Care in Labour Including Risk Assessment

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Key Amendments

Date	Amendments	Approved by

Introduction

This guideline and pathways are based on the NICE Intrapartum care guideline (NICE 2008). They should be used for all women in labour. The pathways should be used for both hospital and home deliveries.

Delivery rooms can be adapted to meet individual women's needs, including removing the bed and introducing exercise balls and a mat or mattress on the floor.

All care must be documented in the relevant section of the woman's records (this includes handheld pregnancy records, antenatal admission sheets, the birth notes and CTG.

Definition of established labour (NICE 2007) - Active labour is established when the cervix is more than 4 cms dilated and fully effaced in the presence of regular, painful contractions.

Details of Guideline

See pathways below (NICE CG 55 Intrapartum Care 2008).

1. Individualised Care in Labour

Each birth is unique and care in labour should be tailored for each individual woman, taking into consideration her values, beliefs and plans (NICE 2007). If obstetric or other medical involvement is necessary, the midwife must continue to be responsible for providing holistic support, maximising continuity of carer and promoting labour, as far as possible, as a normal physiological process (RCOG 2007).

2. Communication

Communication is integral to the care of women in labour and has a significant impact on the provision of optimum care. All women in labour should be treated with respect and should be in control of and involved in what is happening to them. The way in which care is given is key to this (NMC 2008), all health care professionals must establish a rapport with the labouring woman, confirming her needs and expectations for labour, being aware of the importance of tone and demeanour, and of the actual words they use (NICE 2007).

3. Labour Care

The timely diagnosis of active labour can be problematic for both women and midwives. A mistaken diagnosis of active labour can lead to a subsequent diagnosis of labour dystocia and a consequent

cascade of interventions (RCM 2008). NICE (2007) recommends the following definitions for the latent phase and first stage of labour.

The latent phase of labour is 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 4cm. Delivery Suite may not be the most appropriate environment for these women and they may be encouraged to return home and return when they feel more support is needed. An individualised management plan must be agreed with the woman and documented in the woman's records (this includes either the green hand held pregnancy notes, the antenatal admission sheet or the birth notes).

The first stage of labour is defined from when there are regular painful contractions and there is progressive cervical dilation from 4cm (NICE 2007).

4. Clinical risk assessment when labour commences

Initial assessment may take place as part of the telephone triage process, when the labouring woman first contacts the unit. For women who are planning a homebirth, the community midwife attending will assess her continued suitability, considering developing risk factors such as raised blood pressure or meconium stained liquor. Those who attend hospital in labour will be assessed for the following as a minimum: ,

- Confirm gestation
- Medical history
- Anaesthetic history if relevant
- Family history
- Previous obstetric history
- Social and lifestyle history
- Current pregnancy, particularly any documented management plan
- Maternal preferences and plans for labour including pain relief (review written plan if present)

The following minimum observations must be carried out on admission in labour (unless delivery is imminent) and should be recorded on either the Antenatal Admission Sheet or the Birth Notes.

- a history from the woman to include onset and duration of labour, vaginal loss and contractions
- maternal temperature, pulse, blood pressure (BP) and perform urinalysis (unless the woman is unable to provide a specimen – this should be documented in the relevant records).
- abdominal palpation, to confirm presentation, lie and position of fetus
- auscultation of fetal heart rate for one minute with Pinards or handheld Doppler
- palpation of contractions for frequency, duration and strength

- a vaginal examination if clinically indicated

The assessment and observations must be clearly documented. If any risks are identified they should be documented in the management plan.

On identification of any clinical risk factors, the midwife must:

- inform the woman of any risk factors identified
- refer to the Labour Ward Co-ordinator, on-call obstetrician, or any other members of the multidisciplinary team as appropriate
- document referral in the woman's records (this includes either the green hand held pregnancy notes, the antenatal admission sheet or the birth notes).

