NHS
Mid and South Essex
University Hospitals Group

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Related Trust Policies (to be read in conjunction with)	09046 Completion of the Partogram in Pregnancy 04216 Attachment and detachment of identification labels for the newborn 04288 Administration of Oxytocin (Syntocinon) for Induction and Augmentation of Labour 04253 Nutrition in labour and antacid prophylaxis for the pregnant patient at term. 04245 Management of retained placenta 04265 Fetal heart rate monitoring in pregnancy and labour 04237 Waterbirth, labour, delivery in water and third stage management 08095 Administration vitamin K for Neonates 07043 Abdominal palpation and Examination in Pregnancy 09095 The severely ill patient in Maternity Services 12030 Aromatherapy massage in pregnancy and labour 12029 Management of the latent phase of labour 06029 Transfer of Mothers and Babies to Different Care Settings 12029 Management of the latent phase of labour 04259 Management of Meconium Stained Liquor

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1.0 Purpose

1.1 To provide health care professionals with guidance regarding the management of healthy patients and their babies who wish to undergo a normal vaginal delivery.

2.0 Equality Impact Assessment

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix D)

3.0 Scope

3.1 This guideline covers the care of healthy patients and babies at term (37-42 completed weeks of gestation) in the following care settings:

- Home births;
- In a stand-alone Midwife-Led Unit (MLU);
- In a Consultant-Led Unit (CLU); to include the Co-located Birthing Unit

3.2 This guideline includes patients without co-existing morbidities (including previous uterine surgery or complications of previous deliveries which may impact upon this delivery).

3.3 Patients need to have commenced labour spontaneously and have a single healthy, term fetus. The fetus needs to be presenting head first without any clinical confirmation of intrauterine growth restriction or macrosomia.

4.0 Definition

4.1 Labour is a normal physiological process characterised by a spontaneous onset between 37 and 42 weeks gestation in a patient whose pregnancy has been uncomplicated.

5.0 Background

5.1 The government is committed to ensuring that all patients will have a choice in where and how they have their baby and whichever pain relief to use, depending on their individual circumstances.

5.2 Maternity Services throughout the UK are aiming to increase the normal birth rate towards a realistic objective of 60%. With appropriate care and support the majority of healthy patients can give birth with a minimum of medical procedures and most prefer to avoid interventions, providing that their baby is safe and they can feel that they can cope.

5.3 Throughout her pregnancy the patient should be fully involved in planning her birth so that care is flexible and tailored to meet her needs and those of her baby. Patients

should have the opportunity to make informed decisions regarding their care and any treatment needed.

5.4 Decisions should be supported by the provision of evidence-based written information tailored to the needs of the individual patient.

5.5 Maternity Services, senior staff and all health care 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.

5.6 Senior staff should demonstrate, through their own words and behaviour, appropriate ways of relating to and talking about women and their birth companions and of talking about birth and their choices to be made when giving birth.

6.0 The Key Professionals who Provide Antenatal Care

6.1 **The midwife** - the midwife specialises in normal birth. By working across a variety of health care settings, the midwife can provide optimal care for all patients regardless of the place of delivery.

6.2 Patients in established labour receive **one-to-one** care from a midwife.

6.3 **General practitioner** - the general practitioner works in collaboration with the midwife and the obstetric consultant providing overall care for the patient and her family.

6.4 **The obstetrician** - the obstetrician is the lead professional for all patients with confirmed or suspected complications of pregnancy.

6.5 **The Antenatal and Newborn Screening Coordinator** - the role of the Antenatal and Newborn Screening Coordinator is to coordinate antenatal screening services for patients and health care professionals providing advice, support and counselling. To contact the Antenatal and Newborn Screening Coordinator phone: 01245 513333 between the hours of 0900 -1700, Monday to Friday.

7.0 The Booking Procedure

7.1 Patients should be offered the choice of planning birth as follows:

- At home;
- Stand-alone Birthing Unit
- Co-located Midwife-led Unit (MLU);
- Consultant –led Unit (CLU).

