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Maternity Clinical Guideline for Intrapartum Care

For use in:	Maternity Services
By:	Obstetricians and Midwives
For:	The care of women in labour in all care settings
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Name of document author:	Practice Development Midwives Updated by Tracey Miller. Updated In May 2020 By Mr Charles Bircher. Updated in March 2021by Malissa Rayfield.
Job title of document author:	MLBU, Team Leader
Name of document author's Line Manager:	Emma Hardwick
Job title of author's Line Manager:	Head of Midwifery
Supported by:	Mr David Fraser - Consultant Miss Daisy Nirmal - Consultant
Assessed and approved by the:	Maternity Guidelines Committee (MGC) If approved by committee or Governance Lead Chair's Action; tick here ☑
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Compliance links: *(is there any NICE related to guidance)*	NICE (2014) CG55 Intrapartum care. Care of healthy women and their babies during childbirth.
If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why?	No

This guideline has been approved by the Maternity Guidelines Committee as an aid to the diagnosis and management of relevant patients and clinical circumstances. Not every patient or situation fits neatly into a standard guideline scenario and the guideline must be interpreted and applied in practice in the light of prevailing clinical circumstances, the diagnostic and treatment options available and the professional judgement, knowledge and expertise of relevant clinicians. It is advised that the rationale for any departure from relevant guidance should be documented in the patient's case notes.

The Trust's guidelines are made publicly available as part of the collective endeavour to continuously improve the quality of healthcare through sharing medical experience and knowledge. The Trust accepts no responsibility for any misunderstanding or misapplication of this document.

Version and Document Control:

Version Number	Date of Update	Change Description	Author
9.3	01/05/2020	Risk assessment form corrected	Mr Charles Bircher
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10.1	05/03/2021	Minor amendment made.	Malissa Rayfield
10.2	26/11/2021	Low risk changes – amendment to appendix	Tracey Miller Beth Revell

This is a Controlled Document

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Quick reference guideline

For the purpose of this guideline, labour means 'established labour' which is classified as the onset of regular painful contractions, accompanied by progressive cervical dilatation from 4cm (NICE 2014). Observations of demeanour, body language and vocalisations will contribute to the assessment of onset and progress in labour and the woman's ability to cope.

Objectives

To facilitate a safe, emotionally fulfilling birth experience.

Rationale for the recommendations

Care in labour should be aimed towards achieving the best possible outcome for mother and baby. The primary purpose of risk assessment in obstetrics is the prevention and consequent reduction of maternal and perinatal morbidity and mortality through early identification and intervention.

This guideline provides standards of care in labour for women at term in all care settings and is adapted from NICE intrapartum care (2014).

Risk assessment for appropriate place of birth

All women are risk assessed for place of birth in the antenatal period. They are subsequently reassessed when making contact with the midwife via the telephone when labour commences which is documented on electronic telephone contact on E3 and should refer to any risks/alerts on E3. On arrival in labour a further risk assessment should be carried out using the assessment tool (Appendix 1), ensuring the appropriate place of birth has been identified.

If risk assessed as low risk, women can still request delivery on the consultant lead unit.

Any woman who has risk factors identified but may be suitable for midwife led care on delivery suite or MLBU should be reviewed by the obstetric team on call and an individualised plan documented in her maternity hand-held records.

If a woman attends for delivery without her hand held records and without any other means of identification to verify who she is, then she should not be discharged with a baby until we have satisfactory evidence of her identity. The partner or a relative/friend should be asked to collect the hand held records. If any adverse reaction or refusal to get the records (prior to discharge) ensues, then it can reasonably be assumed that this is a suspect case and further investigations should be undertaken with the Safeguarding Children Team, CADS (Children's Advice and Duty Service) and potentially the hospital where they profess to have been booked at.

Observations to be carried out on admission in labour

Document all observations.

