENS) - This is a widely used nonpharmacological method of pain relief. It stimulates the nerve endings in the skin, which is said to stimulate the production of endorphins, which are one of the group of opiate-like peptides produced physiologically.
Transcutaneous electrical nerve stimulation (TENS) should not be offered to women in established labour as it does not provide any pain relief. There are no trials of its use in latent labour when some women choose to use it.

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.
Entonox has the advantage that it acts very quickly and rapidly passes out of the system without affecting the baby and it can be used anywhere – even in the bath. It takes the edge off the pain and helps many women. Some women feel dizzy or lightheaded when using it but the advantage of Entonox is that if the woman does not like it, it can be stopped and the side effects will also stop

Opioid analgesia – Pethidine and Diamorphine, are available in all birth settings located within the hospital. Women should be informed that these will provide limited pain relief during labour and may have significant side effects for both the woman including drowsiness, nausea and vomiting. Her baby may experience short-term respiratory depression and drowsiness which may last several days potentially impacting on breastfeeding.

- *Fetal wellbeing should always be assessed by auscultation of the fetal heart and questioning the woman regarding fetal movements prior to the administration of Opioid drugs.*
- *Opioid drugs should be given* with antiemetic cover.
- Women should not enter water (a birthing pool or bath) within 2 hours of opioid administration or if they feel drowsy.
- Pethidine can be administered by intramuscular injection of 50-100mg, 1-3 hourly. The first dose can be given with an anti-emetic (NICE, BNF 2020)

- Midwives can give two doses of pethidine by midwives exemptions to a woman over 37 weeks gestation once she is in established labour, further doses should be prescribed by an obstetrician
- Diamorphine can be administered by intramuscular injection of 5-10 mg, 4 hourly (by prescription). Pethidine should not be given to women with epilepsy.

Epidural analgesia - Women should be informed about the risks and benefits, and the implications for their labour

- Any arrangements for transfer to the appropriate area and the time involved. 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, which may reduce mobility.
- 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.
- if epidural analgesia is contraindicated, consider use of remifentanyl.

For further information see Obstetric Anaesthetic guidelines including CG140 Epidural and Dural tap.

All forms of pharmacological and non-pharmacological pain relief given should be documented in the woman's hospital held records. All drugs administered by the midwife should be written in red ink in the woman's maternity record and signed on the prescription chart.

Assessing progress in labour

Vaginal examinations are routinely chosen as the definitive method of confirming the onset of labour and assessing progress by estimating the rate of cervical effacement and dilation, and the descent and position of the presenting part. The number of vaginal examinations should be limited to the strictly necessary, usually once every 4 hours is enough.

- cervical dilatation is not the only indicator of progress in labour. An assessment of length, strength and frequency of contractions as well as the resting tone and abdominal palpation should inform the management plan.
- Where possible, the same clinician should perform repeat examinations as progress is more likely to be reported accurately.

- Informed consent should be obtained prior to any vaginal examination and documented in the maternity record

All findings should be clearly documented in the maternity record including the partogram and a management plan made and documented.

Fetal heart assessment

- intermittent auscultation of the fetal heart rate (FHR) is recommended for lowrisk women in established labour in any birth setting, undertaken by either doppler ultrasound or pinard stethoscope. FHR, length of time of FHR auscultation and method/equipment used to auscultate should be documented whenever auscultation is performed
- initial auscultation of the fetal heart is recommended at first contact in early labour and at each further assessment
- the maternal pulse should be palpated if there is suspected fetal bradycardia or any other FHR anomaly to differentiate the two heart rates
- once a woman is in the established first stage of labour, intermittent auscultation of the fetal heart after a contraction should be at least every 15 minutes.
- the FHR must be auscultated for one whole minute immediately following a contraction and recorded as a single rate (the documentation should state that this has taken place).
- once a woman is in the second stage of labour, intermittent auscultation of the fetal heart after a contraction should be at least every 5 minutes for a period of one minute.
- NICE Intrapartum Care recommends that the FHR should be recorded as a single rate and record accelerations and decelerations if heard.
- the FHR should also be recorded every 30 minutes on the partogram.

Changing from intermittent auscultation to continuous electronic fetal monitoring (EFM) in low-risk women should be advised for the following reasons, this list is not exhaustive:

- moderate and severe hypertension
- meconium stained liquor
- abnormal FHR detected by intermittent auscultation
- maternal pyrexia (defined as 38.0 °C or above once or 37.5 °C or above on two consecutive occasions 2 hours apart)
- fresh vaginal bleeding that develops in labour oxytocin use for augmentation
- the woman's request.
- prolonged rupture of membranes
- confirmed delay in 1st stage of labour

If the above are present with any other risk factor continuous electronic fetal monitoring (CEFM) is advised.

A discussion should be undertaken with the woman if her risk changes and she requires CEFM. This should be offered and the reason for this change must be clearly documented in the hospital maternity records.

CEFM in labour aims to identify the fetus at risk of hypoxia before it is sufficient to lead to damaging acidosis and long-term neurological adverse outcome. *If there is a bradycardia of the fetal heart for 3 minutes, and it is not recovering, the emergency bell must be pulled.*

For further information regarding fetal monitoring in labour see CG263 Electronic Fetal Monitoring in labour and CG489 Guideline for Intermittent Auscultation.

Whichever method of monitoring is undertaken, there needs to be a balance between correctly identifying the babies who have given rise to an appropriate cause for concern, and over identifying babies as having problems when they do not, leading to higher rates of intervention.

