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 the routine management of labour within the

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 Patient Experience Midwife
Caitlin Wilson	Consultant Midwife
Laura Veal	Consultant Obstetrician (Clinical Director for Maternity)
Approved by *Maternity Governance Meeting* on:	28th February 2025
Approved by Medicines Safety Committee on: *Where medicines included in guideline*	13th September 2023
Review Date: This is the most current document and should be used until a revised version is in place	28th February 2028

Key amendments to this guideline

Date	Amendment	Approved by:
Aug 2023	Complete revision of Guideline to bring in line with NICE guidance.	MGM
Feb 2025	Updates including second midwife at birth, clarity around MBC criteria for GDM and updated BRAINS tool.	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:	**MGM 28/02/2025**

Contents

Communication of Care throughout Labour

All care professionals will treat all women in labour with respect. Ensuring that the woman 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, 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 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 that all is going well.
- Knock and wait before entering the woman's room, respecting it as her personal space, and ask others to do the same.
- Ask how the woman is feeling and whether there is anything in particular she is worried about.
- If the woman has a written birth plan, read and discuss it with her.
- Assess the woman's knowledge of strategies for coping with pain and provide balanced information to find out which available approaches are acceptable to her.
- Encourage the woman to adapt the environment to meet her individual needs.
- Ask her permission before all procedures and observations, focusing on the woman rather than the technology or the documentation.
- Show the woman and her birth 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 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.

Decision making

All decision making before, during and after labour should encompass the BRAIN 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'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 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.

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'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 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 as per WHAT

- 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 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 about the risks and benefits of the procedure. The woman and her birthing partners should be aware that artificial rupture of membranes is an intervention.

Latent stage of Labour

Latent first stage of labour can be defined as a period of time, 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 how she is, and about her wishes, expectations and any concerns she has
- Asking the woman about the baby's movements, including any changes
- Give information about what the woman 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, 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's Home
- On the Midwifery Led Unit
- In Maternity Triage

And should include:

- All of 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. (See Fetal Monitoring -Intrapartum)

If the woman appears to be in established labour, a vaginal examination should be offered. This should be discussed with the woman 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, 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 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 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'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 and her partner. This care should be continually assessed with the aim of enabling the woman to feel confident to return home.

- Contacts should be made with the woman **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

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

Following assessment and discussion with the woman, it is important to put a care plan in place. Encouragement should be given for the woman 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 needs to be transferred

If there is a delay in transfer of the woman of more than 30 minutes due to capacity or staffing issues provide 1:1 care on the ward or in triage and document all care given.

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

Transfer of care from MLC to CLC

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

Observations of the woman:

- 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 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.

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 woman
- 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 reported by the woman.

If none of these are observed, continue with previous plan of care unless the woman requests transfer (NICE 2014).

If birth is imminent, assess whether birth in the current location is preferable to transferring the woman to an obstetric unit and discuss this with the shift leader (NICE 2014). If birth is not imminent, transfer the woman to obstetric-led care (please follow Transfer of Care guidance)

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

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 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.

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 is being transferred from triage or the ward to delivery suite, this may not be possible but should be done as soon as the woman has been transferred). 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, temperature and offer vaginal examination

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

Consider the woman's emotional and psychological needs, including her desire for pain relief.