Clinical risk factors are not exhaustive; the midwife should refer any deviations from normal to the Obstetrician. Clinical risk assessment should be ongoing throughout the woman's labour. The importance of one to one care is paramount, allowing for identification of clinical risk factors if and when they occur during labour. At any point a healthcare professional who is unhappy with the advice given can contact the Consultant Obstetrician and/or Supervisor of Midwives for support and advice. Contact details are available on Delivery Suite or via Switchboard.

5. Individualised management plan

An agreed plan for labour should be documented in the Birth Notes. During labour all discussions and changes to the management plan should be documented and the lead professional identified.

6. Observations in the first stage of labour (Appendix A)

The partogram must be commenced when established labour is confirmed.

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.

7. One to one care in labour.

Once established labour has been confirmed, it is recommended that the woman should receive supportive one-to-one care and not be left on her own except for short periods or at her request (NICE 2007). Continuous support in labour is associated with less use of pharmacological analgesia, fewer operative births and associated with increased satisfaction of childbirth. Safer Childbirth (RCOG 2007) recommend as a minimum standard that women in established labour receive one-to-one care throughout established labour: enhancing maternal health, satisfaction and fetal outcome. This guideline recognises that one to one care is not always possible.

8. Birth Environment and support

The environment in which a woman labours can have a significant effect on the amount of fear and anxiety experienced. Hospital can be an environment which may contribute towards a woman feeling a loss of control. Increased anxiety exacerbated by loss of control can interfere with the normal effective physiology of labour. Respect for a woman's wishes and her involvement in decision making is essential to her care in labour (NICE, 2007). A home-like environment is associated with lower rates of analgesia, augmentation and operative delivery, as well as greater satisfaction with care. The woman should be encouraged to adapt the labour room to meet her individual needs (NICE 2007). The birth environment is key to freedom of movement, there should be a variety of props available in the room that encourage women to try different positions in labour.

Midwives must be proactive in demonstrating and encouraging different positions in labour (RCM 2008). The use of postural coping strategies during the first stage of labour is associated with providing some pain-relief. Women often 'choose' to do what is expected of them, the most common image of the labouring woman is 'on the bed'. Therefore women must be encouraged and helped to move and adopt whatever positions they find most comfortable throughout labour (NICE 2007).

Women in labour have need for companionship, empathy and help. The majority of women are accompanied in labour by their partners, women should be encouraged to have support by birth partners of their choice (NICE, 2007). Continuous support has been shown to reduce the need for analgesia in labour, operative birth and dissatisfaction with their childbirth experiences.

9. Progress in the 1st stage of labour (Appendix A)

Monitoring the progress of labour requires more than the cervical changes and fetal descent. Midwives should give weight to their other skills, such as abdominal palpation and a knowledge of women's changing behaviour. Vaginal examinations remain the most accepted method of measuring progress in labour.

However vaginal examinations should only be carried out after discussion with the woman and when the midwife can justify that it will add important information to the decision making process (NICE 2007). Vaginal examinations are an imprecise measure of the progress of labour when performed by different examiners because of the potential for inter-observer variability. Where possible they should be carried out by the same midwife or obstetrician, consent for each vaginal examination must be obtained (NICE 2007).

Progress in the first stage of labour should include:

- Cervical dilation of 2cm in 4 hours

When assessing progress, consideration must be given to the following:

- Descent and rotation of the fetal head
- Changes in strength, duration and frequency of contractions

Consideration of the woman's total wellbeing (refer to record of observations). These features should be recorded in the birth notes in addition to a record of the fetal heart rate.

Clinical intervention should not be offered or advised where labour is progressing normally and when the woman and baby are well.

If delay is suspected, discuss this with the delivery suite co-ordinator and record this in the birth notes. Refer to appendix D.

At this stage, the woman should be informed and offered support, hydration and appropriate pain relief.

10. Pain relief

Midwives must inform the woman regarding choices of pain relief, helping her choose from non-pharmacological and pharmacological methods. The value of women's own coping resources should be recognised and maximised, rather than placing an over-emphasis on pharmacology. Coping mechanisms can be enhanced through supportive one-to-one care in labour. Midwives must consider their personal attitude to coping with pain in labour and ensure that care supports the woman's choice. Support and encouragement is paramount, as is informing the woman that she may ask for analgesia at any point during labour (NICE 2007).

