# Care in Labour

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

## Introduction

Guideline for providing care in labour at WAHT. All aspects of routine labour care are included, as well as referral, transfer and escalation triggers. NICE (2023) Intrapartum care guideline has been used to form this guideline but is not included in its entirety. Therefore, this guideline should be used alongside the NICE Guidance Recommendations | Intrapartum care | Guidance | NICE if further information is required.

## This guideline is for use by the following staff groups:

All Maternity staff providing labour care

## Lead Clinician(s)

| | |
|---|---|
| Claire Berrow | Meadow Birth Centre Lead Midwife |
| Daisy Austin | Audit, Guideline and PE Midwife |
| Claire Bayliss | Intrapartum Matron |
| Caitlin Wilson | Consultant Midwife |
| Laura Veal | Consultant Obstetrician |

| | |
|---|---|
| Approved by *Maternity Governance Meeting* on: | 19th September 2025 |
| Approved by Medicines Safety Committee on:<br>*Where medicines included in guideline* | 13th September 2023 |
| Review Date:<br>This is the most current document and should be used until a revised version is in place | 19th September 2028 |

**Key amendments to this guideline**

| Date | Amendment | Approved by: |
|---|---|---|
| Aug 2023 | Complete revision of Guideline | MGM |
| Feb 2025 | Updates including second midwife at birth, clarity around MBC criteria for GDM and updated BRAINS tool. | MGM |
| Sept 2025 | Addition of Documentation, Transfer guidance and NICE GAP analysis performed. | GF/MGM |

## Ockenden Maternity Guidelines Assessment

| | |
|---|---|
| Is there National Guidance Available for this guideline? | Yes |
| National Guidance used to inform guideline *e.g. NICE/RCOG* | NICE guideline [NG235] Intrapartum Care (2023) |
| Does the guideline follow National Guidance if available? *If no, what rationale has been used.* | Yes |
| If no national guidance available or national guidance not followed, what evidence has been used to inform guideline. | N/A |
| **Ratified at Maternity Guidelines Forum:** | 19/09/2025 |

**Inclusion statement**

We recognise that although our policy uses words such as women/woman, not all birthing people or post-natal parents will identify as such. We encourage all staff to be welcoming of the diversity of our local population, be respectful of preferred language, pronouns, and adapt their communication appropriately. All staff should accommodate mothers and parents with individual needs or disabilities, whether they be physical or not visible, and adapt their care to support them with their pregnancy.

# Contents

### Communication of Care throughout Labour

All care professionals will treat all women in labour with respect. Ensuring that the woman/birthing person is in control of and involved in what is happening to her and recognise that the way in which care is given is key to this.

To facilitate this, establish a rapport with the woman/birthing person, ask her about her wants and expectations for labour, and be aware of the importance of tone and demeanour, and of the actual words used.

To establish communication with the woman:

- Greet the woman/birthing person with a smile and a personal welcome, establish her language needs, introduce yourself and explain your role in her care.
- Maintain a calm and confident approach so that your demeanour reassures the woman/birthing person that all is going well.
- Knock and wait before entering the woman/birthing person's room, respecting it as her personal space, and ask others to do the same.
- Ask how the woman/birthing person is feeling and whether there is anything in particular she is worried about.
- If the woman/birthing person has a written birth plan, read and discuss it with her.
- Assess the woman/birthing person'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/birthing person to adapt the environment to meet her individual needs.
- Ask her permission before all procedures and observations, focusing on the woman/birthing person rather than the technology or the documentation.
- Show the woman/birthing person and her birth companion(s) how to summon help and reassure her that she may do so whenever and as often as she needs to. When leaving the room, let her know when you will return.
- Involve the woman/birthing person in any handover of care to another professional, either when additional expertise has been brought in or at the end of a shift.
- Effective communication is central to promoting patient safety.
- A structured handover of care between staff can be achieved using SBAR tool. (Situation – Background – Assessment – Recommendation) tool.

### Birth Partners

Birth Partners should be encouraged to offer support during labour. Up to 2 Birth Partners will be allowed for support in labour.

### Decision making

All decision making before, during and after labour should encompass the BRAINS acronym (Appendix 1)

*In **emergency** situations it may not be possible to allow time for discussions to take place, however, women and birthing partners should still be made aware of what is happening and be involved in the process if possible.*

### Choosing and Planning Place of Birth

Explain to both multiparous and nulliparous women that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth. This should be discussed in the antenatal period and the woman/birthing person’s wishes discussed and documented on her Badgernet record.

Explain to low-risk nulliparous women that planning to give birth in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby.

Explain to low-risk multiparous women that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.

Our Midwifery-Led Unit - Meadow Birth Centre (MBC) and homebirth is available to primiparous and multiparous women who meet the following criteria:

- 37-42 weeks' gestation
- Maternal Age 16-40 years at Conception.
- BMI < 40 at booking
- HB > 85G/L and asymptomatic
- Spontaneous onset of labour
- Pre-labour SROM at term < 24 hours
- Induction of labour for postdates with x1 Propess and with no additional risk factors
- Previous 3rd or 4th degree tear (if wishing vaginal delivery)
- Previous Retained Placenta
- Previous PPH <1000mls (advise active third stage if > 500mls)
- Group B strep (MBC for Abx)
- Hypothyroidism (well controlled throughout third trimester)
- Gestational Diabetes - Well controlled on diet only, with no additional risk factors
- Platelets >100

Any woman/birthing person with additional risk factors wishing to birth at home or on Meadow Birth Centre (MBC) should be referred to the consultant midwife or their named consultant for Personalised Care Planning.