If continuous monitoring has been commenced due to concerns arising from intermittent auscultation, but there are no non-reassuring or abnormal features on the CTG trace after 20 minutes, return to intermittent auscultation.

First stage of labour

Duration of the first stage of labour - women may be informed that while the length of established first stage of labour varies, first labours last on average 8 hours and are unlikely to last over 18 hours. Second and subsequent labours last on average 5 hours and are unlikely to last over 12 hours.

Observations during the established first stage of labour - A pictorial record of labour (partogram) should be used once labour is established.

Observations by a midwife during the first stage of labour and documented on the partogram include:

- 4 hourly temperature and blood pressure
- hourly pulse
- half-hourly documentation of frequency of contractions
- frequency of emptying the bladder
- vaginal examination offered 4 hourly, unless indicated otherwise (after abdominal palpation and assessment of vaginal loss).

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 a single rate.

The maternal pulse should be palpated if a FHR abnormality is detected to differentiate the two heart rates.

All observations should be recorded on the partogram and documented in the hospital maternity records. The partogram should be completed contemporaneously.

If any of the indications for transfer to obstetric led care are met transfer the woman as appropriate. In all stages of labour, women who have left the normal care pathway due to development of a complication can return to it if the complication resolves.

On-going 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.

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

Definition of delay in the established first stage of labour

A diagnosis of delay in the established first stage of labour needs to take into consideration all aspects of progress in labour and should include:

- cervical dilatation of less than 2 cm in 4 hours for first labours
- cervical dilatation of less than 2 cm in 4 hours or a slowing in the progress of labour for second or subsequent labours
- descent and rotation of the fetal head
- changes in the strength, duration and frequency of uterine contractions.

Actions for delay in first stage of labour - Where delay in the established first stage is suspected the following should be considered:

- parity
- cervical dilatation and rate of change
- uterine contractions
- station and position of presenting part
- the woman's emotional state
- women should be offered support, hydration, appropriate and effective pain relief and should be referred to an Obstetrician

If delay in the established first stage of labour is suspected, amniotomy should be considered for all women with intact membranes after explanation to the woman that it could shorten her labour by about an hour and may increase the strength and pain of contractions.

Whether or not a woman has agreed to an amniotomy, all women with suspected delay in the established first stage of labour should be offered a vaginal examination 2 hours later, and if progress is less than 1 cm a diagnosis of delay is made.

Women with intact membranes were a delay in the established first stage of labour is confirmed, should be advised that an amniotomy would be beneficial in aiding the labour to progress and she should be offered a repeat vaginal examination 2 hours later whether her membranes are ruptured or intact.

Amniotomy alone for suspected delay in the established first stage of labour is not an indication to commence CEFM.

For women with suspected delay in labour who are at home or on the MLBU, the midwife should inform and discuss the situation with the Delivery suite co-ordinator. An individual management plan of care should be agreed and documented in the woman's maternity notes.

Where a diagnosis of delay in the established first stage of labour is made, continuous EFM should be offered.

When delay in the established first stage of labour is confirmed advice should be sought from an obstetrician and the use of Oxytocin should be considered. Explain to the woman that the use of oxytocin will increase the strength and frequency of contractions and that CEFM is recommended. Inform her that it will bring forward the time of birth but will not influence the mode of birth or other outcomes.

An obstetrician should perform a full assessment in all women with a confirmed delay in the established first stage of labour before a decision is made about using oxytocin. For more information refer to the use of CG262 Oxytocin in Labour guideline CG262
Offer all women support and effective pain relief.
See Delay in first stage of labour flow chart Appendix 2.

Amniotomy

Routine amniotomy is not appropriate in normal labour
Most women in spontaneous labour will have reached the second stage of labour before the membranes rupture spontaneously.
When there is delay in the established first stage of labour, there is high-level evidence that the duration is shortened by amniotomy, by about an hour, and may increase the strength and pain of her contractions.

Amniotomy in labour may be indicated for several reasons, which should be discussed with the woman prior to undertaking the procedure. Consideration should be given as to whether transfer to consultant led care is necessary.
These reasons may include

- maternal request
- to accelerate slow labour
- application of a fetal scalp electrode

- obtain fetal scalp pH

Second stage of labour

Observations for women and babies in the second stage of labour - All observations should be documented on the partogram. Observations by a midwife of a woman in the second stage of labour include:

- hourly blood pressure
- 15 minute pulse rate
- continued 4 hourly temperature
- vaginal examination offered hourly in the active second stage or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss)
- half-hourly documentation of the frequency of contractions
- frequency of emptying the bladder
- on-going consideration of the woman's emotional and psychological needs.

All observations in the second stage of labour should be recorded on the partogram and documented in the hospital maternity records.

In addition:

- Assessment of progress should include maternal behaviour, effectiveness of pushing and fetal wellbeing, taking into account fetal position, rotation and station throughout the second stage.
- 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.
- On-going consideration should be given to the woman's position, hydration, coping strategies and pain relief throughout the second stage.

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

Women's position and pushing 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.

- In the absence of strong evidence supporting a specific method or timing of pushing, patient preference and clinical situations should guide decisions.
- Women should be encouraged to push based on their comfort and preferences.

- 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.

Duration and definition of delay in the second stage of labour

Advise and encourage the woman to actively push 1 hour after passive second stage of labour.

Nulliparous woman - Delivery should be expected within 3 hours of the start of the active second stage.

- diagnose delay if the active second stage has lasted 2 hours.
- suspect delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 1 hour of active second stage.
- request the obstetrician to review the woman when delay in labour is suspected or diagnosed.