- Listen to her history including fetal movements, and review records
- Temperature, pulse, blood pressure (BP), respiratory rate and urinalysis
- MEOWS attributed and if ≥ 3 follow call out cascade
- Weight (not for homebirths).
- Length, strength and frequency of contractions.
- Abdominal palpation (AP).
- Auscultation of fetal heart with Pinard's stethoscope or hand held Doppler for at least one minute after a contraction, with simultaneous palpation of maternal pulse to differentiate the two.
- Admission CTG only in high risk women.
- Assessment of woman's pain.
- If she appears to be in established labour, offer vaginal assessment.

Criteria for MLBU care (low risk women) – See Appendix 1

- Between 37+0 and 42+0 weeks gestation.
- Age: if > 40 at booking, in spontaneous labour before planned induction of labour (IOL), as agreed with consultant obstetrician.
- Para 0-5 (excluding miscarriages and terminations).
- Singleton pregnancy.
- BMI < 40 on admission in labour and good mobility – the admitting midwife needs to calculate and assess this on admission.
- Cephalic presentation.
- Spontaneous onset of labour or artificial rupture of membranes (ARM) only IOL.
- If membranes have ruptured, liquor must be clear/non-significant meconium stained.
- Rupture of membranes must be less than 24 hours at onset of labour.
- No epidural requested.
- No known or envisaged medical, obstetric, anaesthetic or neonatal complication.
- No previous significant obstetric history.
- No known history of HIV or Hep B.

- HB over 9.0g/l.

Multi-disciplinary care in low risk women not suitable for MLBU

Some factors require a multidisciplinary team approach. For example, women who are a grand multip but are otherwise deemed low risk will be suitable for midwifery led care on the delivery suite after discussion between obstetricians, anaesthetists and midwifery coordinators. See Appendix 1

Guidance on referral to obstetric care when risks are identified

Ongoing risk assessments are essential throughout labour. These must be formally recorded at each handover of care using the trust approved SBAR handover sticker. If at any time during labour a low risk woman deviates from the normal pathway, transfer to delivery suite for Obstetric review may be necessary. When obstetric review has been requested the date and time of this request must be documented.

For patients already on continuous fetal monitoring, risk factors should be reviewed and documented every hour with the fresh eyes review.

Any change of lead professional must be documented within the hand held notes and the midwife should inform the receptionist to make the necessary change on PAS.

CARE IN LABOUR

Environment

The birthing environment should be thoughtfully considered as it may influence the woman's psychological wellbeing and her ability to adopt alternative positions and feel relaxed (Walsh 2007). Any emergency equipment including neonatal resuscitation equipment should be prepared and checked in all birth settings and documented in the handheld records. It should also be re-checked at each handover of care.

Communication

Communication with the woman and her birth supporter(s) is vital and can have a positive or negative impact on her birthing experience. All women must be treated with respect and should be in control of and involved with what is happening to them (NICE 2014).

Nurturing a positive emotional state will promote normal labour. Anxiety, body tension and increased stress hormones may reduce oxytocin's influence, increasing the potential for dysfunctional labour (Odent 2001 and Buckley 2004).

Eating and drinking in labour

Low risk women may eat a light diet in established labour unless they have received opioids or they develop risk factors that make general anaesthesia more likely (NICE, 2014). For these women isotonic drinks may be more beneficial than water. Adequate fluid intake to maintain hydration is important and urinalysis will help inform this assessment. High risk women may have clear fluids when in established labour.

Patients meeting the following criteria should be given ranitidine 150mg 6-hourly or Omeprazole 40mg 12-hourly orally during labour:

- Suspected fetal compromise – e.g. Abnormal CTG or FBS, significant meconium.
- Known / suspected placental insufficiency.
- Slow progress in labour.
- Previous uterine scar.
- Multiple pregnancy.
- Breech presentation.
- Diabetics
- PIH / PET
- Known anaesthetic problems

Bladder care

Women should be encouraged to empty their bladder frequently during labour to minimize the risk of retention of urine. After 4 hours the bladder must be emptied. All output must be documented. A full bladder may affect the normal course of labour. Be particularly vigilant in women with regional analgesia whose sensation may be impaired for some time (see guideline Bladder Care in Labour and Postnatally *Trustdocs ID 12617*)

Observations in the First Stage of Labour

Document all observations on the partogram once labour is established. A four hour action line should also be drawn.