10.1 Pain-relieving strategies

- encourage the use of the birthing pool, water often relaxes and reduces pain
- support women's use of breathing / relaxation techniques, massage, music
- acupuncture, acupressure and hypnosis should not be provided, but should not prevented if women wish to use these
- do not introduce transcutaneous electrical nerve stimulation (TENS) to women in established labour

10.2 Inhalation analgesia and opioids

The midwife must provide the woman access to Entonox and opioids such as pethidine or meptazinol. If the woman chooses an opioid an antiemetic must be offered, and the women advised not to use the birthing pool or bath within 2 hours of the dose or if she remains drowsy beyond this time.

10.3 Epidural anaesthesia

- If a woman is considering choosing an epidural, she should be informed how it will be

administered and possible effects upon her labour. Prior to administration a thorough discussion with the anaesthetist will take place and informed consent will be gained.

11. The 2nd stage of labour (Appendix B)

NICE (2007) recommend the following definitions of the second stage of labour

Passive second stage of labour:

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

Active second stage of labour:

- expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilation of the cervix
- active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions
- the baby is visible

11.1 Care in the 2nd stage of labour

If full dilatation of the cervix has been diagnosed in a woman without epidural analgesia, but she does not get an urge to push, further assessment should take place after 1 hour.

- consider the woman's position, hydration and pain relief needs
- provide support and encouragement

11.2 Observations in the second stage of labour

All observations should be continued in accordance with clinical judgment and documented on the partogram or in the birth notes, as in the 1st stage of labour. However increased monitoring must include:

- In active second stage every 5 minutes following a contraction: check the FHR for a full minute
- assessment of progress must include maternal behaviour, effectiveness of pushing and fetal wellbeing, taking into account fetal position and station at the beginning of the second stage. These factors will assist in timing of further vaginal examination and the need for obstetric review.
- if there is suspected fetal bradycardia or any other anomaly in the fetal heart rate, the maternal pulse must be palpated to differentiate the two heart rates.

11.3 Risk assessing in the 2nd stage of labour (See appendix D).

Nulliparous women:

- birth would be expected to take place within 3 hours of the start of the active

stage of labour

- a diagnosis of delay in the active second stage should be made when it has lasted 2 hours. Referral should be made to the obstetrician if birth is not imminent.

Parous women:

- birth would be expected to take place within 2 hours of the start of the active stage of labour
- a diagnosis of delay in the active second stage should be made when it has lasted 1 hour. Referral should be made to an obstetrician if birth is not imminent

When delay in the second stage of labour is diagnosed the Delivery Suite Co-ordinator must be informed and Obstetric referral must be made. This must be discussed with the woman and documented in the Birth Notes. An individual management plan must then be made and recorded in the Birth Notes.

The midwife / student midwife / doctor must ensure a swab and instrument count is performed pre and post delivery. Checking procedures should be documented and signed in the yellow birth records. (NPSA Safety Alert – Retained swabs after vaginal birth; May 2010)

11.4 Interventions to reduce perineal trauma in the 2nd stage of labour

Antenatal perineal massage is an effective approach to increasing the chance of an intact perineum and in reducing instrumental deliveries.

- perineal massage must not be performed in the second stage of labour
- tested effective analgesia must be provided prior to carrying out an episiotomy, except in an emergency due to acute fetal compromise
- episiotomy should not be offered routinely at vaginal birth following previous 3rd or 4th degree trauma
- women with previously undisclosed infibulated genital mutilation should be informed of the risks of delay in the second stage of labour and spontaneous laceration together with the need for an anterior episiotomy and the possible need for defibulation in labour

12. The 3rd stage of labour. (Appendix C)

The third stage of labour is the time from the birth of the baby to expulsion of the placenta and membranes, midwives should be competent in both active and physiological management. Physiological management can be seen as the logical ending to a normal physiological labour. Women at low risk of postpartum haemorrhage who request physiological management of the third stage of labour should be supported in their choice (NICE 2007).