7.2 Patients should be informed of the following:

- That giving birth is generally very safe for both the mother and her baby;
- Although the available information on planning the place of birth is not of good quality, it suggests that there is a higher likelihood of normal birth, with less intervention for those patients who plan to deliver at home or within a MLU;
- Consideration needs to be given with regards to the time delay in transfer;
- That the CLU provides direct access to obstetricians, anaesthetists and paediatricians;
- That if something goes unexpectedly, seriously wrong during labour at home or in a MLU, the outcomes for the mother and baby could be worse than if they were in the CLU with access to specialised care.

8.0 Criteria for Choosing the Place of Birth

8.1 The clinical reasons for choosing a delivery at home or in a MLU are as follows:

- Between 37 completed weeks and under 42 weeks of pregnancy;
- A low risk obstetric history;
  (Refer to appendix A)
- A singleton pregnancy;
- A cephalic presentation;
- A baby of normal growth;
- The absence of abnormal bleeding or meconium per vaginum.

9.0 Indications for a Consultant Led Unit Booking

9.1 Maternal indications
(Refer to appendix A)

10.0 Considerations for a Consultant/Specialist Referral Regarding Individual Assessment

(Refer to Appendix B)

10.1 Patients who are referred to a consultant obstetrician or anaesthetist, or whose condition has been referred to a paediatrician may resume the normal care pathway once their condition has been assessed as appropriate for low risk care.

10.2 It should be made clear on the patient's health care records whom the lead professional is at all times. When patients are identified as requiring consultant led care the reason for this must be stipulated on the antenatal notes at the end of the booking.

11.0 Indications for Intrapartum Transfer to a Consultant Led Unit

11.1 Refer to Transfer of Mothers and Babies to Different Care Settings. Register number 06029.

12.0 Self-diagnosis of Labour

12.1 Patients may either contact their community midwife when they believe that labour has commenced or directly contact the MLU's or Labour Ward.

12.2 The community midwives may visit these patients at home to determine if labour is established prior to either delivering at home or admission to the MLU's or CLU.

12.3 Clinical intervention should not be offered where labour is progressing normally.

12.4 Patients should be encouraged to remain at home for as long as possible with analgesia, light diet and relaxation techniques such as immersion in water.

13.0 The Latent Phase of Labour

13.1 For information on determining the latent and the prolonged latent phase of labour refer to the guideline entitled Management of the latent phase of labour, register number 12029.

14.0 Support in Established Labour

14.1 Support in labour - always maximise the communication between the patients and the healthcare professionals.

14.2 Ensure an approach of warmth and calm, demonstrating confidence in both the patient and her midwife.

14.3 Ensure that the patient and her partner have access to privacy, confidentiality and dignity throughout their time with the health care professionals. Permission should be sought before others enter the room.

14.4 Discuss the patient's birth plan, involve her in care decisions and staff handovers.

14.5 Encourage the patient to adapt the environment to her individual needs including her birth supporters.

14.6 Ensure consent is gained before all procedures are undertaken.

14.7 Ensure one-to-one midwifery is implemented throughout labour. If the health professional needs to leave the room for a short period she will need to stipulate why and demonstrate how assistance can be sought in her absence.

14.8 Do not leave a woman in established labour on her own except for short periods or at the woman's request.

14.9 Following assessment at the Midwife-led Unit where a woman booked for Consultant-led care is found to be in established labour, the woman can arrange her own transport to the CLU if none of the contraindications detailed in 'Transfer of mothers and babies to different care settings; register number 06029 are present and/or labour is found not to be advanced.

14.10 Utilize equipment provided (mats, bean bags, birthing balls, peanut balls) and techniques to encourage active birth.

15.0 Coping Strategies

15.1 Positions in labour – patients should be encouraged to adopt whichever position they find most comfortable. Use of aids and labour supports must be appropriate.

15.2 Eating and drinking in labour - encourage drinking during labour; isotonic drinks may be more beneficial than water. A light diet may be taken in established labour unless the patient has received intramuscular opioids or she develops risk factors making general anaesthesia more likely.
(Refer to 'Nutrition in labour and antacid prophylaxis for the pregnant patient at term; register number 04253).

16.0 Analgesia in Labour

16.1 Healthcare professionals should ensure that their care and attitudes with regards to pain in labour supports the patient's choices.

16.2 If a woman chooses to use breathing and relaxation techniques in labour, support her in this choice.

16.3 If a woman chooses to use massage techniques in labour that have been taught to birth companions, support her in this choice.