**Documentation throughout labour**

**Labour and Birth form**

Should be completed at the onset of established labour or commencement of oxytocin for induction of labour.

**Intrapartum Fetal Monitoring assessment**

This should be completed:

- At onset of ALL labours
- Every 1 hour if continuous monitoring is in progress
- Every 4 hours for Intermittent Auscultation

**Labour assessment form**

**Initial** - Complete following labour commenced on labour and birth form, click 'yes' to record vaginal examination under labour progression, complete the form if Vaginal Examination performed. Ensure 'Expected dilatation' is set to '1cm every 2 hours' this sets the partogram correctly. If **no vaginal examination** has been performed, you can now untick the box and the partogram settings will be saved.

**Ongoing** – complete every hour during the first stage of labour and every 30 minutes during the second stage of labour.

**Observations (MEOWS)**

All Observations should be documented on the MEOWS chart. Full Observations should be completed every 4 hours.

**Bladder Care/Fluid Balance**

An accurate fluid balance **MUST** be recorded (in line with local documentation guideline) on a paper fluid balance chart. This can also be entered digitally onto the Badgernet record for completeness, but the paper chart must be completed and scanned into the Badgernet record.

Bladder Care should be reviewed every 4 hours. This should include: Frequency of passing urine and bladder sensation and evaluating the need for a urinary catheter if there are any ongoing concerns around passing urine.

Intrapartum and Postpartum Bladder Care Guideline 2021

**Pressure Ulcer Prevention**

Pressure Ulcer Risk assessment should be completed at the following points during labour:

- Admission in established labour/antenatal ward
- Mobile with Intact Membranes – every 6 hours
- Mobile with SROM – every 4 hours (reassessment should be completed at point of SROM)
- Epidural – every 2 hours (reassessment should be completed at point of siting)

**VTE Risk Assessment**

VTE Risk assessment should be completed at the onset of labour/admission to the antenatal ward. This should be reassessed following the birth and LMWH prescribed as appropriate.

**VIP Assessments and scoring**

Anyone with a cannula requires:

- Vascular Access Device/Urinary Catheter form completed at point of insertion
- VIP form completed every 8 hours as a minimum
- Cannula/Catheter Removal form completed at point of removal

**Catheters**

Anyone with a urinary catheter requires:

- Vascular Access Device/Urinary Catheter form completed at point of insertion
- Urinary Catheter Maintenance Record completed a minimum of every 4 hours.
- Cannula/Catheter Removal form completed at point of removal

**Spontaneous Rupture of Membranes (SROM)**

Pre-Labour rupture of membranes (PROM) guideline should be followed if SROM prior to contractions (or latent phase): Pre-Labour rupture of membranes (PROM) – Preterm and Term Guidelines

If SROM occurs during labour, an assessment should take place comprising of:

- Auscultation of the fetal heart
- Maternal Observations
- Assessment of liquor colour (clear, blood stained, meconium)
- Frequency and strength of contractions
- Risk assessment to ensure no transfer of care is required (i.e. Meconium-stained Liquor)
- SROM time and assessment should be documented clearly on Badgernet.

Vaginal examination is **not** indicated outside of the planned schedule of care.

**Vaginal Examinations and Artificial Rupture of membranes**

Health care professionals who conduct VE's should:

- Be sure the VE is really necessary and will add important information to the decision-making process.
- Be aware that for many women who may already be in pain, highly anxious and in an unfamiliar environment, VE can be very distressing
- Ensure the woman/birthing person's consent is obtained, and that privacy, dignity and comfort are maintained
- Explain the reason for the examination and what will be involved (NICE 2007).
- Explain sensitively the findings of the examination and any impact on the birth plan to the woman/birthing person and her birth companion(s) (NICE 2014)
- Document findings, which includes the following:
    - Date and time of examination
    - Indication for examination
    - Length and effacement of the cervix and application to the presenting part.
    - Position, consistency and dilatation of the cervix
    - Position and station of the presenting part in relation to the ischial spines, presence of caput/moulding
    - Forewaters intact/ruptured and colour of liquor

**Midwifery Scope of Practice for Vaginal Examinations as per WAHT**

- Full Term - ≥ 37 weeks' - Midwifery Led VE
- Preterm - < 36+6 weeks' – Initial Examination from Consultant/Registrar and documented management plan for care going forward.

ARM can be performed during established labour if there is a recognised delay in the progress of labour and the forewaters are intact (See delay in first stage of labour flowchart). Midwives may perform this procedure if the woman/birthing person is >37 weeks.

Preterm ARM should be outlined within a care plan from the obstetric team; it may be appropriate for a midwife to undertake this procedure if outlined within the care plan.

ARM at any gestation should be undertaken following a discussion with the woman/birthing person about the risks and benefits of the procedure. The woman/birthing person and her birthing partners should be aware that artificial rupture of membranes is an intervention.

**Eating and Drinking in Labour**

A light diet may be consumed in established labour unless she has received opioids, or she develops risk factors that make a caesarean birth (general anaesthetic) more likely.

A light diet can include:

- Breakfast cereals
- Bread/toast with lightly spread butter
- Sandwiches (not containing dairy products e.g. egg or cheese)
- Plain biscuits
- Fruit

Avoid fatty foods such as chocolate, crisps etc and consume little and often as required rather than large volumes at a time.