Multiparous woman - Delivery should be expected within 2 hours of the start of the active second stage.

- diagnose delay if the active second stage has lasted 1 hour.
- suspect delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 30 minutes of active second stage.
- request the obstetrician to review the woman when delay in labour is suspected or diagnosed.

An obstetrician should assess a woman with confirmed delay in the second stage before contemplating the use of oxytocin.
For more information refer to use of CG262 Oxytocin in Labour guideline.

Intrapartum interventions to reduce perineal trauma

- perineal massage should not be performed by healthcare professionals in the second stage of labour.
- the RCOG suggest that hands on at the time of delivery should be promoted in order to protect the perineum and reduce the incidence of 3rd and 4th degree tears.
- the Obstetric Anal Sphincter Injury (OASI) care bundle is practiced at Luton and Dunstable as recommended by the RCOG to prevent severe perineal trauma and improve health outcomes for women. (RCOG 2020). Use of the OASI technique should be clearly documented in the woman's notes using the sticker tool.
- lidocaine spray should not be used to reduce pain in the second stage of labour.
- 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 with consent if there is a clinical need such as instrumental birth or suspected fetal compromise and the indication clearly documented.
- tested effective analgesia should be provided prior to carrying out an episiotomy, except in an emergency due to acute fetal compromise.
- women with a history of severe perineal trauma should be informed that their risk of repeat severe perineal trauma is not increased in a subsequent birth, compared with women having their first baby.
- an episiotomy should not be routinely offered at vaginal births after previous 3rd or 4th degree trauma.

Third stage of labour

In this period the woman and birth companions are meeting the baby, therefore all care and interventions during this time should be sensitive to this, minimising separation or disruption of the mother and baby.

Active management - of the third stage involves a package of care, which includes all of these three components:

- routine use of syntometrine
- deferred clamping and cutting of the cord, not before 1 minute unless there is concern, and by 5 minutes to perform Controlled Cord Traction.
- controlled cord traction after administration of oxytocin and signs of separation of the placenta

Exerting traction on the cord or palpating the uterus should only be carried out after administration of syntometrine (ergometrine 500micrograms + oxytocin 5units) or 5units oxytocin on its own as part of active management.

Physiological management - of the third stage involves a package of care, which includes all of these three components:

- no routine use of uterotonic drugs
- no clamping of the cord until pulsation has ceased or the placenta is delivered.
- delivery of the placenta by maternal effort and gravity.

Women at low risk of postpartum haemorrhage and who have a normal labour, 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

Record the timing of cord clamping in active and physiological third stage

Evidence indicates that women whose third stage is actively managed experience a shortened third stage and reduced rates of PPH and anaemia, but experience an increase in nausea and vomiting, after pains and the need for pharmacological analgesia. The readmission rate due to excessive vaginal bleeding is also increased. The management of physiological third stage of labour should be approached holistically; promoting upright positions to aid delivery of the placenta, skin-to-skin contact and breastfeeding, if this is the woman's chosen method of feeding. If the woman has a postpartum haemorrhage refer to CG209 Postpartum Haemorrhage guideline.

The third stage of labour is diagnosed as prolonged if not completed within 30 minutes of the birth of the baby with active management and 60 minutes with physiological management. Once a diagnosis of prolonged third stage of labour has been made, request obstetric review and inform coordinating midwife.

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.

All observations undertaken during the third stage of labour should be documented in the hospital maternity record.

Suturing

If suturing of the perineum is required, this should be commenced within an hour of delivery. If there is a delay in suturing being commenced, the reason should be documented in the hospital maternity care record.
Refer to the Guideline CG200 Guideline for Management of Perineal Tears including Third and Fourth Degree Tears and complete the OASI sticker (see Appendix

Immediate care after birth

Midwives rules and standards 2012 state that at point of qualification a midwife should be able to examine and care for the newborn infant; to take all initiative which are necessary in case of need and to carry out where necessary immediate resuscitation. When active resuscitation is required a neonatologist must be urgently summoned. (Refer to CG025 Resuscitation and immediate care of the Newborn Infant Guideline).

Care of the baby - Women should be encouraged to have skin-to-skin contact with their babies as soon as possible after the birth. To facilitate safe skin-to-skin contact, the midwife should also advise the women on the importance of being vigilant that the baby's airways does not become obstructed during this time.

- The Apgar score at 1 and 5 minutes should be recorded routinely for all births.
- Record the time from birth to the onset of regular respirations
- If the baby is born in poor condition (the Apgar score at 1 minute is 5 or less), then double-clamp the cord to allow paired cord blood gases to be taken.
- The Apgar score should continue to be recorded until the baby's condition is stable.
- Paired cord blood samples should not be taken routinely
- In order to keep the baby warm, he or she should be dried and covered with a 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. Cessation of skin to skin contact should be documented, including the reasons why.
- Initiation of breastfeeding should be encouraged as soon as possible after the birth, ideally within 1 hour. All women to be offered the opportunity to give a first breastfeed
- Head circumference 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; this should also include a neonatal temperature.
- 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.

- The baby needs to have identification bracelets applied (see CG193 Identification of Babies Guideline).

Care of the mother - Should include early assessment of maternal emotional / psychological condition in response to labour and birth.

All swabs and instruments must be checked as present and correct before and after delivery and documented in the maternity notes

Refer to Standard Operating Procedure "Management of swabs, swab counts and vaginal packs in maternity"

Observations taken following the birth of the baby should include:

- maternal observation – temperature, pulse, blood pressure, uterine contraction, lochia
- examination of placenta and membranes – assessment of their condition, structure, cord vessels and completeness
- Successful voiding of the woman's bladder. Women should pass a good volume of urine within 6 hours of delivery, this should be recorded in the notes and referral made to an obstetrician if the women is not passing urine satisfactorily. For further information, refer to CG309 Bladder Care in labour and following delivery.