- **Hourly maternal pulse** - report to obstetrician if greater than 120 on 2 occasions 30 minutes apart (NICE 2014).
- **Four hourly BP** – Refer to Obstetrician if:
    - Single reading >160 systolic or >110 diastolic.
    - Raised systolic >140 or diastolic >90 on 2 readings at least 30 mins apart.
    - +2 or more proteinuria (see Trust Guideline for the Management of: Severe Pre-Eclampsia and Eclampsia *Trustdocs ID 887*)

- **Four hourly temperature** - pyrexia of 38°C or greater on one occasion or 37.5°C twice (2hrs apart) must be reported to obstetrician and co-ordinator (NICE 2014). Hypothermia of less than 35.5°C must be reported to an obstetrician and co-ordinator (see guideline Management of Maternal Pyrexia in Labour *Trustdocs ID 855*).
- **Four hourly respiratory rate** - respiratory rate of less than 12 or greater than 20 must be reported to an obstetrician and co-ordinator. Be vigilant if respiratory rate is increasing or decreasing without a sound reason and review all vital signs.
- A midwife will need to use professional judgement as to whether there is a deviation from the norm requiring multi-professional input or whether there is a momentary deviation which will resolve and relates to non-pathological factors.

- **Contractions** - palpation and documentation of contraction strength, length and frequency should be assessed half hourly. Once contractions are established, a woman will require supportive one-to-one care. If the midwife is not present at any stage the call bell must be accessible at all times. You may wish to comment on the length, strength and frequency of contractions together with observing maternal response to help determine stage and progress in labour and the support the woman requires.
- **Abdominal descent of fetal head** - in normal labour there is progressive descent of the head which can be assessed by abdominal palpation (AP).
- **Vaginal examination (VE)** - AP should always precede VE. In low risk women who appear to be progressing normally, a VE may not be necessary. It should, however, be offered every 4 hours to assess progress and should not be used as an opportunity 'just to see what is happening'.

Student midwife examinations should be checked by the designated mentor and consent gained for both examinations. However, if the mentor has personally assessed and verified competence in VE with a senior student midwife, s/he may choose not to routinely verify findings. The midwife is accountable for all care given.

It is possible and appropriate to perform VE in the pool. However, this is dependant on the indication for VE. If you need an accurate assessment or you are unsure of your initial findings then ask the woman to leave the pool.

- **Fetal monitoring** - in low risk women, intermittent auscultation of the fetal heart rate, immediately following a contraction, for a full minute, every 15 minutes during the first stage. Maternal pulse should be palpated at the same time to differentiate between fetal and maternal HR. If a deviation from normal is detected, commence electronic fetal monitoring (EFM). If the EFM trace is normal after 20 minutes, return to intermitted auscultation unless the woman requests continuous EFM (see Trust Guideline for the use of Fetal Monitoring and Blood Sampling **Trustdocs ID 840**).

  Low risk women with regional analgesia – EFM should be initiated for at least 30 minutes during establishment of regional analgesia and following any top up of 10mL or more.

  In high risk women - continuous EFM must be used (see Trust Guideline for the use of Fetal Monitoring and Blood Sampling **Trustdocs ID 840**)

Guidance on duration of first stage

In first labours, the active first stage of labour lasts on average 8 hours, and is unlikely to last longer than 18 hours. In subsequent labours, the active first stage lasts on average 5 hours, and is unlikely to last over 12 hours (NICE 2014).