Drinking to thirst is encouraged in labour, there is no benefit to drinking more than usual. Isotonic drinks may be more beneficial than water.

If woman/birthing person has diabetes, please refer to Diabetes – Type 1 & 2 (in pregnancy)

**Latent stage of Labour**

Latent first stage of labour can be defined as a period, not necessarily continuous, when there are painful contractions and there is some cervical change, including cervical effacement and dilatation up to 4 cm (NICE, 2007). It can be normal for this stage of labour to last 2-3 days.

Telephone Triage should consist of:

- Asking the woman/birthing person how she is, and about her wishes, expectations and any concerns she has
- Asking the woman/birthing person about the baby's movements, including any changes
- Give information about what the woman/birthing person can expect in the latent first stage of labour and how to work with any pain she experiences
- Give information about what to expect when she accesses care
- Agree a plan of care with the woman/birthing person, including guidance about who she should contact next and when.

All women seeking advice or attending a maternity unit with contractions in latent phase of labour should receive the following:

- Recognition that women may experience painful contractions without cervical change, and although this is described as not being in labour, she may well think of herself as being 'in labour' by her own definition.
- Individualised support, and analgesia if needed
- Encouragement to remain at or return home, unless doing so leads to a significant risk that she could give birth without a midwife present or become distressed.

Face to Face assessments should be **offered** to all women on their **2nd** phone call and **recommended** to all women on their **3rd** phone call to triage for latent phase advice. These face-to-face assessments should have a duration of approximately 1 hour and can be performed:

- In the Woman/birthing person's Home
- In Maternity Triage

And should include:

- All the above telephone triage actions
- Maternal Observations (MEOWS) including Pulse, SATs, Blood Pressure, Temperature and respiratory rate.
- Discuss any discomfort or pain being experienced, and options for pain relief if required.
- Any Vaginal loss
- Assessment of Contraction length, strength and frequency of contractions.
- Abdominal palpation: Fundal Height (if required), Lie, Presentation, Position, Engagement and palpation of contractions.

- Auscultation of fetal heart rate for a minimum of 1 minute immediately following a contraction.

If the woman/birthing person appears to be in established labour, a vaginal examination should be offered. This should be discussed with the woman/birthing person and a personalised plan of care should be made considering her wishes. Vaginal examination may be requested for reassurance; the risks and benefits of this should be discussed with the woman/birthing person, expectations should be managed, and the findings discussed sensitively.

**Care at Home following Initial Assessment**

If labour has not fully established and no risks have been identified on the risk assessment, the woman/birthing person should be encouraged to return home.

Some women have pain without cervical change. Although these women are described as not being in labour, they may well consider themselves as 'in labour' by their own definition. Women who seek advice or attend hospital with painful contractions but not in established labour should be offered individualised support, and analgesia if needed. Encourage her to remain at or return home unless doing so leads to a significant risk that she could give birth without a midwife present or become distressed (NICE 2014).

- Offer early labour leaflet, with advice and tips on how to cope in early labour.
- Reassure the woman/birthing person that she can phone for further advice/support at any time.
- Ensure that she has appropriate follow up arranged.
- Provide guidance and support to the woman/birthing person's birth companion (NICE 2014)

**Early Labour Care in Hospital**

A risk assessment **MUST** be completed at admission and/or the start of established labour that identifies the most appropriate method for fetal heart monitoring. This should be clearly documented within the Badgernet record.

Midwives should use their expertise when planning optimal care in partnership with the woman/birthing person and their partner. This care should be continually assessed with the aim of enabling the woman/birthing person to feel confident to return home.

- Contacts should be made with the woman/birthing person **a minimum of 4 hourly** or more frequently according to clinical need. Observations will be documented on the MEWS chart
- Enquire about: fetal movements / vaginal loss / frequency and strength of contractions / how she is coping and that she passes urine regularly
- Encourage birth partner/s to be supportive in their role.
- Early labour pain can often be short, sharp and very painful, irregular yet frequent, preventing adequate rest. Pethidine may be offered if appropriate.

**Pethidine**

- If Pethidine is requested and administered the women must remain in hospital if not already an inpatient.
- In cases where pethidine is requested to be administered in a High risk CLC case that has not been signed off as suitable for low-risk care, a CTG should be undertaken prior administration to ensure fetal wellbeing, and that no signs of hypoxia are present.

- If women are suitable for low-risk care or have an individual plan after counselling, standard fetal wellbeing assessment should be done before administration.
- Following administration of pethidine, a minimum of Hourly FH's should be auscultated for a minimum of 6 hours.
- For high-risk cases, hourly fetal heart (FH) monitoring should be performed for at least 6 hours, alongside adhering to the CTG monitoring plan already in place.

Pethidine acts as a sedative for both mother and Fetus, crossing the placenta. Monitoring fetal heart rate is necessary to detect any changes promptly.

If any deviations in the fetal heart rate are identified during this period they should be escalated to the Midwife in charge (Band 7) and obstetric team where a CTG should then be commenced to confirm fetal wellbeing and further plan of care to be made.

**Consultant led care** – All women under consultant led care require an obstetric review prior to discharge home.

Following assessment and discussion with the woman/birthing person, it is important to put a care plan in place. Encouragement should be given for the woman/birthing person to return home if assessment is normal, with advice and safety netting as appropriate. The woman should be advised to call triage if any changes or concerns.