16.4 For the use of non-pharmacological analgesia i.e. homeopathic remedies or aromatherapy oils refer to the guideline entitled 'Aromatherapy in pregnancy and labour'; register number 12030.

16.5 Offer women the choice to labour in water (Refer to 'Guideline for waterbirth, labour and delivery in water and third stage management; register number 04237)

16.6 Transcutaneous electrical nerve stimulation (TENS) can be used throughout labour in all birth settings (excluding waterbirths). Its commencement is not recommended in established labour (i.e. if the cervix is dilated by 4cm or more).

16.7 Inhalational analgesia or entonox (50% nitrous oxide and 50% oxygen) can be used in all birth settings. Patients should be informed that it may make them feel nauseous and light-headed, but this is short lived
(Refer to 'Administration of Entonox in labour; register number 10108)

16.8 Intramuscular opioids such as morphine can be used in all birth settings. They will provide limited pain relief during labour and may have significant side effects for both the patient (drowsiness, nausea and vomiting, therefore administered with an anti-emetic)

and her baby (short-term respiratory depression and drowsiness which may last several days). Opioids may interfere with breastfeeding.

16.9 Do not use water papules.

16.10 Do not offer acupuncture, acupressure or hypnosis, but do not prevent women who wish to use these techniques from doing so.

16.11 Encourage the woman to communicate her need for analgesia at any point during labour.

16.12 Support the playing of music of the woman's choice in labour.

17.0 Regional Analgesia

17.1 If a woman is contemplating regional analgesia, talk with her about the risks and benefits, and the implications for her labour, including the arrangements and time involved for transfer of care to an obstetric unit if she is at home or in a midwifery unit, and comply with her request (refer to Epidural Analgesia in Maternity. Register number 09093).

18.0 Normal Labour

18.1 In all stages of labour, patients who have left the normal care pathway due to the development of complications can return to it if and when the complications resolve.

19.0 Initial Observations on Admission

19.1 When performing an initial assessment of a woman in labour, listen to her story and review the clinical records. Take into account her preferences and her emotional and psychological needs. Review her birth plan if she has written one.

19.2 Obtain and review all health care records including ultrasound scans, blood and screening results (MEHT Review) and any relevant referral reports filed in the patient's main notes.

19.3 Obtain history from the patient regarding the onset of labour and the description of any loss per vaginum, including the time and date of any reports of suspected or confirmed spontaneous rupture of the membranes.

19.4 Consideration should be given to the patient's emotional and psychological needs, including her desire for pain relief and this should be reviewed and available throughout her labour

19.5 The Midwife will make an assessment for the most appropriate birth setting based on previously documented plans and the current situation. The assessment should comprise the following:

Observations of the woman:

- Maternal and fetal assessment to be undertaken within 30 minutes of admission to unit; once the woman has been shown to her bed or assessment area;
- Review of the antenatal notes (including all antenatal screening results) and discuss these with the woman;
- Physical observation including temperature, blood pressure, pulse, respirations, and undertake urinalysis;
- Ask the woman about the length, strength and frequency of her contractions which should be documented in the health care records;
- Record any vaginal loss to include show, liquor and blood;
- Assess the patient's pain, including her wishes for coping with labour along with the range of options available for pain relief;
- Patients who are not in established labour but report painful contractions should be offered support and analgesia. They may remain or return home.

Observations of the unborn baby:

- Ask the woman about the baby's movements in the last 24 hours;
- Perform an abdominal palpation to include fundal height, lie, presentation, position and station/engagement of the presenting part; and duration of contractions; (Refer to 'Abdominal palpation and examination in pregnancy'. Register number 07043)
- The FHR (fetal heart rate) should be auscultated for at least 1 minute immediately after a contraction. The maternal pulse should be palpated at the same time to differentiate between the heart rates of the woman and the 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 (refer to Assessment and Procedure for performing VE. Register number 12022)

20.0 The First Stage of Labour

20.1 Labour is deemed established when there are:

- Regular painful contractions;
- There is progressive cervical dilatation from 4cm.

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

20.3 In all stages of labour, women who have left the normal care pathway because of the development of complications can return to it if and when the complication has resolved.

