

# LABOUR CARE

<b>SETTING</b>	Maternity Services – hospital & community
<b>FOR STAFF</b>	Midwives, Obstetricians
<b>PATIENTS</b>	Women in labour

## GUIDANCE

### Communication

All women in labour should be treated with respect and should be in control of and involved in what is happening to them; 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 communication with the woman:

- Introduce yourself and establish her language needs. Explain your role.
- Maintain a calm and confident approach; this demeanour will reassure the woman.
- Knock and wait before entering the woman's room
- Ask permission before all procedures and observations.
- Show the woman and her birthing partner how to summon help. When leaving the room, let her know that you will return.
- Involve the woman in any handover of care to another health professional.

### Support in labour

- A woman in established labour should receive supportive one-to-one care
- A woman in established labour should not be left on her own except for short periods or at the woman's request

### Documentation of observations

- Observations should be carried out on admission, in established first stage of labour, and second stage of labour as per NICE Intrapartum Guideline (listed below)
- When not in established labour observations are recorded on the blue antenatal pages in the hand held records or the MOEWS chart.
- In established labour observations are recorded on the pink partogram and labour record

For guidance on referral to obstetric care in labour see appendix 1

### **On admission / first labour contact**

- 1 Listen to the woman's story. Consider her emotional and psychological needs.
- 2 Review her clinical records – risk assessment (see Appendix 2 and Clinical risk Assessment and Selection of Lead Professional guideline)
- 3 Assess maternal wellbeing:
  - a) Pulse
  - b) Blood pressure
  - c) Temperature
  - d) Urinalysis
  - e) Vaginal loss – show, liquor, blood
  - f) Contractions – length, strength, frequency
  - g) Behaviour
- 4 Assess fetal wellbeing:
  - a) abdominal palpation including symphysis fundal height measurement
  - b) fetal movements in the last 24hrs
  - c) auscultation of the fetal heart with Pinnard or Doppler for at least one minute after a contraction as per Monitoring the Fetus in Labour guideline. Differentiate between maternal and fetal heart rate at this point.
- 5 Discuss birth plan including coping strategies for labour and options for pain relief
- 6 Consider a vaginal examination (VE):
  - a) If the woman does not appear to be in established labour, after a period of assessment it may be helpful to offer a VE
  - b) If the woman appears to be in established labour, a VE should be offered

Note: Healthcare professionals who conduct VEs should:

- be sure that the VE is really necessary and will add important information to the decision-making process
- be sensitive to the fact that VEs are an invasive procedure and that for many women they can be very distressing
- explain the reason for the examination and what will be involved
- be aware that women may decline a VE – if a woman declines a VE document that a VE has been offered and declined
- ensure informed consent is obtained

- ensure the woman's privacy, dignity and comfort
  - explain the findings and their impact sensitively to the woman and her birth companion
  - document the findings, discussion and plan
- 7 Based on the initial assessment the decision should be made as to the appropriate place of birth. If the birth is imminent and the current location is deemed unsuitable, the decision to transfer should be based on whether the current location is preferable to the birth occurring before the transfer is complete.

### **Latent phase of labour**

Definition: A period of time, not necessarily continuous when

- There are painful contractions
  - There is some cervical change including cervical effacement and dilatation up to 4cm
1. Women without complications are encouraged to be at home unless doing so leads to a significant risk that she could give birth without a midwife present or become distressed. She should be given clear written and verbal information about when to seek further midwifery input e.g. SRM, bleeding, contractions increasing, reduced fetal movements
  2. Discuss strategies for coping with contractions e.g. warm bath, mobilisation, simple analgesia, relaxation and breathing techniques, massage, reassurance, fluid and light diet (provide '**Latent Phase of Labour - Ideas to help you**' patient information leaflet)
  3. Do not advise aromatherapy, yoga or acupuncture for pain relief. However, if a woman wants to use these techniques, respect her wishes.
  4. Provide guidance and support to the woman's birth companion.
  5. Should the woman telephone with concerns or for advice, she should be triaged appropriately using the telephone triage documentation. If she would like to be seen she should be invited in to the unit of her planned place of birth.
  6. Women who are admitted for the 3<sup>rd</sup> time in the latent phase of labour should be reviewed by the obstetric team (ST3 or above)

### **Established first stage of labour**

Definition:

- Regular painful contractions
- Progressive cervical dilatation from 4cm

## Duration of first stage of labour

Women should be informed that, while the length of established first stage of labour varies between women, 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.