If physiological management is attempted but intervention is subsequently required, then management must proceed actively. If the placenta is retained after one hour, active management should be considered (NICE 2007)

Active management is superior to physiological in terms of blood loss with the potential adverse

effects of active management being nausea, vomiting, headache and hypertension.

12.1 Physiological management:

- no oxytocin
- no clamping of the cord
- delivery by maternal effort only
- no palpating of the uterus or pulling on the cord

If delivery is not achieved within one hour active management is indicated.

There is increased risk of bleeding if the cord snapped during physiological management. In that case, consider active management of third stage with syntometrine 1ml IM injection.

12.2 Active management

Active Management reduces the risk of haemorrhage and shortens third stage and is achieved by:

- administration of Syntometrine 1ml IM
- clamping and cutting of the cord at 2 minutes
- controlled cord traction after signs of separation have occurred

If delivery of the placenta and membranes is not achieved within 30 minutes of administration of the oxytocic drug, consider a diagnosis of retained placenta and follow the management of retained placenta guideline.

12.3 Observations in the third stage of labour

Observations undertaken should be documented on the partogram or in the birth notes

- If clinically indicated, monitor the woman's physical condition considering her colour, BP, pulse, respirations and her own report of how she feels.
- vaginal blood loss

In the presence of haemorrhage and or maternal collapse frequent maternal observations are required and the management of primary postpartum haemorrhage including massive obstetric haemorrhage guideline (WAHT-OBS-030) must be followed.

13. Care immediately post-delivery (Appendix C)

13.1 Perineal assessment

Assessment of perineal trauma should be performed gently and with sensitivity in the immediate period following birth (NICE 2007).

Before assessing for perineal trauma ensure analgesia is effective and afterwards, explain and

document the extent of any trauma in the birth notes.

If perineal trauma is identified a systematic assessment of genital trauma should be undertaken and for perineal repair follow the guideline Perineal Tears and Repair

13.2 Maternal observations

Maternal observations to be completed following the completion of the third stage must include the following and be recorded in the birth notes:

- maternal temperature
- pulse rate
- blood pressure
- uterine contractility
- lochia
- examination of the placenta and membranes to include
    - assessment of their condition
    - number of cord vessels
    - completeness of the placenta and membranes
- normal voiding of urine in accordance with the bladder care policy (Intrapartum & postpartum bladder care).

13.3 Care of the baby

Early mother-baby contact should be encouraged as soon as clinically possible and preferred by the mother. Early close contact has positive effects on the initiation and duration of breastfeeding.

Mothers should have access to support for their baby's first breastfeed.

Documentation

The midwife must maintain contemporaneous records (NMC 2004) and is responsible for the completion of the following documentation:

- the partogram, to include documentation of all maternal and fetal observations.
- labour summary
- baby health care records
- postnatal records
- birth notification

- birth register
- Registering the baby on the hospital PAS system.

Appendix A- First Stage of Labour Algorithm

Care throughout labour

- Discuss the woman's options and expectations for labour
- Don't intervene if labour is progressing normally
- Ensure supportive one to one care when clinical judgment
- indicates the need
- Do not leave the woman on her own when in active labour
- Encourage the support of birth partner(s)
- Encourage the woman to mobilise and adopt comfortable
- positions
- Do not give H2 receptor antagonists or antacids routinely
- to low risk women

Vaginal Examination

- Tap water may be used for cleansing prior to the exam
- Ensure exam is really necessary
- Ensure consent is obtained
- Record and explain findings

Initial Assessment

- Review records for relevant social, medical and obstetric history
- Undertake baseline observations, according to clinical judgment: Temperature, pulse, blood pressure, urinalysis
- Palpate abdomen and observe contractions and monitor fetal heart rate in accordance with clinical judgment
- Offer vaginal exam, in accordance with clinical judgment

For coping with pain see page 6

Women not in established labour

If, according to clinical judgment, initial assessment is within normal limits, offer support and encourage woman to remain at or return home