20.4 Risk assessment is an on-going process throughout labour. When labour is deemed established the midwife responsible for the patient should:

- Undertake a risk assessment, encompassing a full review of the antenatal health care records i.e. whether the patient is low or high risk, identifying the risk factors and documenting the findings in the healthcare records;
- If any risks are identified the midwife should refer the patient to the appropriate professional for advice/review, and update the individual's management plan.

20.5 Inform women that, while the length of established first stage of labour varies between women:

- **First labours last on average 8 hours** and are unlikely to exceed 18 hours;
- **Second and subsequent labours last on average 5 hours** and are unlikely to exceed 12 hours;
- The length of labour will vary between individuals.
- It is expected that the cervix will dilate:

  More than or equal to 2cm in 4 hours for first, second and subsequent labours.

- The head will rotate and descend;
- The contractions will remain frequent, strong and the duration of each contraction will lengthen.

20.6 Do not offer either H_2-receptor antagonists or antacids routinely to low-risk women.

21.0 Observations during the First Stage of Labour

21.1 Record the following observations in the Labour Care Record, using the MEOWS chart and partogram:

- Hourly pulse;
- 4-hourly temperature, respirations and blood pressure;
- Frequency of passing urine - the bladder should be emptied 4 hourly and a urinalysis performed;
- Offer a vaginal examination 4-hourly or more frequently if there is concern about progress or in response to the woman's wishes;
- Half –hourly documentation of the length, strength and frequency of contractions.

21.2 Undertake an abdominal palpation.
(Refer to Abdominal palpation and examination in pregnancy; register number 07043)

21.3 In normally progressing labour, do not perform amniotomy routinely.

21.4 The bladder should be emptied via intermittent catheterisation if women are unable to void.
(Refer to 'Bladder care in maternity services; register number 09007)

21.5 Best practice recommends that the midwife should assess the FHR every 15 minutes immediately following a contraction for at least 1 minute. If the circumstances prevent this assessment occurring, the midwife should document the reason in the patient's healthcare records:

- Vomiting;
- Out to the toilet;
- Patient declines assessment of FHR;
- Vaginal examination.

(Refer to Fetal heart rate monitoring in pregnancy and labour; register number 04265)

22.0 Delay in the First Stage of Labour

22.1 For permissible time frames in labour refer to Appendix C.

22.2 If a delay in the established first stage is suspected, assess all aspects of progress including:

- Cervical dilatation of **less than 2cm in 4 hours for first, second and subsequent labours.**
- Fetal position;
- Descent and rotation of the fetal head;
- Station of the fetal head;
- A decrease in the strength, duration and frequency of uterine contractions;
- Urinalysis.

22.3.1 If a delay is diagnosed, amniotomy should be considered for all women with intact membranes, to augment labour. Explain the procedure and advice that it will shorten her labour by about an hour and may increase the strength and length of her contractions (Refer to 'Management of artificial rupture of membranes; register number 07076)

22.3.2 Assess the woman's emotional state; offer support, hydration, nutrition and appropriate and effective pain relief. Consider additional measures to promote normality for example, encourage emptying of the bladder, getting out of the pool, mobilisation and aromatherapy

22.3.3 Perform a **vaginal examination 2 hours after the amniotomy. If cervical dilation is** less than 1cm then a delay is diagnosed and a review from the obstetric registrar or consultant should be sought (refer to ''Administration of Oxytocin (Syntocinon) for induction and augmentation of labour'. Register number 04288)

23.0 The Second Stage of Labour

23.1 Definition of the second stage of labour is when the cervix is fully dilated until complete expulsion of the baby. It is defined in two stages.

23.2 **Passive second stage of labour** is defined as full dilatation of the cervix prior to or in the absence of persistent (occurring with every contraction) involuntary expulsive contractions.

23.3 **Active second stage of labour**:

- The baby is visible;
- Persistent involuntary 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.

24.0 Observations during the second stage of labour

24.1 Observations during the second stage of labour should be recorded in the healthcare records by the midwife. (Refer to ‘‘Completion of the partogram in pregnancy’. Register number 09040)

- Hourly blood pressure and pulse (palpated simultaneously with the FHR);
- Hourly temperature;
- Vaginal examination should be offered **hourly** in the active second stage or as the patient wishes, acknowledging the fetal position and station at the onset of the second stage;
- Abdominal palpation (with reference to the presentation and position of the baby) prior to vaginal examination;
- Half-hourly documentation on the frequency, length and strength of contractions;
- Ensure bladder emptied at least 4 hourly and a urinalysis performed; record frequency of passing urine;
- Observation on the colour and the amount of the liquor if membranes ruptured.