All observations undertaken in the immediate post birth period should be documented in the hospital maternity record. The initial post birth observations should also be documented on the summary of labour page in the hospital maternity record.

Discharge Planning

A documented individualised postnatal care plan will be developed (ideally antenatally) with women or as soon as possible after birth. Postnatal care will be culturally appropriate and sensitive to women's beliefs and values.
The postnatal plan of care will be dependent upon the health and wellbeing of the women and her baby and the level of social support available following discharge. Early transfer home should be offered and facilitated to women who have had a normal labour and birth, providing there are no complicating factors to prevent early discharge home e.g. social problems.
For further information about postnatal care and discharge planning, refer to CG413 Postnatal Care guideline.

Audit

Standards to be Audited.	Lead for the audit.	Frequency, audit tool and methodology.	Reporting arrangements.	Acting on recommendations and lead(s).	Change in practice and lessons to be shared.
1. Appropriate method of fetal heart monitoring is used. 2. There are documented discussions and reviews of women's birth plans and choices. 3. Maternal and fetal observations in labour are being documented on the partogram and other maternal records. 4. Midwifery led referral tool is being completed for all low risk transfers to delivery suite. 5. Documentation in the maternity notes to evidence that women are being encouraged to mobilise and adopt various positions in labour. 6. Standards outlined in other guidelines that relate to the care of women in labour will be audited within their own remit.	Will be nominated by the maternity audit leads (Consultant Obstetrician Midwife or Midwife) according to the maternity governance audit plan.	This will be performed according to audit plan. Data will be collected using an audit proforma (designed by the auditors and approved by the maternity audit leads. The auditors will analyse the data and develop recommendations and action plans from the audit results.	The audit results, recommendations and action plans will be presented either at an audit meeting, a clinical governance day or at a risk and audit meeting.	The O & G risk and governance committee will approve recommendations and action plans to be implemented within a specific time frame. The auditors will implement and monitor action plans with support from the clinical leads, senior midwives and pertinent groups.	The audit results and approved action plans will be disseminated by the maternity audit team to all relevant staff groups, pertinent meetings and through the delivery suite newsletter, risk and governance newsletter, the senior staff meetings, the delivery suite forum and by email. The Trust Audit and Clinical Effectiveness Group will be updated regularly by the maternity audit team.