For prelabour rupture, **see OBS-005/ OBS-009**

First stage of labour

Use a partogram once labour is established

Use clinical judgment 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
- Every 30 mins: document frequency of contractions
- Every hour: check pulse
- Every 4 hours: Check BP, temperature and offer vaginal exam
- Check frequency of bladder emptying in accordance with the bladder care policy **(see WAHT-OBS-094)**

Concerns (seek obstetrician advice)

Indications for electronic fetal monitoring (EFM) in low risk women eg. Significant meconium-stained liquor, abnormal FHR, maternal pyrexia, fresh bleeding **see WAHT-OBS-001**

↑diastolic BP (over 90mm\Hg) or ↑systolic BP (over 140 mmHg twice), at least 30 mins apart

Uncertainty about the presence of a fetal heart rate

Suspected delay:
Nulliparous < 2cm dilatation in 4 hrs

Parous <2cm dilatation in 4 hrs or slowing in progress

Appendix B- Second Stage of Labour Algorithm

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Second stage of labour

- In active second stage every 5 min after a contraction: Check FHR
- Every hour: check BP, pulse
- After a baseline temp is taken, repeat every 4 hrs if clinically indicated
- Check frequency of bladder emptying in accordance with the bladder care policy
- Assess progress, including fetal position and station
- If woman has full dilatation and no urge to push, assess after 1 hour
- Consider the woman's position, hydration and pain-relief needs- provide support and encouragement

For coping with pain see page 6

Concerns (seek obstetrician advice)
Indications for electronic fetal monitoring (EFM) in low risk women eg. Significant meconium-stained liquor, abnormal FHR, maternal pyrexia, fresh bleeding
Nulliparous: consider oxytocin and discuss pain relief options, if contractions inadequate at onset of second stage
Delay
Nulliparous: active second stage 2 hours
Parous: active second stage 1 hour

Episiotomy
(seek obstetrician advice/ healthcare professional trained in operative vaginal birth)

Carry out episiotomy only when there is:

- Clinical need such as instrumental birth
- Suspected fetal compromise

Do not offer routinely following previous third- or fourth- degree trauma

Use mediolateral technique (between 45° and 60° to right side, Originating at vaginal fourchette)

Use appropriate analgesia

Birth

Appendix C- Third Stage of Labour Algorithm

Third Stage of labour
Observe physical health
Active Management:

- administer syntometrine (1Ml),
- clamp and cut the cord after 2 minutes and
- controlled cord traction after signs of separation have occurred

Physiological Management:

- no oxytocin
- no clamping of the cord
- delivery by maternal effort only
- no palpating of the uterus or pulling on the cord

Concerns (seek obstetrician advice)
Retained Placenta

Active Management: >30 min

Physiological Management: >1hour

See WAHT-OBS-091

Care after birth
Woman: If clinically indicated, observe and record the woman's temperature, BP, pulse, respirations, how she feels, uterine contractions, lochia and bladder voiding (see WAHT-OBS-094)
Examine the cord, placenta and membranes.
Baby: record Apgar score at 1 and 5 min and keep warm
Encourage skin to skin contact between woman and baby as soon as possible and avoid separating woman and baby in the first hour, in accordance with clinical judgment and woman's choi
Aim to initiate breastfeeding within the first hour
After 1 hour record baby's body temperature and weight

Concerns (seek obstetrician advice)

Suspected postpartum haemorrhage: take emergency action,

Basic resuscitation of newborn babies should be started with air, see **WAHT-NEO-003**

Perineal Care
Carry out systematic assessment of any trauma with the use of analgesia, including a rectal examination. Explain assessment to the woman and document the extent of any trauma in the Birth notes.

Second degree trauma: suture vaginal wall and muscle for all second-Degree tears. Suture skin unless well opposed.

Use continuous non-locked technique for suturing vaginal wall and muscle.