24.2 Assessment of progress should include maternal behaviour, effectiveness of pushing and fetal wellbeing, taking into account fetal position and station at the onset of the second stage and the subsequent descent of the presenting part. These factors will assist in deciding the timing of further vaginal examination and the need for obstetric review

24.3 Document the effectiveness of pushing, the patient’s position, behaviour and how she feels she is managing her labour

24.4 Best practice recommends that the midwife should assess the FHR at least every 5 minutes, immediately following a contraction for one minute. If circumstances prevent this assessment occurring please document as above

24.5 Assess the patient’s pain, discussing her preferred coping strategies and supporting her wishes

24.6 Discourage the woman from lying supine or semi-supine in the second stage of labour and encourage her to adopt any other position that she finds most comfortable.

24.7 Inform the woman that in the second stage she should be guided by her own urge to push.

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

24.9 If any of the indications for transfer are met transfer the woman to obstetric-led care. Follow the general principles for transfer of care described in the guideline entitled 'Transfer of mothers and babies to different care settings'; register number 06029.

25.0 Delay in the Second Stage of Labour

25.1 For permissible time frames in labour see Appendix C

25.2 In a **nulliparous** patient delay is diagnosed when the active second stage has reached **2 hours,** at this point the patient should be referred to the obstetric registrar unless the birth is imminent. All findings should be documented in the health care records contemporaneously by the responsible health care professional.

25.3 In a **multiparous** patient delay is diagnosed when the active second stage has lasted **1 hour.** At this point the patient should be referred to the obstetric registrar unless the birth is imminent. All findings should be documented in the health care records contemporaneously by the responsible health care professional.

25.4 For patients **without** an epidural who have a fully dilated cervix and who do not have an urge to push, a vaginal assessment should be undertaken **1 hour** after full dilatation.

26.0 Intrapartum Intervention to Reduce Perineal Trauma during the Second Stage

26.1 'Hands on' (guarding the perineum and flexing the baby's head) or the 'hands poised' (with hands off but in readiness) techniques should be used and consent gained from the woman.

26.2 Midwives should ask women if they would like a warm compress to be used on the perineum to help reduce the risk of serious tears.

26.3 In the event of a water birth a hands off approach should be used, and verbal direction and encouragement should be given to achieve a controlled birth.

26.4 Do not carry out a routine episiotomy during spontaneous vaginal birth**.** For episiotomy guidance refer to 'Management of Episiotomy'; register number 07045 and Assessment and Repair Of Perineal Trauma; register number 07066.

27.0 The Third Stage of Labour

27.1 The third stage of labour is the time from the birth of the baby to the expulsion of the placenta and membranes.

27.2 Explain to the woman antenatally and during the initial assessment in labour about what to expect with each package of care for managing the third stage of labour and the benefits and risks associated with each. Document in the records the decision that is agreed with the woman about management of the third stage

27.3 **Physiological management** as follows:

- Uterotonic drugs (oxytocin) are not used;
- The cord is not clamped until the pulsations have ceased;
- The placenta is delivered by maternal effort.

27.4 Explain to the woman that **physiological management:**

- Is associated with nausea and vomiting in about 50 in 1000 women;
- Is associated with an approximate risk of 29 in 1000 of a haemorrhage of more than 1 litre;
- Is associated with an approximate risk of 40 in 1000 of a blood transfusion

27.5 If a woman at low risk of postpartum haemorrhage requests physiological management of the third stage, support her in her choice.

27.6 **Active management** as follows:

Active management of the third stage involves a package of care comprising the following components:

- Routine use of uterotonic drugs with the birth of the anterior shoulder or immediately after the birth of the baby and before the cord stops pulsating or is clamped and cut;
- Deferred clamping and cutting of the cord;
- Controlled cord traction after signs of separation of the placenta.

27.7 Explain to the woman that **active management:**

- Shortens the third stage compared with physiological management;
- Is associated with nausea and vomiting in about 100 in 1000 women;
- Is associated with an approximate risk of 13 in 1000 of a haemorrhage of more than 1 litre;
- Is associated with an approximate risk of 14 in 1000 of a blood transfusion

27.8 Changing from physiological management to active management is indicated as follows:

- Excessive bleeding of haemorrhage occurs;
- Failure to deliver the placenta within one hour;
- The patient’s desire to shorten the third stage.