**Liaise with the midwifery led unit / delivery suite if the woman/birthing person needs to be transferred**

If there is a delay in transfer of the woman in labour of more than 30 minutes due to capacity or staffing issues. 1:1 care on the ward or in triage should be provided and all care should be documented in the Badgernet record.

An incident form should be completed when appropriate and the escalation policy should be implemented.

**Transfer**

**Transfer of care from MLC to CLC**

Transfer to obstetric led care if any of the following are observed on initial assessment or during labour**:**

Observations of the woman/birthing person:

- Pulse over 120 beats/minute on 2 occasions 30 minutes apart
- A single reading of either raised diastolic blood pressure of 110 mmHg or more or raised systolic blood pressure of 160 mmHg or more
- Either raised diastolic blood pressure of 90 mmHg or more or raised systolic blood pressure of 140 mmHg or more on 2 consecutive readings taken 30 minutes apart
- A reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (90 mmHg or more) or raised systolic blood pressure (140 mmHg or more)
- Temperature of 38°C or above on a single reading, or 37.5°C or above on 2 consecutive readings 1 hour apart
- Any vaginal blood loss other than a show
- Rupture of membranes more than 24 hours before the onset of established labour
- The presence of significant meconium
- Pain reported that differs from the pain normally associated with contractions

- Any risk factors recorded in the Badgernet record that indicate the need for obstetric led care.

Observations of the unborn baby:

- Any abnormal presentation, including cord presentation,
- transverse or oblique lie
- High (4/5–5/5 palpable) or free-floating head in a nulliparous
- Suspected fetal growth restriction or macrosomia
- Suspected anhydramnios or polyhydramnios
- Fetal heart rate below 110 or above 160 beats/minute
- A deceleration in fetal heart rate heard on intermittent auscultation
- Reduced fetal movements in the last 24 hours

If none of these are observed, continue with previous plan of care unless transfer is requested.

If birth is imminent, assess whether birth in the current location is preferable to transferring to an obstetric unit and discuss this with the shift leader. If birth is not imminent, transfer to obstetric-led care.

Base any decisions about transfer of care on clinical findings and discuss the options with the woman/birthing person and her birth companion(s).

Communication should be maintained throughout the transfer process and expectations should be set where possible i.e. timeframe, location, rationale/need and mode of transport. Any concerns or questions should be addressed.

**Transfer of Care during Active Labour**

Transfer of care from the antenatal ward, triage or meadow birth centre in active labour should be performed as per the below table.

Obstetric Review for all transfers in labour should be performed within 30 minutes of arrival on delivery suite. If there is immediate concerns to maternal or fetal wellbeing, this should happen immediately on arrival on delivery suite.

If transferring from MBC/Triage/Antenatal ward, use of a chair or trolley should be assessed according to clinical need. However, a trolley should be utilised in the first instance if possible. Maternal dignity and comfort should be maintained, including blankets and pillows where appropriate.

**If transferring via ambulance:**

Ambulance staff and personnel should be aware that certain positions may cause discomfort or fear and affect labour; the woman should be supported in choosing her own movements and positions, in line with service protocols.

Ensure a midwife who has been involved in the woman's care up to that point travels with the woman/birthing person.

Monitor throughout the transfer, as appropriate for the stage of labour, including intermittent auscultation of the fetal heart if possible and safe to do.

Enable birth companion(s) to travel in the ambulance if that is what the woman/birthing person wants, and this is agreed by her care team and the ambulance crew.

**On arrival to destination**

- SBAR handover in the room with the woman/birthing person and birth partner (if present) and receiving midwife (if applicable) or Delivery suite co-ordinator.
- Fetal monitoring is continued/Continuous CTG is commenced if appropriate.
- Request Obstetric review if required, specifying timeframe as per above recommendations.

**Intrapartum Transfer Table (Inpatients)**

| **Life Threatening Transfer** |
|---|
| ‘Scoop and Run’<br>*Transfer Immediately to Delivery suite.* 2222 call stating **Delivery Suite** as the location, the team will meet you there. |
| • **PPH**<br>• **APH**<br>• **Fetal Bradycardia**<br>• **Cord Prolapse** |
| ‘Stay and Deal’ – Until Stable<br>*2222 call stating **Current Location** as the location. Staff will attend area for emergency.*<br>*Transfer should be initiated as soon as stable or required.* |
| • **Maternal Collapse (until airway secure)**<br>• **Shoulder Dystocia**<br>• **Neonatal Resuscitation**<br>• **Eclampsia** |
| **Urgent Transfer** |
| Transfer to **Delivery Suite** as soon as possible (Aim for within 30 minutes - If not possible, escalate) notify delivery suite prior to transfer. |
| **Observations of the woman** |
| **MEOWS**<br>• Pulse over 120 beats a minute on 2 occasions 15 to 30 minutes apart<br>• Temperature of **≥**38°c on a single reading, or **≥**37.5°c on 2 consecutive readings 1 hour apart.<br>**Hypertension**<br>• A single reading of either raised diastolic blood pressure of **≥** 110 mmhg or systolic blood pressure of **≥**160 mmhg<br>• Diastolic blood pressure of **≥**90 mmhg or systolic blood pressure of ≥140 mmhg (on 2 consecutive readings taken 15 to 30 minutes apart)<br>• Respiratory rate of less than 9 or more than 21 breaths per minute on 2 occasions 15 to 30 minutes apart |