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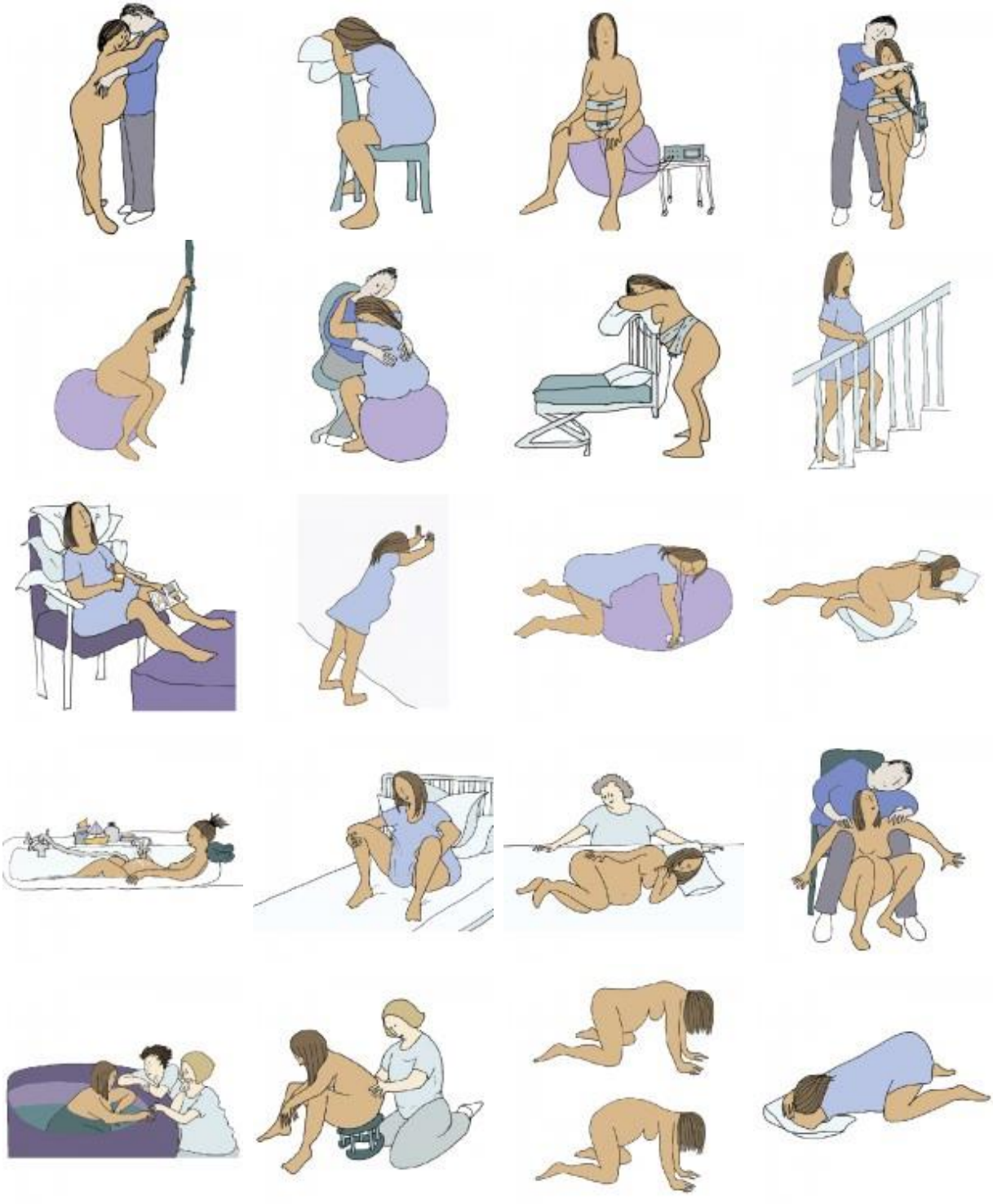
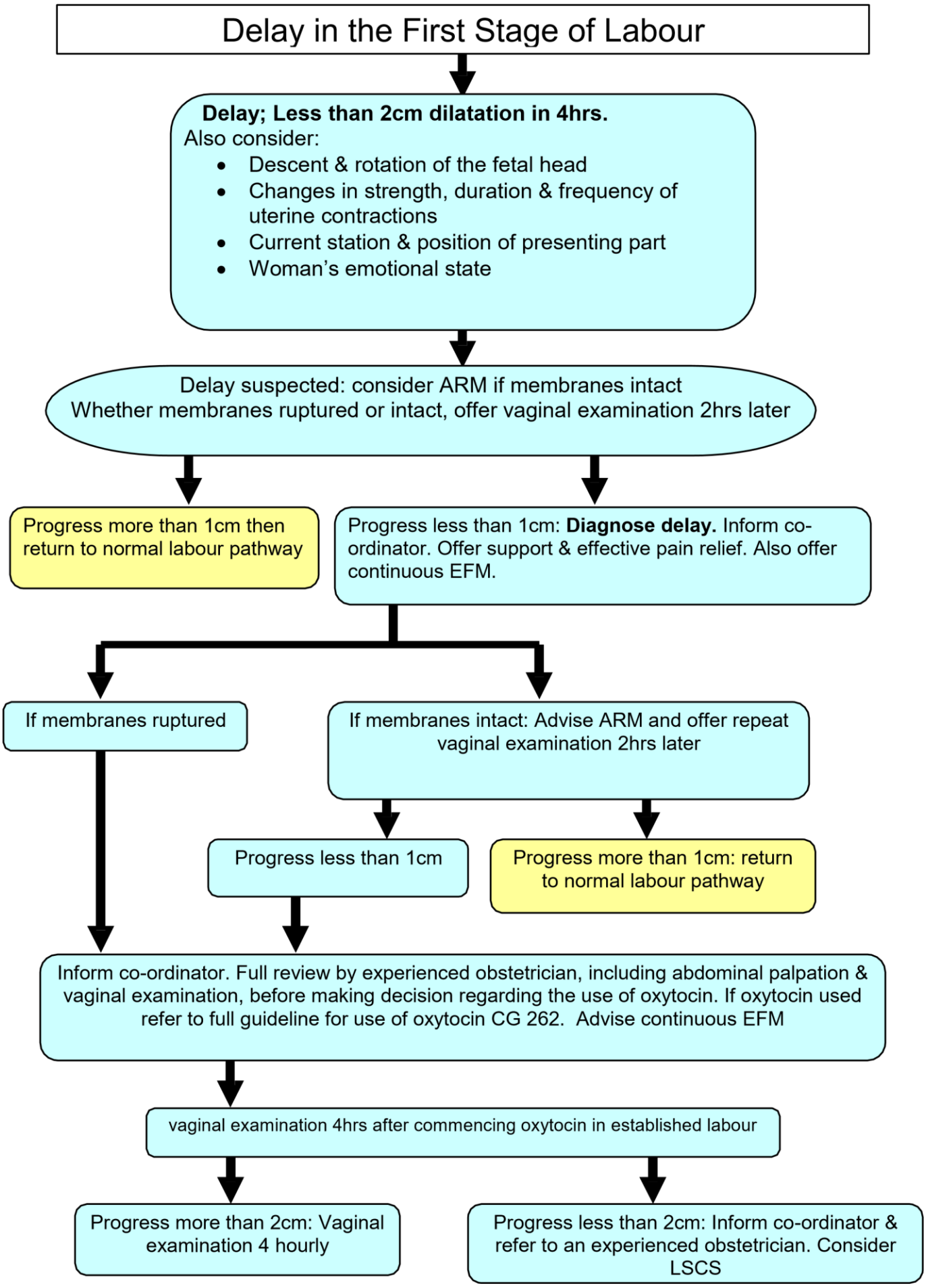
Appendix 1