27.9 After administering the oxytocic, clamp and cut the cord. Do not clamp the cord earlier than 1 minute from the birth of the baby unless there is concern about the integrity of the cord or the baby has a heartbeat below 60 beats/minute that is not increasing. Clamp the cord before 5 minutes in order to perform controlled cord traction as part of active management. If the woman requests that the cord is clamped and cut later than 5 minutes, support her in her choice.

27.10 After cutting the cord, use controlled cord traction.

27.11 Record the timing of cord clamping in both active and physiological management.

27.12 Do not use either umbilical oxytocin infusion or prostaglandin routinely in the third stage of labour. If retained placenta is diagnosed.
(Refer to guideline entitled 'Management of retained placenta'; register number 04245)

28.0 Observations in the Third Stage of Labour

28.1 should include:

- Estimating the amount of vaginal blood loss;
- Assessing the general condition of the mother i.e. her respirations, colour and her own report of how she feels;
- Where haemorrhage, retained placenta or maternal collapse is diagnosed;
(Refer to the 'Severely ill patient in maternity services'; register number 09095)
- Documentation.

29.0 Delay in the Third Stage of Labour

29.1 Delay is diagnosed if not completed within:

- **60 minutes** of physiological management;
- **30 minutes** of active management.

30.0 Care of the Patient Immediately following Delivery

30.1 Initial assessment of the mother:

- Mother's psychological wellbeing;
- Observations of blood pressure, pulse, respirations and temperature;
- Ensure that the uterus is contracted. Observe loss per vaginum;
- Examination of the placenta and membranes-assessment of their condition, structure, cord vessels and completeness. Ensure correct disposal;
- In terms of bladder care, the time and volume of the first void should be recorded in the health care records;
- Re-inspect the perineum, if the mother complains of continued discomfort
- Encourage skin to skin with the baby
- Support feeding of baby

30.2 Recognise that the time immediately after the birth is when the woman and her birth companion(s) are meeting and getting to know the baby. Ensure that any care or

interventions are sensitive to this and minimise separation or disruption of the mother and baby.

31.0 Inspection of the Perineum

31.1 Repair of the perineum should be undertaken as soon as possible to minimise the risk of infection and blood loss.
(Refer to guideline for 'Assessment and repair of perineal trauma'; register number 07066)

31.2 Delay suturing for 1 hour if perineal tissue is waterlogged following labour/delivery in the pool.

32.0 Care of the Baby Immediately after Birth

(Refer to the 'Examination of the newborn infant' Register number 04225)

32.1 Record the APGAR score at 1 and 5 minutes (if born in a poor condition; at 1, 3, 5 and 10 minutes or until the baby's condition is stable). Record the time from birth to regular respirations.

32.2 If there are any concerns regarding the baby's wellbeing, double clamp the cord 10cm apart immediately after delivery to allow paired blood gases to be obtained. Continue to evaluate and record the baby's condition until it is improved and stable. Do not take paired cord samples routinely. Ensure a double clamp for paired cord blood samples is available in all care settings.

32.3 Skin-to-skin should be initiated immediately after delivery, covering the baby with a warm dry towel and a hat to facilitate thermoregulation.

32.4 Initiate feeding, ideally within one hour of birth.

32.5 Avoid separation of the baby from the mother within the first hour after birth for routine procedures (weighing, checking and labelling) unless the mother requests it or the baby's condition is concerning.

32.6 An initial examination of the newborn is to be undertaken with parental consent, to detect any abnormalities and to identify any problems that may require referral.

32.7 Take measurements of the head circumference, weight (undressed) in kilograms and axilla temperature. Apply two identity ankle bracelets
(Refer to 'Attachment and detachment of identification labels for the newborn'; register number 04216)

32.8 Administer vitamin K 1mg intramuscularly with prior parental consent.
(Refer to 'Administration vitamin K for neonates; register number 08095)

33.0 Staffing and Training

33.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.

33.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

34.0 Infection Prevention

34.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

34.2 Normal warm tap water is to be used for cleansing prior to vaginal examination. Normal infection prevention and control measures are to be taken in compliance with Trust guidelines.