- 1 Assume normality unless proven otherwise
- 2 Ensure privacy and confidentiality
- 3 Use positive, empowering language
- 4 Encourage mobilisation and the use of birthing aids such as balls, immersion in water and mats
- 5 Ensure hydration and encourage nutrition in early labour - Isotonic drinks reduce maternal ketosis without increasing gastric volume
- 6 Encourage the woman to empty her bladder 2-4 hourly
- 7 Explain how to summon help, and if leaving her alone inform her when you will return
- 8 Consider ongoing emotional and psychological wellbeing and changes in behaviour and requirements for pain relief.
- 9 Assess & document maternal wellbeing (Observations as per NICE intrapartum guideline):
  - a) Frequency and strength of contractions half-hourly
  - b) Pulse hourly
  - c) Blood pressure and temperature\* 4-hourly
 

\*If maternal temperature  $\geq 37.5^{\circ}\text{C}$  at any stage in labour it should be rechecked after an hour
  - d) Frequency and volume of emptying the bladder – see bladder care guideline
  - e) Abdominal palpation prior to vaginal examination
  - f) Vaginal examination offered 4-hourly to assess descent of the presenting part, position of presenting part, and cervical dilatation, or where there is concern about progress or in response to the woman's wishes. A sticker should be used for all vaginal examinations and completed fully. If there are any concerns about the position such as cannot feel a suture line think is it an abnormal presentation, consider your earlier palpation and a second opinion should be sought if appropriate. Any mal-presentations **MUST** be escalated to a Consultant led care setting immediately for delivery.

Vaginal examinations are not recommended in the birthing pool to ensure you can undertake a complete assessment. NB see point e above this cannot be done in the pool.

  - g) Assessment of vaginal loss hourly and prior to vaginal examination
- 10 Assess & document fetal wellbeing
  - a) Monitoring of the fetal heart as per Monitoring the Fetus in Labour guideline
  - b) Vaginal loss – liquor, blood, meconium staining of the liquor.

- Significant meconium staining is defined as either dark green or black fluid that is thick or tenacious, or any meconium stained fluid containing lumps of meconium thick or fresh
- If significant meconium is present ensure that the woman is transferred to a consultant led obstetric unit

## 11 Progress of labour:

Assessment of progress needs to take into consideration all aspects of progress in labour and should include:

- a) Cervical dilatation of less than 2 cm in 4 hours for nulliparous women
- b) Cervical dilatation of less than 2cm in 4 hours or a slowing in the progress of labour for second or subsequent labours.
- c) Overall progress in labour – whether progress is maintained or slows
- d) Descent and rotation of the fetal head
- e) Changes in the strength, duration and frequency of uterine contractions. In case of uterine Hyperstimulation see [Oxytocin use in labour](#).

If concerns around sepsis, see Pyrexia in Labour on page 8.

Where a diagnosis of delay is made see section below: Management of Delay in Labour

### Second stage of labour

1. Assess maternal wellbeing as in first stage of labour (Observations as per NICE intrapartum guideline)
2. Assess fetal wellbeing as in Monitoring the Fetus in Labour guideline
3. Encourage all fours, upright or left lateral positions
4. Ensure adequate hydration
5. Encourage frequent bladder emptying
6. Women should be reassured making noise is normal

### Passive second stage of labour

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

Leave one hour and then:

- 1 Abdominal palpation
- 2 Vaginal assessment
- 3 Assess fullness of the bladder, encourage bladder emptying
- 4 Assessment of frequency and strength of contractions
- 5 Consider change of position
- 6 Offer obstetric referral and transfer to consultant unit if still no urges to push

### **Active second stage of labour:**

- Expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix
  - Active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions.
- 1 Allow the woman to be guided by her own urge to push
  - 2 Encourage maternal effort as appropriate (including where epidural analgesia in use)
    - a) Use positive language
    - b) Avoid prolonged Valsalva (breath holding) pushes
  - 3 Encourage the mother to change position to maintain comfort and facilitate pushing. Avoid lithotomy and recumbent positions as this increases fetal distress and the risk of perineal trauma.