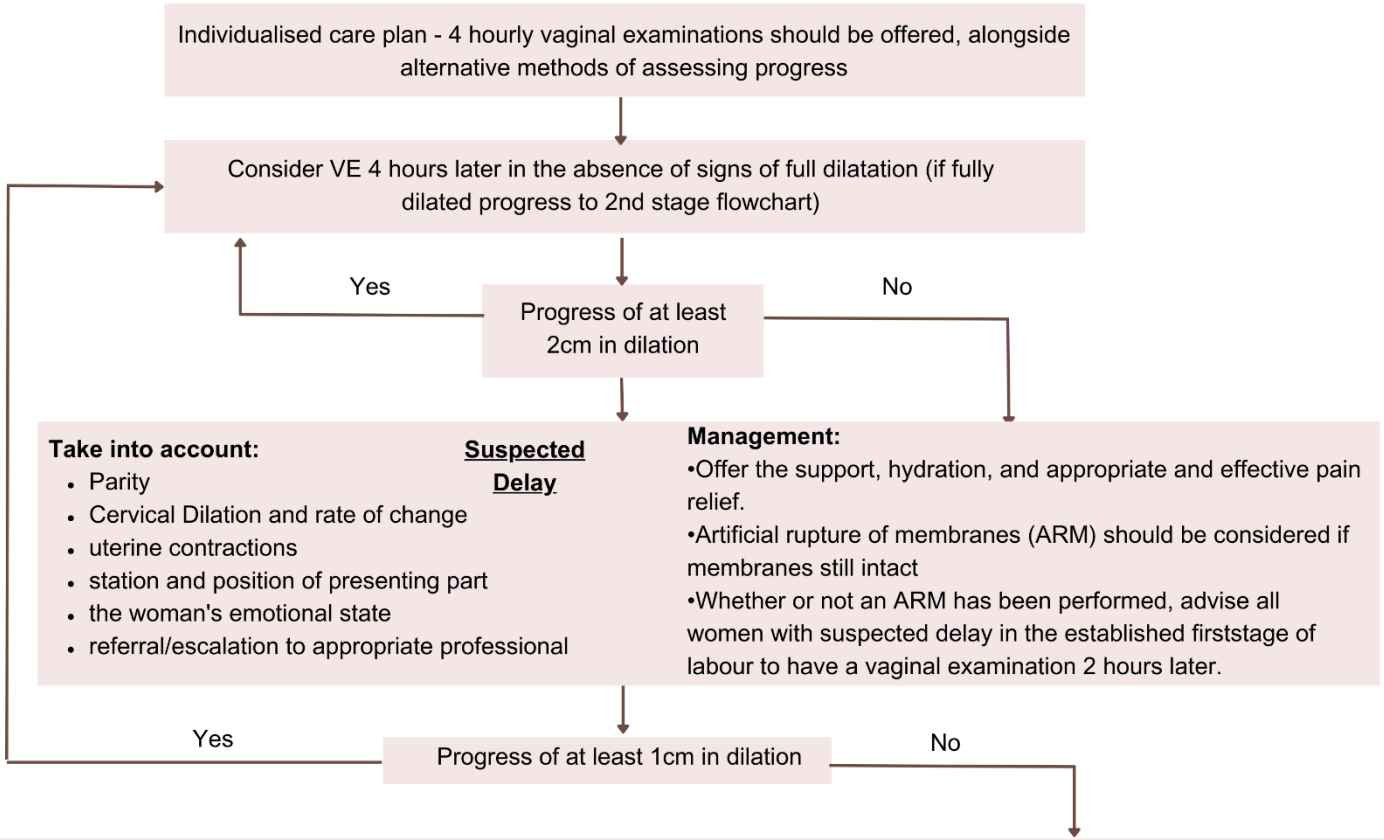
Encourage the woman to communicate her need for analgesia at any point during labour.

- Do not routinely offer the package known as active management of labour (one-to-one continuous support; strict definition of established labour; early routine amniotomy; routine 2-hourly vaginal examination; oxytocin if labour becomes slow).
- In normally progressing labour, do not perform amniotomy routinely.
- Do not use combined early amniotomy with use of oxytocin routinely.

Follow Fetal Monitoring -Intrapartum

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

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.

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

Carry out the following observations in the second stage of labour, record all observations on the partogram and assess whether transfer of care may be needed (see the recommendation on ongoing assessment):

- half-hourly documentation of the frequency of contractions
- hourly blood pressure
- continued 4-hourly temperature
- frequency of passing urine
- offer a vaginal examination hourly in the active second stage, or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss).

In addition:

- Continue to take the woman's emotional and psychological needs into account.
- Assess progress, which should include the woman's behaviour, the effectiveness of pushing and the baby's wellbeing, taking into account 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 woman's pulse every 15 minutes to differentiate between the two heartbeats.
- Ongoing consideration should be given to the woman's position, hydration, coping strategies and pain relief throughout the second stage.

Physiological positions and pushing

- 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.
- Inform the woman 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, 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 the woman 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 to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.

For a Primiparous woman, suspect delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 1 hour of active second stage. Offer vaginal examination and then offer amniotomy if the membranes are intact. [2007, amended 2014]

For a multiparous woman, 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. [2014]

If full dilatation of the cervix has been confirmed in a woman without regional analgesia, but she does not get an 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 is excessively distressed, support and sensitive encouragement and the woman's need for analgesia/anaesthesia are particularly important.

An obstetrician should assess a woman 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 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 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.

Do not offer episiotomy routinely at vaginal birth after previous third- or fourth-degree trauma.

In order for a woman 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.

Provide tested effective analgesia before carrying out an episiotomy, except in an emergency because of acute fetal compromise.