34.3 All staff should ensure that they follow Trust guidelines on infection prevention. All invasive devices must be inserted and cared for using High Impact Intervention guidelines to reduce the risk of infection and deliver safe care. This care should be recorded in the Saving Lives High Impact Intervention Monitoring Tool Paperwork (Medical Devices).

35.0 Professional Midwifery Advocates

35.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

36.0 Audit and Monitoring

36.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

36.2 As a minimum the following specific requirements will be monitored:

- Maternal observations to be carried out on admission;
- Maternal observations to be carried out during established first stage of labour;
- Maternal observations to be carried out during second stage of labour;
- Maternal observations to be carried out during third stage of labour;
- Documentation of all of the above maternal observations;
- Guidance on duration of all stages of labour;
- Guidance on referral to obstetric care;
- Timing of the clinical risk assessment in all care settings;
- Medical conditions to be considered, including anaesthetic history;
- Factors from previous pregnancies;
- Lifestyle history to be considered;
- Risk assessment for appropriate place of birth;

- Documentation of an individual management plan when risks are identified during the clinical risk assessment;
- Process for referral of women when risks are identified during the clinical risk assessment;
- Documentation of all the above, where clinically relevant.

36.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 40.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

36.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

36.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

36.6 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.

36.7 Key findings and learning points will be disseminated to relevant staff

37.0 Guideline Management

37.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

37.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

38.0 Communication

38.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

38.2 Approved guidelines are published monthly in the Trust's staff newsletter that is sent via email to all staff.

39.0 References

National Institute for Health and Care Excellence (2014) Intrapartum care for healthy women and babies. Clinical Guideline (CG190) London: NICE

Available at: https://www.nice.org.uk/guidance/cg190

National Institute for Health and Care Excellence (2019) Intrapartum care for women with existing medical conditions or obstetric complications and their babies. NICE Guideline (NG 121). London: NICE
Available at: https://www.nice.org.uk/guidance/ng121

C Barnett, V Hundley, H Cheyne, F Kane (2008). Not in Labour: Impact of sending women home in the Latent Phase. British Journal of Midwifery,16 (3), p144 – 153.

Department of Health (2007) Maternity Matters: choice, access and continuity of care in a safe service London: Department of Health

Maternity Care Working Party (2007) Making Normal Birth a Reality. Consensus statement from the Maternity Care Working Party: our shared views about the need to recognise, facilitate and audit normal birth. London: National Childbirth Trust, Royal College of Midwives, Royal College of Obstetricians

Royal College of Midwives (2018) Midwifery care in labour guidance for all women in all settings
Available at:
https://www.rcm.org.uk/publications/?publicationtype=bluetopguidelines&page=1

Appendix A

Indications for a Consultant Led Unit Booking

Maternal indications

Respiratory

Asthma requiring a 'step-up' in treatment, or hospital treatment within the last year

Cystic fibrosis

Cardiovascular

Cardiac disease

Hypertensive disorders

Renal

Renal disease requiring supervision by a renal specialist

Abnormal renal function

Recurrent infection

Gastro-intestinal

Liver disease

Crohn's disease

Ulcerative colitis

Infective

TB-under treatment

HIV-carrier and infected

Sexually transmitted disease

Hepatitis B/C with abnormal liver function tests

Toxoplasmosis if occurs when pregnant

Chicken pox if occurs when pregnant

Rubella-if pregnant

Genital herpes if pregnant

Group B streptococcus

Haematological

Haemoglobinopathies such as beta Thalassaemia major, sickle-cell disease

Family history of previous thrombo-embolism

Evidence of or suspected thromboembolitic disorders

Suspected thrombocytopaenia, a platelet count below 100 or abnormal platelet formation

Von Willibrand's disease

Bleeding disorders in the woman or the unborn baby

Immune

Rheumatoid arthritis

SLE (systemic lupus erethromatosis)

APS (antiphosphoid antibody syndrome)

Scleroderma

Other connective tissue disease.

Endocrine

Thyroid disorders

Diabetes or previous history of gestational diabetes or current gestational diabetes

Other significant disorders e.g. Cushing's disease

Neurological

Epilepsy

Myasthenia gravis

Spinal abnormalities

Previous cerebrovascular accident

Neurological defects

Psychiatric disease

Substance misuse

Alcohol dependency requiring assessment or treatment.