Delay in the first stage of labour takes into account, among other things, parity, dilatation, contractions, station and position of the presenting part and the woman's emotional state.

NICE (2014) guidance on delay in the active first stage of labour:

- <2cm dilatation in 4 hours for first labours.
- <2cm dilatation in 4 hours **or** slowing of progress for subsequent labours.
- Failure of rotation and descent of fetal head.
- Changes in the strength, duration or frequency of contractions.

If delay is suspected, refer to an obstetrician for a plan of care. Amniotomy should be considered for all women if there is delay in the active first stage of labour after explanation to the woman that it will shorten her labour by approximately an hour, and may increase the strength and pain of contractions.

Women with suspected delay in the first stage of labour, where there is no indication to expedite delivery, should be advised to have a repeat VE 2 hours later, and a diagnosis of delay can be confirmed if there is less than 1cm progress.

With a confirmed delay in the active first stage of labour, advise women oxytocin will bring forward the time of birth, but not influence the mode of birth. In multiparous women, a full obstetric assessment should be made before starting oxytocin, including abdominal palpation and vaginal examination, as delay in previously established labour is unusual (see Syntocinon Infusion Regime guideline *Trustdocs ID 891*).

Commencement of Oxytocin should not be delayed to allow epidural analgesia, unless the woman specifically requests this.
If oxytocin is used, expect progress of at least 2cm in 4 hours

Positions in the first stage of labour

Women should be encouraged and helped to assume which ever position they find most comfortable. There is also high quality evidence to suggest that:

For women *without* an epidural, walking and being upright reduces the duration of labour, risk of caesarean birth, need for epidural and does not appear to be associated with increased intervention or negative effects.

For women *with* an epidural, adopting upright or mobile positions reduces the duration of first stage of labour with no additional risk to mother or baby (Lawrence et al, 2013).

Positions for the second stage of labour

Women should be encouraged and helped to assume which ever position they find most comfortable. There is also high quality evidence to suggest that:

For women *without* an epidural, upright positions are associated with a very small reduction in the duration of labour, reduced episiotomy rates and assisted delivery rates. However there evidence to suggest that upright positions are associated with more PPH>500mLs and second degree tears (Gupta et al, 2017).

For women with an epidural, lateral positions which avoid lying flat on the back, result in more unassisted births, a better experience and no harm to mother or baby when compared with upright positions (Walker et al, 2018).

Signs of transition between 1st and 2nd stage

Observe for signs of transition and assess the woman's emotional and psychological needs. Such signs may include:

- Agitation, restlessness and vocalisation of increasing distress. It is typically the time a woman asks for pain relief.
- The woman might experience rectal pressure and may support her lower abdomen with her hand(s) during contractions. Continuous support and reassurance is essential at this time to minimise the distress for women.

Second Stage of Labour

The passive second stage of labour is defined as the findings of full dilatation without expulsive contractions. Signs include:

- Expressions of feeling rectal pressure.
- A line of discolouration arising from the anal margin and extending upwards to reach the nape of the buttock.
- Vulval gaping and anal dilatation with contractions.

Active second stage has multiple definitions, including the baby being visible, expulsive contractions with the finding of full dilatation and active maternal effort following confirmation of full dilatation.

Maternal and fetal observations to be carried out during second stage of labour

Observations should be recorded on the partogram.

- Four hourly temperature.
- Hourly BP.
- VE offered hourly in second stage or at woman's request following AP. Consider and record fetal position and station.
- Half hourly documentation of frequency of contractions.
- Frequency of passing urine.
- Effectiveness of pushing to be recorded in the narrative.
- Intermittent auscultation of fetal heart following a contraction for at least one minute every five minutes in low risk women. This may be recorded every 15 minutes on the partogram to see a trend. If it is not possible to listen as frequently, the reason must be clearly documented.
- Maternal pulse should be palpated every 15 minutes to differentiate it from the fetal heart rate.
- Continuous electronic fetal monitoring in women whom it is deemed necessary, or where there is suspected abnormality heard on intermittent auscultation.