Visual aids for labour and birthing positions

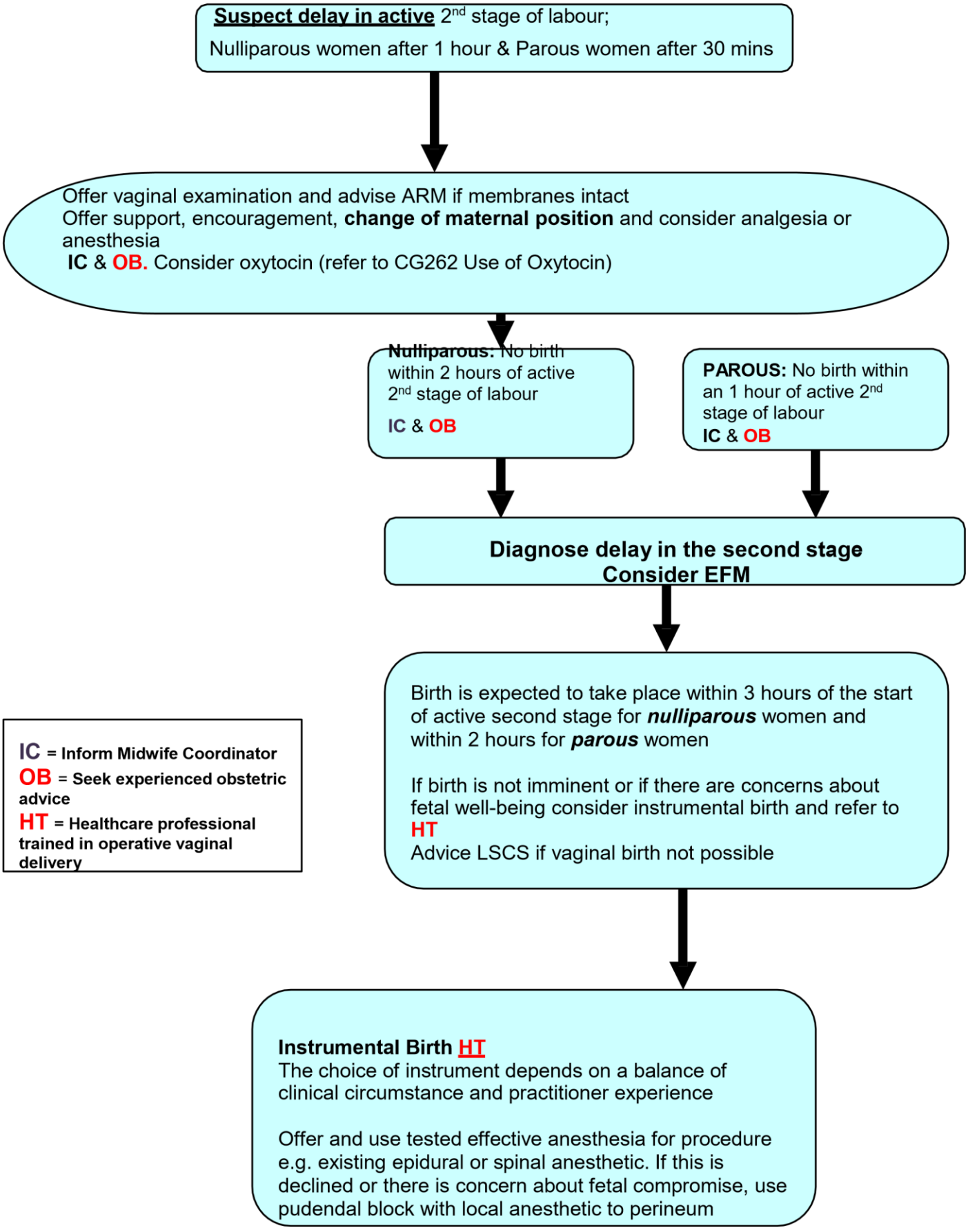


(Reference: http://www.rcmnormalbirth.org.uk/birthing-positions-in-practice/visual-aids-forbirthing-positions/)

Appendix 2Appendix 2

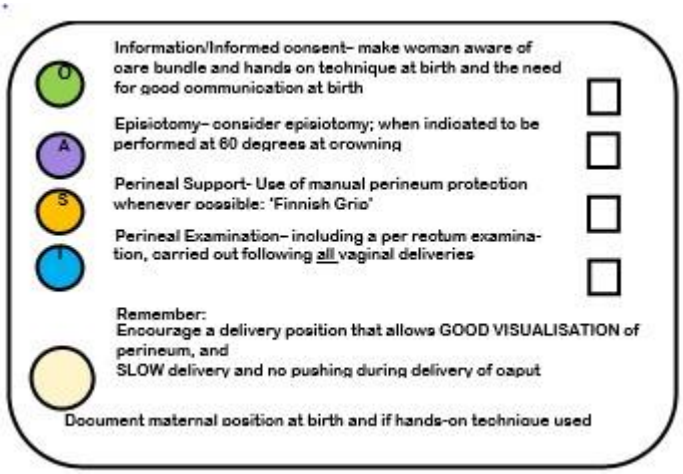

Delay in the First Stage of Labour
Delay; Less than 2cm dilatation in 4hrs.
Also consider:
Descent & rotation of the fetal head
Changes in strength, duration & frequency of uterine contractions
Current station & position of presenting part
Woman's emotional state
Delay suspected: consider ARM if membranes intact
Whether membranes ruptured or intact, offer vaginal examination 2hrs later
Progress more than 1cm then return to normal labour pathway
Progress less than 1cm: Diagnose delay. Inform co-ordinator. Offer support & effective pain relief. Also offer continuous EFM.
If membranes ruptured
If membranes intact: Advise ARM and offer repeat vaginal examination 2hrs later
Progress less than 1cm
Progress more than 1cm: return to normal labour pathway
Inform co-ordinator. Full review by experienced obstetrician, including abdominal palpation & vaginal examination, before making decision regarding the use of oxytocin. If oxytocin used refer to full guideline for use of oxytocin CG 262. Advise continuous EFM
vaginal examination 4hrs after commencing oxytocin in established labour
Progress more than 2cm: Vaginal examination 4 hourly
Progress less than 2cm: Inform co-ordinator & refer to an experienced obstetrician. Consider LSCS

Delay in the Second Stage of Labour



APPENDIX 4

OASI STICKER TOOL



APPENDIX 5

SOP Management of Retained Placenta

The 3rd stage of labour is defined as period of time from the delivery of the baby until the delivery of the placenta. (Flow Chart 1)

The placenta is defined as “retained” when it has not been delivered within 30 minutes of active management, or within one hour if physiologically managed. It requires early recognition and appropriate management to minimise blood loss and reduce patient morbidity/mortality. Appendix 5.