Second Midwife

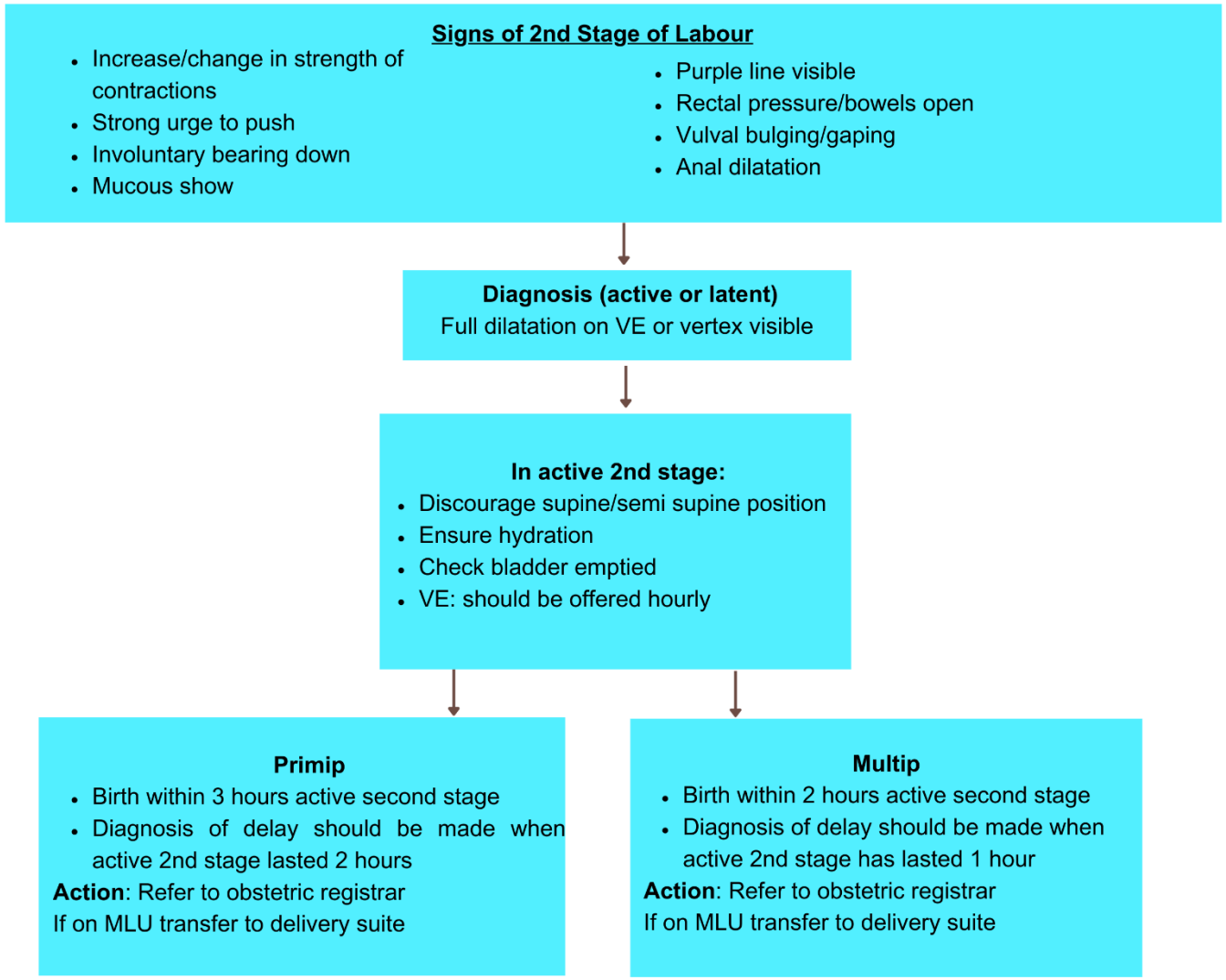
There should be a second midwife present for the birth, and they should remain present until the 3rd stage of labour has been completed, and the woman is stable.

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 cases of hypertension or any contraindications to syntometrine. A woman 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'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 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 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

CO-PRODUCED WITH WORCESTERSHIRE MNVP

BRAINS Supporting you to make decisions about your maternity care

NHS Worcestershire Acute Hospitals NHS Trust

Every time a doctor or midwife is talking to you about possible treatment/actions it is your choice whether this is right for you and your baby. To help you make decisions about your care, all our doctors and midwives have been trained to discuss your options using the BRAINS tool.

B – BENEFITS

Why have I been offered the treatment/ action?

What are the possible benefits?

R – RISK

What are the risks to me and my baby?

How could this affect my birth options and experience of pregnancy and birth?

A – ALTERNATIVES

What are all of the alternative choices available to me?

If I'm not comfortable with all the plan that is recommended, can I choose parts of it?

Consider the risks and benefits.

I – INTUITION

What does my gut tell me?

What do I feel is the right option for me and my baby?

Is there anything else that is important to me?

N – NOTHING

What would happen if we waited an hour? A day? A week?

What would my care look like going forward?

Consider the risks and benefits.

S – SPACE

You should always be given time and space to make a decision, this should include:

- Time to discuss with your support partner.
- Time to consider extra information or research.
- Time to ask questions.

The time you are given may vary depending on how urgent the decision is. For example, the time may be limited.

Please ask questions and ask for evidence or additional information.
You can change your mind at any time.

Version 1: February 2025

Contribution List

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
All Maternity Staff - Newsletter

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Maternity Governance Meeting Medicines Safety Committee