Body Mass Index greater than 35 at booking

Disorders requiring current inpatient care.

Anaesthesia risk

Known airway problems

History of drug

Latex allergy

Spinal abnormalities

Surgical

Myomectomy

Hysterectomy

Spinal surgery

Vascular surgery

Previous fractured pelvis

Obstetric problems

Previous complications

Previous still birth/neonatal death

Previous baby with neonatal encephalopathy

Pre-eclampsia requiring pre-term delivery

Eclampsia/HELLP syndrome

Uterine rupture

Placental abruption with adverse outcomes

Primary postpartum haemorrhage requiring additional treatment or blood transfusion.

Retained placenta requiring manual removal in theatre

Caesarean section

Obstetric cholestasis

Babies >4.5 kg

Shoulder dystocia

Postpartum haemorrhage

Manual removal of placenta

Fetal indications

Rhesus disease

Atypical antibodies

Confirmed uterine death

Obstetric problems

Current pregnancy

Multiple pregnancy

Unstable lie

Malpresentation

Placenta praevia

Recurrent antepartum haemorrhage

Placental abruption

Pre-term (less than 37 weeks gestation)

Pre-eclampsia or pregnancy induced hypertension BP >140/90 or 15mmhg above booking diastolic or 30mmhg above booking systolic.

Proteinuria >+1on dipstick (30mg of protein)

Epigastric pain

Pre-term rupture of the membranes

Pre-labour rupture of the membranes

Induction of labour

Anaemia Haemoglobin less than 8.5 g/dl at the onset of labour

Seizures

Maternal age of less than 16 or > 40

Appendix B

Considerations for a Consultant/Specialist Referral Regarding Individual Assessment

Disease area	Medical condition
Cardiovascular	Cardiac disease without intrapartum implications
Haematological	Atypical antibodies which are not putting the baby at risk of haemolytic disease
	Sickle cell trait
	Thalassaemia trait
	Anaemia-haemoglobin of 8.5-10.5 g/dl at onset of labour
Infective	Hepatitis B/C with normal liver function tests
Immune	Non-specific connective tissue disorders
Endocrine	Unstable hyperthyroidism such that a change in treatment is required
Skeletal/ neurosurgical	Spinal abnormalities
	Previous fractured pelvis
	Neurological deficits
Gastrointestinal	Liver disease without current abnormal liver function
	Crohn's disease
	Ulcerative colitis
Previous complications	Stillbirth/neonatal death with a known non-recurrent cause
	Pre-eclampsia developing at term
	Placental abruption with good outcome
	History of a previous baby more than 4.5kg
	Extensive vaginal, cervical,or third or fourth degree perineal trauma
	Previous term baby with jaundice requiring exchange transfusion.
Fetal indications	Fetal abnormality
Previous gynaelogical history	Major gynaecological surgery
	Cone biopsy or large loop excision of the transformation zone
	Fibroids
Social reasons	Women who may need protection from domestic abuse
	Women whose babies need a child protection strategy plan
	Women who may require the services of an interpreter.

Appendix C

Permissible time limits in normal labour-based on cervical dilatation of 2cm in 4 hours

	Nulliparous	Multiparous
First stage of labour	12 hours	12 hours
Second stage – passive	1 hour	1 hour
Additional allowance for an epidural	1 hour	1 hour
Second stage- active	1 hour – if no progress with rotation and/or descent – offer VE + ARM if membranes are intact Allow another 1 hour - diagnose delay when it has lasted 2 hours and refer to obstetrician Total – 3 hours (from start of active second stage to birth)	30 mins – if no progress with rotation and/or descent – offer VE + ARM if membranes are intact Allow another 30 mins - diagnose delay when it has lasted 1 hour and refer to an obstetrician Total – 2 hours (from start of active second stage to birth)
Third stage - physiological	1 hour	1 hour
Third stage- active	30 mins	30 mins

Appendix D: Preliminary Equality Analysis

This assessment relates to: Management of Normal Labour / 09079

A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Full Review
2. Why are you making this change? (What will the change achieve?)	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

Name	Annie Dutta Alison Groves	**Job Title**	Obstetric Consultant Senior Midwife	**Date**	June 2019