Causes of a Retained Placenta

1. Placenta has separated but not expelled from the vagina e.g. maternal exhaustion and failure to push, constriction cervical ring, full bladder.
2. The placenta fails to separate e.g. uterine atony (most common) or morbidly adherent.

Complications of a Retained Placenta

There is an increased risk of postpartum haemorrhage if treatment is delayed. If the patient is actively bleeding or becomes haemodynamically compromised then urgent action needs to be taken. The Massive Obstetric Haemorrhage (MOH) protocol may need to be initiated in certain situations. Other complications include sepsis, subinvolution, life threatening haemorrhage requiring hysterectomy, and death.

Management of a Retained Placenta in the Unit. (Flow Chart 2)

If there is active bleeding or suspicion of concealed bleeding (rising fundus on abdominal palpation) at any point then urgent obstetric review is required. If the patient is haemodynamically stable it is reasonable to continue conservative management if patient wishes however there is a higher risk of significant blood loss.

- Prompt recognition and timely management of post-partum haemorrhage as these patients are high risk of increased blood loss.
  Once a retained placenta has been identified there should be active management, if not already performed.
- Empty the bladder. Consider inserting Foleys catheter.
- Perform a vaginal examination to ensure the placenta is not sitting within the vagina.
- Consider breastfeeding or nipple stimulation.
- Change position (upright if possible).
- Further attempts to deliver by the placenta by controlled cord traction (CCT). If the patient complains of pain/discomfort then this may need to be abandoned early and would be taken to theatre for manual removal under regional anaesthesia.
- Maternal observations (BP, pulse and respiration rate) must be taken regularly and documented. If any of the observations trigger on the MEOWS chart then refer for urgent obstetric review.

 Avoid significant delays once a decision has been made for the patient to go to theatre.

Blood loss needs to be measured accurately and documented whilst awaiting delivery of the placenta.

Initiate MOH call if appropriate (Blood Loss > 1000ml) – See CG209 Guidelines for the Management of Postpartum Haemorrhage including the Management of Retained Placenta.

If the placenta is still not delivered after 30 minutes then an obstetric review is required.

Manual removal of retained placenta.

Once a retained placenta is confirmed by an obstetrician, the patient will require manual removal in theatre. Written consent is required and patient needs to be counselled about the risk of infection, haemorrhage, retained products and trauma.

The decision for theatre needs to be communicated to the on-call consultant obstetrician, midwife in charge, obstetric anaesthetist and maternity theatre team.

All patients should be transferred to theatre within 30 minutes of decision. Any delays should be documented.

Whilst awaiting theatre, if there are any clinical changes then these must be escalated urgently to the obstetric team and midwife in charge e.g. significant delays or patient becomes haemodynamically unstable.

In theatre management of retained placenta.

- WHO check list should be done.

- Manual removal is usually performed under regional anaesthesia; either via epidural top-up or spinal anaesthetic. General anaesthesia can be required at the discretion of the anaesthetist, or patient choice. If a patient reports pain during the procedure then she needs to be made comfortable before proceeding.

- Prophylactic antibiotics need to be given prior to starting the procedure with a single dose 1.2g Co-amoxiclav IV or 900mg Clindamycin IV (if allergic to penicillin).

- The placenta should be retrieved in one piece to minimise the risk of retained products. Once delivered the placenta is carefully examined to ensure that it is complete.

- The perineum, vaginal wall and cervix need to be examined systematically to identify and repair any tears/lacerations that were sustained during either delivery or from the manual removal.

- If there is suspicion of a morbidly adherent placenta then the procedure should be interrupted as inappropriate trauma can aggravate bleeding. The consultant obstetrician should be informed and also the consultant anaesthetist.

- The time of delivery is documented to signify the completion of the 3rd stage.

- All retained placentas require DATIX incident reporting.

Retained placenta during Home delivery.

Once a retained placenta has been identified there should be active management, if not already performed.

- Empty the bladder. Consider inserting Foleys catheter.
- Perform a vaginal examination to ensure the placenta is not sitting within the vagina.
- Consider breastfeeding or nipple stimulation.
- Change position (upright if possible).

  - If placenta has not delivered within 30 minutes of an actively managed third stage, the Delivery Suite coordinator should be contacted, and transfer to hospital by blue light ambulance considered.

Communication and documentation.

- A team member should be allocated to ensure clear line of communication is upheld between the women and her partner and the team providing care throughout the process of management of retained placenta.

Major Obstetric Haemorrhage Call

In the event of major Obstetric PPH for any estimated blood loss of 1500mls or 1000mls and continuing to bleed or is clinically compromised

The following must be activated.