- A reading of 2+ of protein on urinalysis and 1x reading of either: raised diastolic blood pressure (≥90 mmhg) or raised systolic blood pressure (≥140 mmhg)

**Vaginal Loss**

- Fresh red bleeding or blood-stained liquor
- Rupture of membranes more than 24 hours before the onset of established labour
- The presence of meconium

**Uterine Activity/Pain**

- Hyperstimulation with FHR Abnormalities
- Pain reported by the woman that differs from the pain normally associated with contractions
- Any risk factors recorded in the woman's notes that indicate the need for obstetric-led care
- Maternal request for additional pain relief

**Observations of the unborn baby**

In Labour:

- Non-cephalic fetal presentation
- High (4/5 to 5/5 palpable) or free-floating head in a nulliparous woman
- Concerns about fetal monitoring
- Reduced fetal movements in the last 24 hours reported by the woman
- Cord presentation

### First Stage of Labour

A risk assessment **MUST** be completed at admission or start of labour that identifies the most appropriate method for fetal heart monitoring. This should be clearly documented within the Badgernet record.

At the outset of the first stage of labour, birth preferences should be discussed with the woman/birthing person and their birthing partners. The antenatal birth preferences on Badgernet should be discussed and signed.

The partogram must be commenced when established labour is confirmed. One to one care should commence in line with partogram care.

### Observations

Clinical judgement should be used to determine the need for the frequency of the following observations ensuring they are undertaken at a minimum of the following times, where possible (i.e. if a woman/birthing person is being transferred from triage or the ward to delivery suite, this may not be possible but should be done as soon as the transfer has been completed). When this is not achieved, the reason should be clearly documented in the relevant records:

- Every 15 mins: after a contraction listen to fetal heart rate (FHR) with Pinards or Handheld Doppler for 1 minute
- Every 30 mins: document frequency of contractions
- Every hour: check pulse
- Every 4 hours: Check BP and temperature

### Vaginal Examinations

Vaginal Examinations should be offered every 4 hours throughout labour so long as progress is as expected.

An abdominal palpation and assessment of vaginal loss and contractions should always be performed prior to a vaginal examination.

Vaginal Examinations should include assessment of:

- Cervical Dilatation and Effacement
- Station and position of presenting part

### Expected Progress (Cervical Dilatation)

For both primiparous and multiparous women/birthing people the expected progress is 2 cm in 4 hours (0.5cm in 1 hour). For Multiparous women, consideration should be given to a slowing in progress trajectory.

### Diagnosis of delay in labour

If delay in the established first stage is suspected, assess all aspects of progress in labour when diagnosing delay, including:

- Cervical dilatation slower than expected progress
- Descent and rotation of the baby's head
- Changes in the strength, duration and frequency of uterine contractions.

If delay in the established first stage of labour is suspected, discuss the findings and the options available with the woman, and support her decision.

If delay is suspected Flowchart 1 should be followed.

**Interventions for delay in the first stage of labour**

If an intervention (for example ARM) due to delay in first stage of labour is required, notification of the delay in labour and the care plan should be communicated to the delivery suite coordinator prior to the intervention being performed.

Consideration should be given as to whether the delay requires a transfer of care i.e. MBC to Delivery suite or MLC to CLC on delivery suite. Do not advise transfer to obstetric-led care for amniotomy alone.

**Pain Relief**

Women/birthing people should be made aware they can request pain relief throughout their labour. The options available at WAHT are:

- Water (if appropriate)
- Breathing and Relaxation techniques
- Inhalational analgesia (Entonox)
- Opioids (Pethidine)
- PCA (Remifentanil)
- Regional Analgesia (Epidural, Spinal, CSE)

Monitor frequency of bladder emptying in accordance with the intrapartum and postpartum bladder care guideline.

Consider the woman/birthing person's emotional and psychological needs, including their desire for pain relief.

Encourage the woman/birthing person to communicate her need for analgesia at any point during labour.

Follow Fetal Monitoring -Intrapartum

Bladder care should be undertaken as per Intrapartum and postnatal bladder care guideline.

**Rupture of membranes and meconium-stained Liquor**

If SROM, continuous monitoring of liquor colour should be undertaken and appropriate management if meconium or blood-stained liquor is present.

If meconium is present, consider the character of the meconium and recommend transfer to obstetric-led care with the woman. Explain that meconium:

- May increase the risk to the baby
- Means that continuous cardiotocography monitoring may be advised (see the fetal monitoring in labour guideline)
- May mean that healthcare professionals trained in advanced neonatal life support are needed as soon as the baby is born.