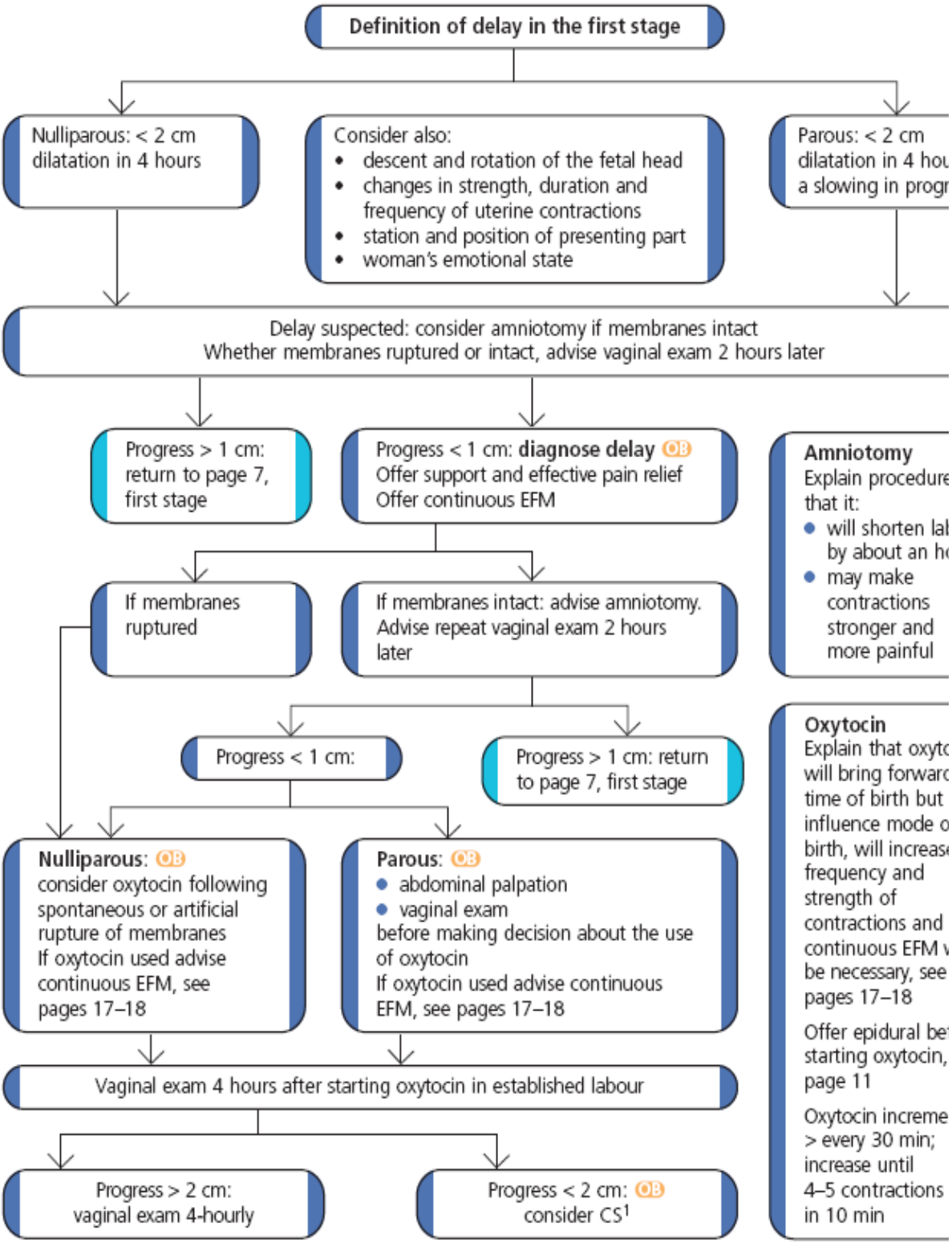
Use continuous subcuticular technique for suturing skin.
Consider offering rectal NSAIDs following perineal repair.