Helpful strategies in the second stage of labour

Discourage the woman from lying supine or semi-supine in the second stage of labour, and encourage her to adopt any other position which she finds helpful. Women should be informed that in the second stage they should be guided by their own urge to push.

If pushing is ineffective, strategies to assist birth can be used such as support, change position, emptying bladder and encouragement (NICE 2014).

Perineal trauma can be minimised by gentle birth of the baby's head. Evidence supports the 'hands on' method of delivery for reducing perineal trauma. Routine episiotomy is not indicated, but in selected cases it may reduce the incidence of 3rd degree tears. Episcissors are the instruments of choice crafted to achieve a 60 degree angle to the midline. The method used and the maternal position at the time of birth should both be clearly documented in the records.

To prevent swab retention all swabs must be counted and verified with another person when the delivery pack is opened and after the birth, on completion of perineal inspection. This information should be documented and both checkers should sign to say it is correct.

Guidance on duration of second stage

Delay is defined by NICE (2014) as an **active** second stage lasting over 2 hours for primiparous and 1 hour for multiparous women. It is important to diagnose delay in second stage and seek obstetric opinion in order to ensure timely delivery. Delivery would be expected within 3 hours of the start of the active second stage in primips, and within 2 hours of the start of active second stage in multips.

Delay can be suspected sooner than this. In primips, if after one hour of active second stage there is little progress in terms of descent, or rotation, offer VE to assess progress and offer ARM in membranes are intact. In multips, this offer of abdominal palpation, VE and ARM should happen after 30 minutes of active 2nd stage (NICE 2014)
If there is no significant urge to push, with or without regional anaesthesia, the woman can be given an hour of **passive** second stage to allow descent and/or rotation of the presenting part.

When a diagnosis of delay is made an obstetrician should be informed and an individualised management plan for delivery or further review should be made. If the woman is on the MLBU the woman must be promptly transferred to Delivery Suite and an obstetrician contacted

EFM should be offered when a diagnosis of delay in second stage is made and hourly documentation should be made regarding: maternal effort, progress and the strength and frequency of contractions.

Starting oxytocin in the second stage should be a senior Obstetric opinion, and only when contractions are inadequate. Starting oxytocin in the second stage in multiparous women is not routinely recommended and therefore should be a Consultant decision.

An incident report must be completed when a multiparous woman has an active second stage >2 hours or when a nulliparous woman has an active second stage >3 hours.

Third Stage of Labour

See Management of the Third Stage of Labour (*Trustdocs ID 818*).

Perineal trauma

As soon as possible following birth, the midwife must gain consent and ensure there is adequate pain relief, prior to examining the woman's perineum, vagina and labia. All second degree tears must be repaired. First degree tears where the skin is not well apposed should also be repaired (NICE 2014).

If the midwife considers repair is not required this must be confirmed by a second, senior midwife. When trauma has been sustained, the midwife must also examine the rectal sphincter to identify any damage. If there is any doubt about the extent of trauma, the midwife should refer to an obstetrician for further assessment. See Trust Guideline for the Management of Perineal Trauma Following Childbirth (*Trustdocs ID 867*).

Initial assessment of the mother following spontaneous birth

Assess and record the following:

- Temperature, pulse, respiratory rate, BP, uterine tone and lochia
- MEOWS score.
- The placenta and membranes should be examined for condition, structure, cord vessels and completeness.
- Early assessment of the maternal psychological condition in response to the labour and birth.
- Successful voiding of the bladder, time and volume must be documented. Be especially vigilant following regional analgesia and complicated births (see guideline Bladder Care in Labour and Postnatally *Trustdocs ID 12617*).

IMMEDIATE CARE OF THE NEWBORN

Initial observations

Apgar score should be recorded routinely. Cord gases should be taken if the baby is born in poor condition, at instrumental delivery or if there have been any concerns about fetal wellbeing during labour or birth.