### **First labours:**

- A diagnosis of delay in the active second stage should be made when it has lasted 2 hours and women should be referred to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.
- Birth would be expected to take place within 3 hours of the start of the active second stage in most women.

### **Second and subsequent labours:**

- A diagnosis of delay in the active second stage should be made when it has lasted 1 hour and women should be referred to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.
- Birth would be expected to take place within 2 hours of the start of the active second stage in most women.

Where a diagnosis of delay is made see section below: Management of Delay in Labour

### **Management of Delay in Labour**

#### **First stage;**

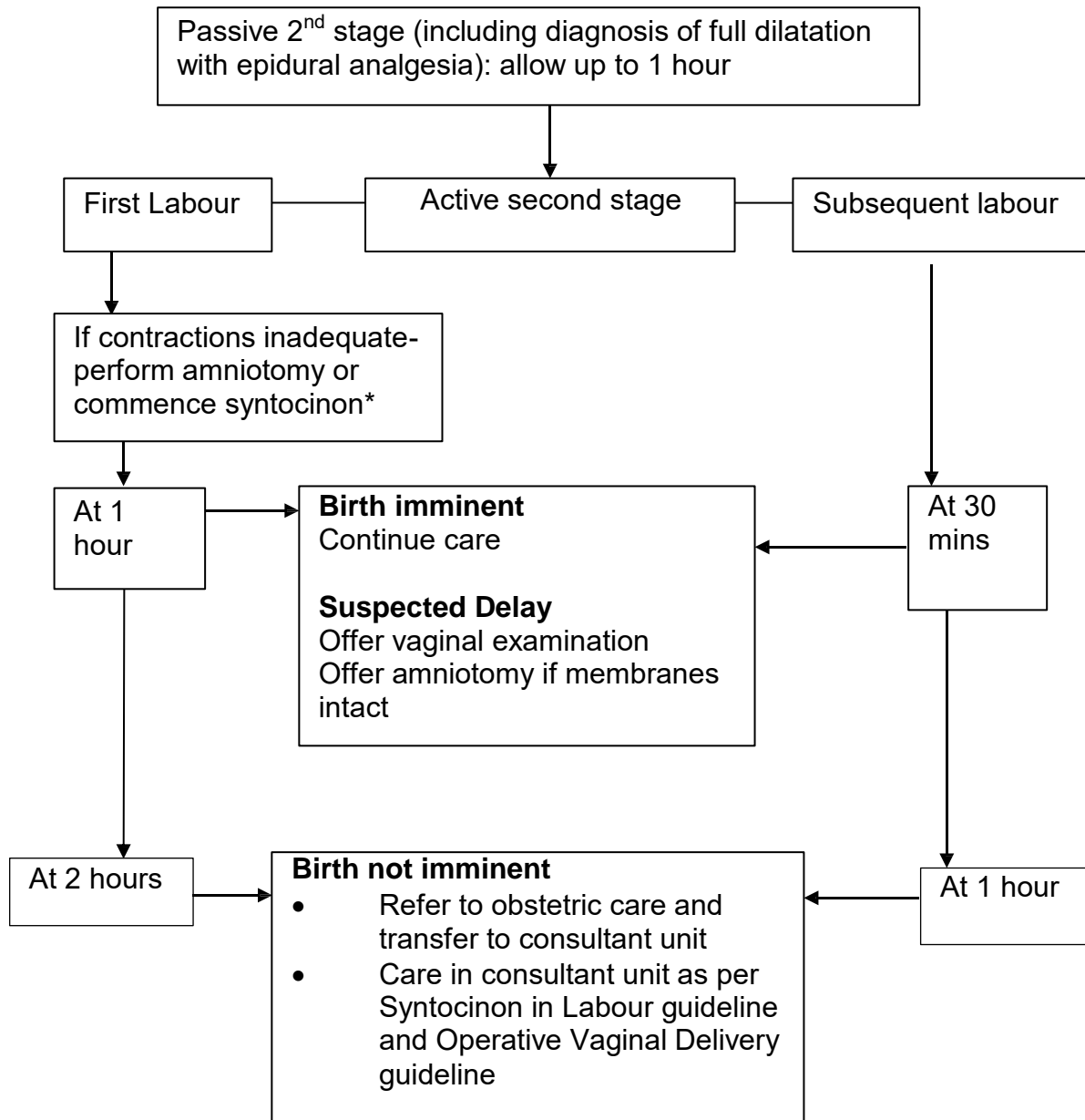
- 1 Change position – encourage upright position, avoid lithotomy and recumbent positions
- 2 Ensure good hydration
- 3 Ensure bladder empty
- 4 Consider Artificial Rupture of Membranes
- 5 Consider referral to obstetric care and transfer to consultant unit