Concerns (seek obstetrician advice)
Refer if uncertain of the nature / extent of trauma

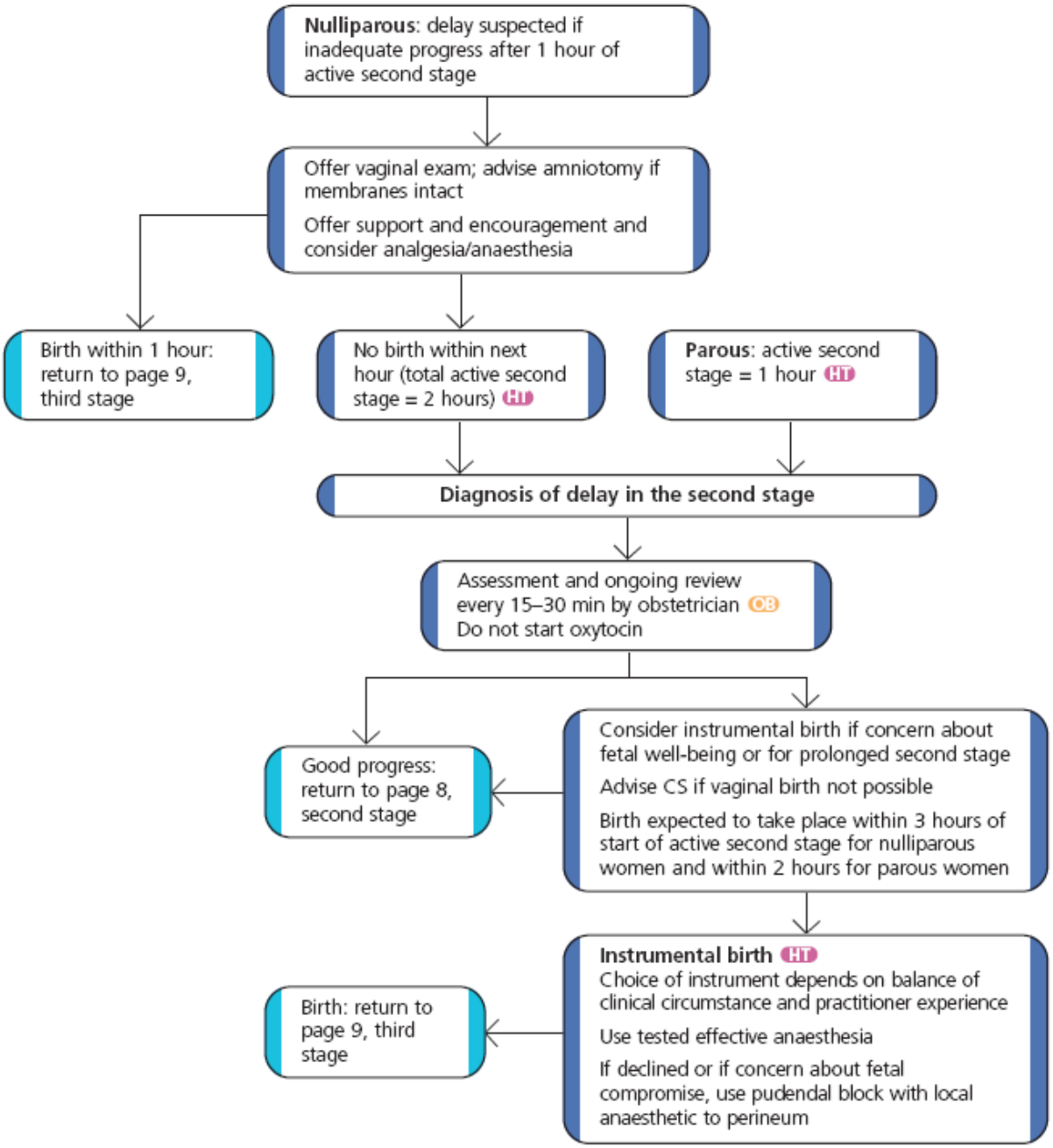
Third- or fourth-degree trauma

Complications

Delay in the first stage



Delay in the second stage



Key:

OB seek obstetrician advice (transfer to obstetric unit if appropriate)

HT healthcare professional trained in operative vaginal birth