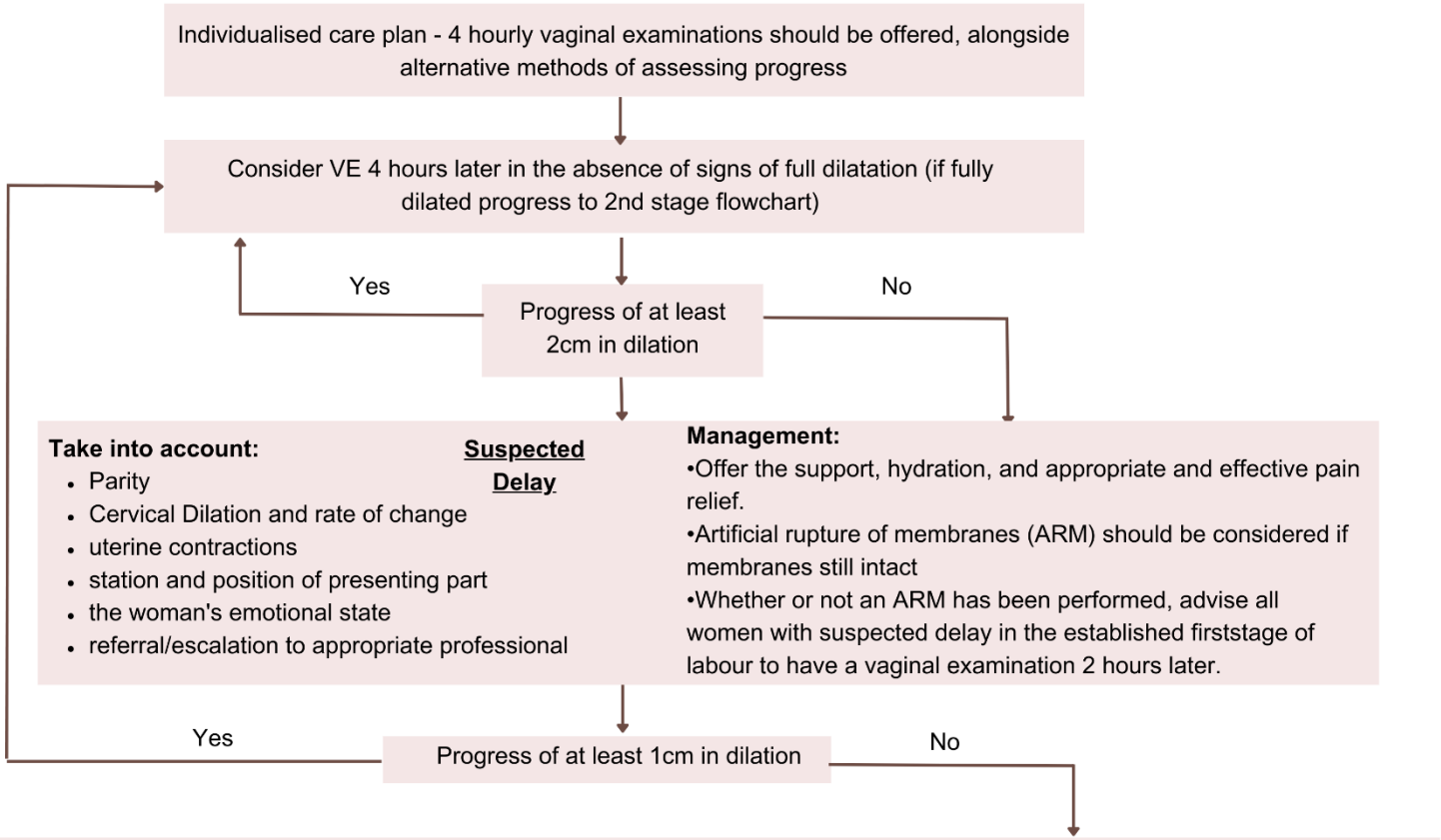
Be aware that meconium is more common after full term but should still trigger a full risk assessment and discussion with the woman about the option of transfer to obstetric-led care.

**Positioning throughout labour**

Encouragement and support should be offered to adopt positions that are comfortable. Mobilising/changing positions should be encouraged wherever possible, with an avoidance of laying flat on the back.

If an epidural is in situ, regularly changing positions using the bed and turning should be supported to encourage both labour progression and pressure relief.

## Flow chart 1: First stage of labour and expected progress




**Confirmed delay in the first stage:**

If membranes are intact and delay in the first stage of labour is confirmed, advise the woman to have an ARM, and to have a repeat vaginal examination 2 hours later whether her membranes are ruptured or intact.

All women with confirmed delay in the first stage of labour should be transferred to obstetric-led care for an obstetric review and a decision about management options, including the use of oxytocin.

For a multiparous woman with confirmed delay in the established first stage of labour, an obstetrician should perform a full assessment, including abdominal palpation and vaginal examination, before a decision is made about using oxytocin.

Offer all women with delay in the established first stage of labour support and effective pain relief.

## Second Stage of Labour

### Passive second stage of labour:

- the finding of full dilatation of the cervix before or in the absence of involuntary expulsive contractions.

### Onset of the active second stage of labour:

- the baby is visible.
- 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.

### Observations

Continue with observations of the woman and baby, and assessment of risk as described for the first stage of labour. Fetal Monitoring should increase in line with Fetal Monitoring - Intrapartum.

A vaginal examination should be offered in the active second stage, or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss). To assess progress, the vaginal examination should include:

- position of the head
- descent
- caput and moulding.

In addition:

- Continue to take the woman/birthing person's emotional and psychological needs into account.
- Assess progress, which should include the woman/birthing person's behaviour, the effectiveness of pushing and the baby's wellbeing, considering the baby's position and station at the onset of the second stage. These factors will assist in deciding the timing of further vaginal examination and any need for transfer to obstetric led care.
- Perform intermittent auscultation of the fetal heart rate immediately after a contraction for at least 1 minute, at least every 5 minutes. Palpate the maternal pulse every 15 minutes to differentiate between the two heartbeats.
- Ongoing consideration should be given to the woman/birthing person's position, hydration, coping strategies and pain relief throughout the second stage.