## 6 Care in consultant unit as per Syntocinon in Labour guideline

### Second stage;

1. Change position – encourage upright position, avoid lithotomy and recumbent positions
2. Ensure good hydration
3. Ensure bladder empty
4. Support and encouragement

### Second stage of labour flowchart:



\* See [Oxytocin use in labour](#)

## Pyrexia in labour

Tympanic temperature of  $\geq 38^{\circ}\text{C}$  on one occasion or  $\geq 37.5^{\circ}\text{C}$  on two consecutive occasions at least an hour apart

- Inform obstetric team
- Commence continuous electronic fetal monitoring
- Administer Paracetamol 1gram orally or intravenously
- Recheck temperature in 1 hour

*(If at high risk of sepsis such as prolonged rupture of membranes, consider early recourse to antibiotic therapy.)*

On rechecking: if temperature still  $\geq 38^{\circ}\text{C}$  or  $37.5^{\circ}\text{C}$  with other signs of maternal infection (e.g. maternal tachycardia, tachypnoea or fetal tachycardia)

- Perform investigations:
  - Blood cultures
  - Full blood count, CRP
  - Throat swab
  - High vaginal swab
  - Midstream specimen of urine
  - Placental swabs – maternal and fetal surface
- Commence intravenous antibiotics as per antibiotic policy
- Inform Neonatologists of concerns re maternal sepsis at delivery
- See maternity sepsis guideline
- Commence Modified Obstetric Early Warning Score (MOEWS) chart postnatally

**Note:** Where there is any concern about changes in any maternal observations consider increasing the frequency of the observations and referring for obstetric opinion.

## Intrapartum interventions to reduce perineal trauma

- Good communication with the mother to control delivery of the head.
- Do not perform perineal massage or offer lidocaine spray in the second stage of labour
- Warm compress on the perineum during and between the contractions
- NICE intrapartum guideline suggests that there isn't a difference between Hands On or Hands poised approach; however RCOG provide evidence that a Hands on approach to support the perineum and slow delivery of the head may reduce trauma and protect the perineum.



## Third Stage of Labour

- Recognise that the time immediately after the birth is when the woman and her birth companion are meeting and getting to know the baby. Ensure that any care or interventions are sensitive to this and minimise separation.

To facilitate informed choice, all women will:

- Have management of the third stage of labour discussed with them in the antenatal period including the risks and benefits of both the active and physiological methods (see appendix 1)
- Receive the UHBristol Patient Information leaflet called 'Third Stage of Labour' in the antenatal period.
- Have their choice for management of the third stage confirmed by the midwife caring for them in labour
- Advise women to have active management because of the lower risk of haemorrhage but support them if they request a physiological management. Document clearly in the notes

### Physiological Third Stage

- No routine use of uterotonic
- Do not clamp or divide cord until the cord has stopped pulsating
- Avoid controlled cord traction (CCT)
- Deliver the placenta by maternal effort

60 mins

If:

- Baby requires resuscitation
- Excessive blood loss
- Woman desires to change

### Managed Third Stage (see note 1)

- Recommended if
  - woman is at increased risk of haemorrhage e.g. previous haemorrhage
  - has intervention in labour e.g. Induction of labour, augmentation, epidural anaesthesia
- Administer uterotonic (Syntocinon 10units IM or Syntometrine 1ml IM) with delivery of anterior shoulder or as soon as possible after the birth
- Delay clamping of the cord for approximately 2 minutes unless baby requires resuscitation
- If the woman requests the cord be clamped after 5 mins, support her in her choice if appropriate
- Wait for the next uterine contraction and signs of placental separation
- Deliver the placenta by controlled cord traction

30 mins

### Delay in third stage

If blood loss not excessive:

- Administer a uterotonic if not already administered and consent given
- Empty urinary bladder
- Consider change of maternal position
- Encourage breastfeeding to promote oxytocin production
- Keep woman informed at all times**
- Ensure consent & adequate analgesia for any VE**
- Perform CCT with analgesia

### Document maternal observations in pink labour notes

- general physical condition, as shown by her colour, respiration and her own report of how she feels
  - vaginal blood loss
- Frequent Pulse, BP, Resps may also be required if significant bleeding, or resuscitation required
- Also document the timing of cord clamping in both methods**

**Placenta fails to deliver, excessive blood loss or maternal collapse**

**Transfer to Obstetric-led care for Manual Removal of Placenta (see Guideline)**

## Active Management of the Third Stage in Women at risk of Hypertension or with Maternal Cardiac Disease

- If a blood pressure assessment has not been undertaken during labour avoid Syntometrine for a managed third stage of labour.
- Any woman with antenatal evidence of proteinuric hypertension, pregnancy induced hypertension requiring medication, or who has had a blood pressure  $\geq 140/90$  mmHg during labour will not receive Syntometrine.
- Syntocinon is used to avoid the transient blood pressure rise associated with use of Syntometrine.
- A plan for the management of women with cardiac disease should have been made in the antenatal period. This should be in the handheld notes and make clear whether an alternative regime of 5 units of Syntocinon in 10ml normal saline over 10 minutes, followed by a Syntocinon infusion of 30 IU in 500ml normal saline over 4 hours, is required.

## The Placenta

All placentae that are not required for investigations are placed in a small yellow bag provided in each room and taken to sluice in Central Delivery Suite and placed in the yellow clinical waste bin. The bag must be labelled with the woman's name, date and time (use of a sticker with details on is recommended)

### 1. Taking a placenta home

Any woman wishing to take a placenta home must be told that it is human tissue and therefore an infection risk if not disposed of in a suitable way. It must be disposed of in a safe manner and she must sign in her buff notes that she understands that she is taking responsibility for its disposal.

**Lotus birth, or umbilical nonseverance**, is the practice of leaving the umbilical cord attached to both the baby and the placenta following birth, without clamping or severing, and allowing the cord the time to detach from the baby naturally. In this way the baby, cord and placenta are treated as a single unit until detachment occurs, generally two to three days after birth. If a mother chooses lotus birth discuss with a Supervisor of Midwives.

### 2. Cytogenetics.

In the case of a stillbirth or abortion a small portion of the placenta may be sent for cytogenetics if requested by the obstetrician. The transport medium is found in the freezer on CDS in the treatment room. Consent is required by the mother.

### **3.Placentae requiring histological examination:**

All Placentae should be placed in a bucket of formalin and sent to:

The mortuary if a stillbirth or neonatal death has occurred

The BRI Histopathology department with a placental histopathology request if:

- Suspected chorioamnionitis
- Fetal abnormality
- Intra-uterine growth retardation (<2.5kg)
- Preterm <34 weeks
- Birth asphyxia (Apgar <7/10 at 5 mins or arterial cord pH equal to or less than 7.05)
- Unplanned admission to NICU
- Placentae that look abnormal
- Placental abruption
- Vasa praevia
- All multiple pregnancies. The cords must be clearly marked.

It is essential that they are transported in the transport box to comply with health and safety regulations

This is not an exhaustive list and a clinician (midwife, neonatologist or obstetrician may request placental histology on a case by case basis)

A placental swab from the fetal surface is sent to Microbiology when there is:

- maternal pyrexia
- offensive liquor

Please ensure the name of the consultant is written on the request form it to ensure the report is processed accurately

## Appendix 1

When discussing the risks and benefits of the two methods of managing the third stage, the midwife should explain the following:

### Active Management;

- Shortens the third stage compared to the physiological method
- Is associated with nausea and vomiting in about 100:1000 women
- Is associated with an approx. risk of 13:1000 of haemorrhage of more than 1 litre.
- Is associated with an approx. risk of 14:1000 of a blood transfusion

### Physiological Management;

- Is associated with nausea in about 50:1000 women
- Is associated with an approx. risk of 29:1000 of a haemorrhage of more than 1 litre
- Is associated with an approx. risk of 40:1000 of a blood transfusion

## Appendix 2

The following risks and benefits should be assessed when considering transfer from midwife led care to obstetric care. If transferring from a setting outside the consultant unit the likelihood of birth taking place during the transfer should be taken into account.