♦ Dial 2222 and state 'Major Obstetric Haemorrhage and location'
Switchboard will put out a group bleep with voice over stating 'Major Obstetric Haemorrhage and location' as follows: ♦ At Bedford state "Code Read and location"

At Luton site:	At Bedford site:
140 Obstetric Junior Doctor 726 Obs & Gynae Registrar 600 Anaesthetic Registrar 550 Senior Midwife 552 Maternity Porter 553 MLSO for Haematology 555 Senior Nurse and ODP 515 Consultant Obstetrician (09:00-17:00 M-F)	430 Obstetric Junior Doctor 435 Obs & Gynae Registrar 002 Anaesthetic Registrar 142 Senior Midwife 356 Maternity Porter 474 MLSO for Haematology 372 Senior Nurse and ODP 190 Consultant Obstetrician (09:00-20:00 M-F)

Then switchboard will contact Consultant Obstetrician, Anaesthetist and Haematologist on call. The Consultant will then contact and liaise with the coordinating midwife at Luton bleep 550; at Bedford Bleep 142.

The consultant obstetrician should attend in person where the haemorrhage is more than 1.5 litres and is continuing and a Major Obstetric Haemorrhage protocol has already been instigated.

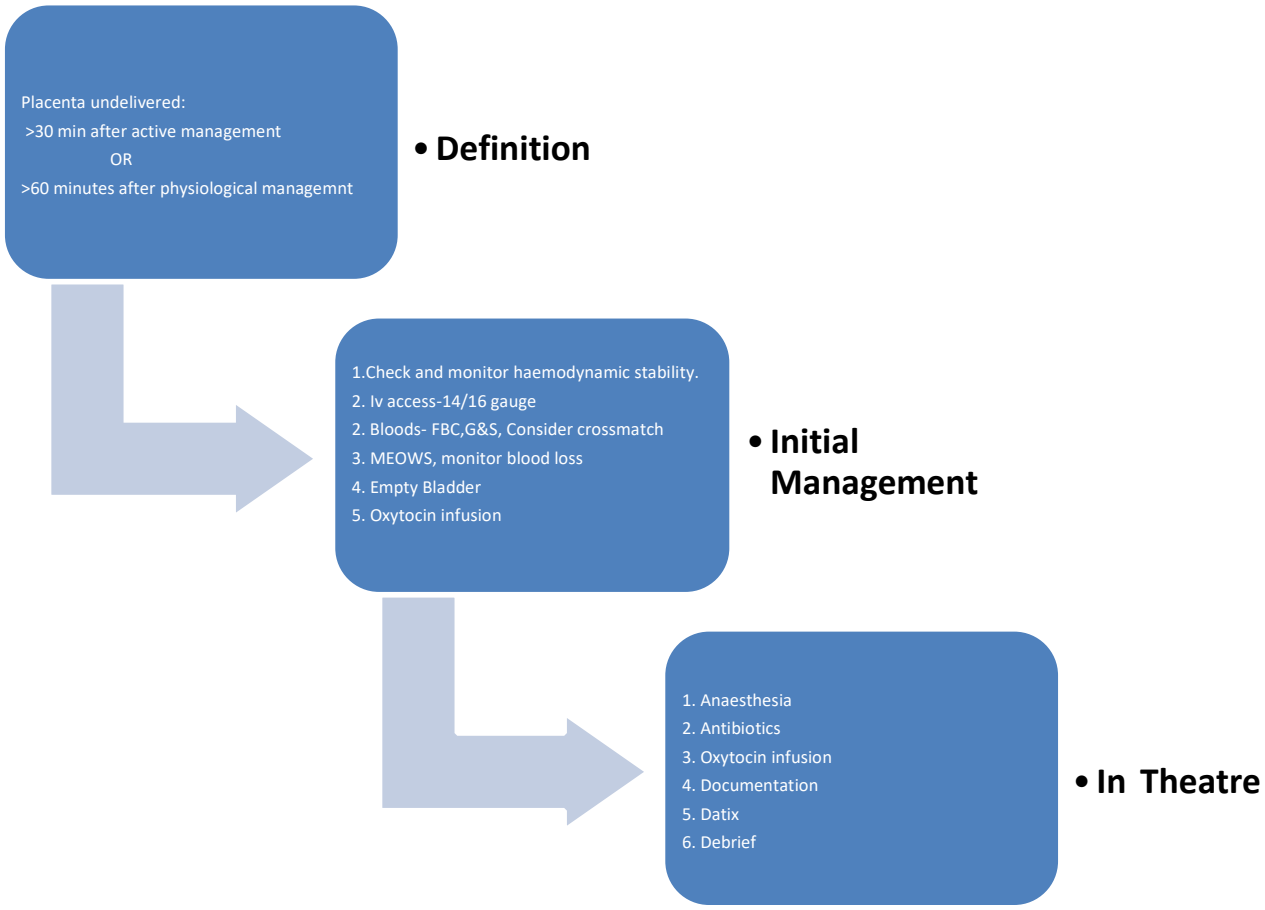
The Senior Midwife co-ordinating will:
- advise switchboard if there is no response from any consultant within 15 minutes.
- be contacted by the Transfusion Laboratory (at Luton site x7217 (or 7388)) and will request the following details of the woman (name, dob, hospital number, blood group, weight of women if available).

Switchboard will use all means available including home telephone numbers, mobile telephone numbers to alert the Consultant(s).

Portering Staff (552 at Luton) (356 at Bedford) must respond immediately and report to the senior midwife co-ordinator at the scene. The porter will collect blood samples

drawn from the patient and transport them directly to the Medical Laboratory Scientific Officer (MLSO) in the Pathology Laboratory and wait until the blood is issued (4 units). The blood must then be transported directly to the scene of the incident. Further units of blood may be required as the emergency evolves. The porter will not leave the scene until the senior midwife co-ordinator confirms there is no further action.

Management of Retained Placenta



Management of Delay in Third Stage of Labour