### Physiological positions and pushing

- Discourage 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.
- If an epidural is in situ, lying in a lateral position may increase the likelihood of a spontaneous vaginal birth, upright positions should be considered if comfortable.
- If no epidural is in situ, any comfortable position can be adopted. Upright positions and keeping mobile may be beneficial.
- Inform the woman/birthing person that in the second stage she should be guided by her own urge to push.
- If pushing is ineffective or if requested by the woman/birthing person, offer strategies to assist birth, such as support, change of position, emptying of the bladder and encouragement.

**Duration of the second stage and definition of delay**

Primiparous:

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

Multiparous:

- birth would be expected to take place within 2 hours of the start of the active second stage in most women
- diagnose delay in the active second stage when it has lasted 1 hour and refer the woman/birthing person to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.

For a Primiparous, suspect delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 1 hour of active second stage. Offer vaginal examination and then offer amniotomy if the membranes are intact.

For a multiparous woman/birthing person, suspect delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 30 minutes of active second stage. Offer vaginal examination and then offer amniotomy if the membranes are intact.

If full dilatation of the cervix has been confirmed in a labour without regional analgesia, but there is no urge to push, carry out further assessment after 1 hour.

Consideration should be given to the use of oxytocin, with the offer of regional analgesia, for nulliparous women if contractions are inadequate at the onset of the second stage.

**Confirmed Delay**

If there is delay in the second stage of labour, or if the woman/birthing person is excessively distressed, support and sensitive encouragement and the woman/birthing person's need for analgesia/anaesthesia are particularly important.

An obstetrician should assess a woman/birthing person with confirmed delay in the second stage (after transfer to obstetric-led care) before contemplating the use of oxytocin.

After initial obstetric assessment of a woman/birthing person with delay in the second stage, maintain ongoing obstetric review every 15 to 30 minutes.

**Reducing perineal trauma**

Do not perform perineal massage in the second stage of labour.

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

Do not carry out a routine episiotomy during spontaneous vaginal birth.

Inform any woman/birthing person with a history of severe perineal trauma that her risk of repeat severe perineal trauma is not increased in a subsequent birth, compared with women having their first baby.

Episiotomy should not be routinely offered at vaginal birth after previous third or fourth degree trauma.

In order for a woman/birthing person who has had previous third- or fourth degree trauma to make an informed choice, talk with her about the future mode of birth, encompassing:

- current urgency or incontinence symptoms
- the degree of previous trauma
- risk of recurrence
- the success of the repair undertaken
- the psychological effect of the previous trauma
- management of her labour

If an episiotomy is performed, the recommended technique is a Medio lateral 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.

Perform an episiotomy if there is a clinical need, such as instrumental birth or suspected fetal compromise. Tested effective analgesia should be provided before carrying out an episiotomy, except in an emergency because of acute fetal compromise.

**Second Midwife**

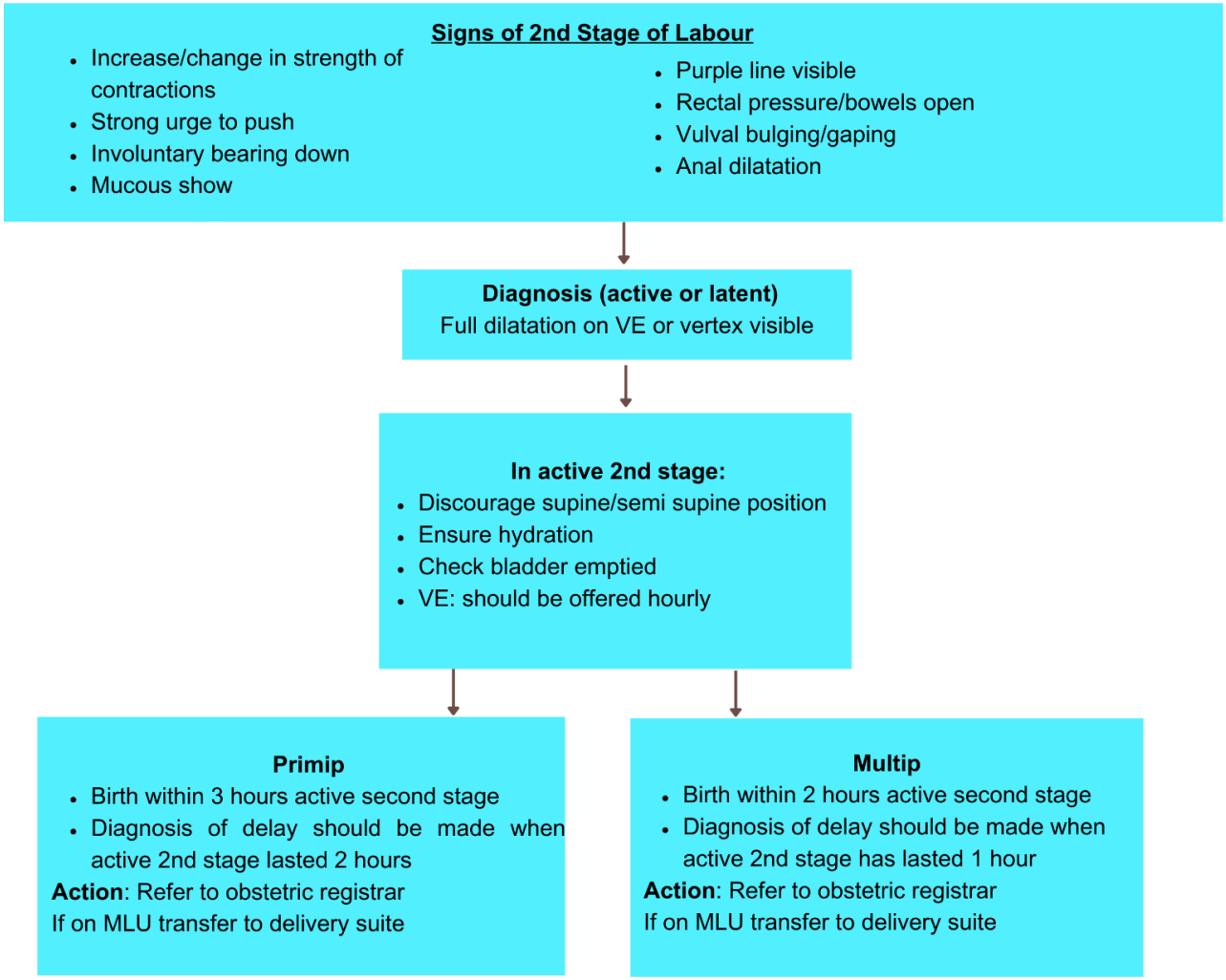
There should be a second midwife present for the birth, and they should remain present until the 3rd stage of labour has been completed, and the woman/birthing person is stable.