- Indications for electronic fetal monitoring (EFM) including abnormalities of the fetal heart rate (FHR) on intermittent auscultation
- Delay in the first or second stages of labour
- Significant meconium-stained liquor
- Maternal request for epidural pain relief
- Obstetric emergency – antepartum haemorrhage, cord presentation/prolapse, postpartum haemorrhage, maternal collapse or a need for advanced neonatal resuscitation
- Retained placenta
- Maternal pyrexia in labour - see page 7 of this guideline
- Malpresentation or breech presentation diagnosed for the first time at the onset of labour, taking into account imminence of birth
- Either raised diastolic blood pressure (over 90 mmHg) or raised systolic blood pressure (over 140 mmHg) on two consecutive readings taken 30 minutes apart
- Uncertainty about the presence of a fetal heartbeat
- Third- or fourth-degree tear or other complicated perineal trauma requiring suturing.

## Appendix 3

### High risk labour:

Risk factors (not exhaustive)

Antenatal:

- Previous caesarean section or other uterine scar, previous retained placenta, breech presentation, multiple pregnancy, pre-eclampsia, diabetes mellitus, morbid obesity - B.M.I. > 35 (primigravida), B.M.I. > 39.9 (multigravida if no co-morbidities) IUGR / poor fetal biophysical profile, APH

Intrapartum:

- APH / abruption, Fetal distress / fetal scalp blood sampling, slow labour progress (use discretion), pre-eclampsia identified during labour

Actions

- Take FBC, Group & Save
- Nil by mouth / isotonic sports drinks
- Ranitidine 6 hourly - oral or intravenous

### Monitoring

Process	Tool	Responsibility of:	Frequency of review	Responsibility for: (plus timescales)			
				Review of audit results & recommendations	Development of action plan	Monitoring of action plan and implementation	Making improvement lessons to be shared
Documentation of the maternal observations carried out during established first stage of labour as described in the guideline	Clinical Audit	CDS working party	Ongoing audit	Six monthly at Women's Clinical Audit Meeting	CDS Working Party within 3 months of the Clinical Audit Meeting	CDS Working Party as a minimum 6 monthly	Refer to CDS Working Party Monitoring Form

## Version 4.3

### Authors

Belinda Cox, Practice Development Midwife & Supervisor of Midwives  
Janet Pollard, Patient Safety Midwife & Supervisor of Midwives

### Consultation:

Emma Treloar, Consultant Obstetrician  
CDS working party  
Normal Birth Working Group

**Ratified by:** CDS Working Party

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**Review date:** March 2019

### References

National Institute of Health & Clinical Excellence (December 2014) Intrapartum Care: care of healthy women and their babies during childbirth. RCOG (2015) The Management of Third and Fourth Tears. [www.rcog.org.uk](http://www.rcog.org.uk)

### RELATED DOCUMENTS

Syntocinon in labour guideline <http://nwww.avon.nhs.uk/dms/download.aspx?did=10474>  
Operative Vaginal Delivery guideline <http://nwww.avon.nhs.uk/dms/download.aspx?did=1766>  
Sepsis in pregnancy and the puerperium guideline  
<http://nwww.avon.nhs.uk/dms/download.aspx?did=13812>  
Third stage of labour (pt info) [nwww.avon.nhs.uk/dms/download.aspx?did=9644](http://nwww.avon.nhs.uk/dms/download.aspx?did=9644)  
Manual Removal of Placenta <http://nwww.avon.nhs.uk/dms/download.aspx?did=15184>  
Fetal Monitoring in Labour <http://nwww.avon.nhs.uk/dms/download.aspx?did=1783>  
Clinical Risk Assessment and Selection of Lead Professional  
<http://nwww.avon.nhs.uk/dms/download.aspx?did=11238>

### SAFETY

NA

### QUERIES

Practice Development Midwife, ext 25164, Lisa Damsell, ext 25577 or the coordinating midwife on CDS ext 25213. A supervisor of midwives can be contacted 24/7 via the hospital switchboard.