The role of this midwife is to support the midwife in care for the family, for example:

- Supporting early feeding, skin to skin and newborn thermoregulation
- Scribing for documentation on Badgernet
- Weighing Blood Loss
- Obtaining 3rd stage drugs/Lidocaine if required
- Taking cord blood if required
- Supporting midwife with tasks such as suturing
- Ensuring room is tidy and family are comfortable

It is imperative that the second midwife is respectful of the environment they are entering, and their role should be as a support to the midwife already in the room.

## Flow chart 2: Second stage of labour and expected progress



**Third Stage of Labour**

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

In the presence of no concerns at birth, cord clamping should be delayed by a **minimum** of 60 seconds.

In physiological management, there is no upper limit to when the cord can be cut.

In Active management the cord should be clamped and cut before 5 minutes.

**Active management of the third stage:**

- routine use of uterotonic drugs
- deferred clamping and cutting of the cord
- controlled cord traction after signs of separation of the placenta

**Physiological management of the third stage:**

- no routine use of uterotonic drugs
- no clamping of the cord until pulsation has stopped
- delivery of the placenta by maternal effort.

For women birthing at WAHT, active third stage is typically managed by the administration of IM Syntometrine (500micrograms/5iu). This should be administered via intramuscular injection with the birth of the anterior shoulder or immediately following the birth of the baby prior to the cord being clamped and cut.

The administration of IM Oxytocin 10iu can be used as an alternative drug and should be utilised in cases of hypertension or any contraindications to syntometrine. A woman/birthing person may opt for Oxytocin 10iu if it is her preference, in the presence of risk factors full counselling on recommendations should be made.

If placenta is retained, follow – Manual Removal of Placenta

Placenta and membranes should be examined, assessing, condition, structure, cord vessels and completeness. If any concerns are found – these should be escalated to the obstetric team.
Perineal assessment and repair should be performed within an hour (unless waterbirth) - Perineal Tears and Repairs Guideline

Record the following observations the third stage of labour:

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

If there is postpartum haemorrhage, a retained placenta or maternal collapse, or any other concerns about the woman/birthing person's wellbeing:

- transfer her to obstetric led care
- carry out frequent observations to assess whether resuscitation is needed

**Baby**

APGAR score should be recorded at 1 and 5 minutes for ALL births. This should be recorded on the Badgernet record for the baby.
If the baby requires resuscitation the Resuscitation – Network guideline 2022-24 should be followed.

If the baby requires resuscitation the Resuscitation – Network guideline 2022-24 should be followed.

**Initial Postnatal Assessments and postnatal care**

**Maternal**

Following birth the following observations should be recorded:

- Temperature
- Blood Pressure
- Pulse
- Respiratory Rate
- Uterine contraction and Lochia
- Emotional and Psychological wellbeing
- Bladder care (successful void of urine)

Analgesia requirements should be assessed and offered as appropriate.

Diet and fluids should be offered as soon as the woman/birthing person is able.

**Baby**

Initial Examination should be performed to detect any major physical abnormalities and any problems that require referral to the neonatal team.

If the baby requires resuscitation the Resuscitation – Network guideline 2022-24 should be followed.

Thermoregulation following birth is crucial for neonatal wellbeing. In the absence of neonatal resuscitation, baby should be placed skin to skin with mum if she is well and alternative birth partner if woman/birthing person is unable/wishes not to. If skin to skin is declined, baby should be thoroughly dried, wrapped and kept warm (and dressed as soon as possible). A red blanket should be provided for babies at risk of hypothermia, as per: Temperature management including Hypothermia - Network guideline 2022-24.

Babies should be fed within 1 hour of birth – either breastfeeding or bottle feeding. The first feed should take place in skin to skin, ensuring that the baby is dry and covered to prevent heat loss. Feeding conversations should have taken place in the antenatal period and during the birth plan discussion at the initial assessment.

## Appendix 1: BRAINS