Observations after the first hour following birth

The midwife should undertake an initial examination to detect any major physical abnormality and to identify any problems likely to require referral. Head circumference, temperature, heart rate, respiratory rate and birth weight should also be recorded.

Babies with a history of prolonged rupture of membranes, Group B strep or meconium stained liquor will require additional observation.

See "Newborn babies born to mothers with meconium stained liquor" (**Trustdocs ID 9999**) and "Newborn babies at increased risk of developing neonatal infection" (**Trustdocs ID 9998**).

Skin to skin

This should be encouraged between mother and baby for a minimum of one hour as soon as possible following birth. Its value has been demonstrated in neonatal temperature regulation, initiation of infant feeding, particularly breastfeeding and bonding (UNICEF UK Baby-Friendly Initiative 2008). Whilst maintaining skin contact with the mother, the midwife should dry and cover the baby with warm towels to prevent neonatal hypothermia. Care should be taken to ensure that the baby's position is such that their airway remains clear and does not become obstructed. The midwife will remain vigilant for signs of a non-responsive baby and initiate newborn life support if required.

Initiation of breastfeeding

This should be encouraged as soon as possible after birth, ideally within 1 hour.

Audit

The Maternity Services are committed to the philosophy of clinical audit, as part of its Clinical Governance programme. The standards contained in this clinical guideline will be subject to continuous audit, with multidisciplinary review of the audit results at one of the monthly departmental Clinic Governance meetings. The results will also be summarised and a list of recommendations formed into an action plan, with a commitment to re-audit within three years, resources permitting

Summary of Development and Consultation process undertaken before registration and dissemination

The original version of the guideline was drafted by Julie Mansfield and Rosie Goodsell (Practice Development Midwives) and Mr David Fraser (Consultant - Obstetrics and Gynaecology) in consultation with. A second version was updated by Tracey Miller (Practice Development Midwife). This version was updated by Charles Bircher (Consultant Obstetrician) and Tracey Miller (now MLBU Team Leader) in consultation with and approved by the Obstetric and Multidisciplinary Guidelines Committee.

Distribution List: Clinical Midwifery Managers, Trust Intranet, Community Team Leaders.

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Appendix 1: Risk Assessment on Admission at Onset of Labour

Intrapartum and Fetal Monitoring Risk Assessment Tool

Complete within one hour of labour admission to MLBU or Delivery Suite or arrival of midwife at home.
(This tool may be used to hand over care in labour)

Name
Hospital Number

or add patient identifier label

E3 Alert checked
Tick once confirmed

Weight: *kg*
BMI:

Circle all that apply

Risk Factors – **Continuous fetal monitoring and obstetric involvement required during labour**			
Significant meconium stained liquor	Yes	Multiple pregnancy	Yes
Unbooked in this pregnancy	Yes	APH (previous or current)	Yes
Abnormal fetal movements currently	Yes	Prematurity (<37 completed weeks)	Yes
Abnormal presentation or lie	Yes	Postmaturity (>42 completed weeks)	Yes
Atypical antibodies on G+S	Yes	IUGR / SGA <10th centile	Yes
Diabetes type 1 and 2	Yes	Oligohydramnios / polyhydramnios	Yes
Gestational diabetes	Yes	Low placenta (on most recent scan)	Yes
Epilepsy	Yes	BMI > 40 on admission to labour*	Yes
Cardiac or Renal Disease	Yes	Fetal abnormality*	Yes
Hypertension/ Pre-eclampsia	Yes	Maternal medication*	Yes
VBAC / previous uterine surgery	Yes	Significant psychiatric concerns*	Yes
Pyrexia > 37.5^{0}c or suspected sepsis	Yes	Social factors (e.g. hx of substance misuse, domestic abuse, recent migrants, asylum seekers or refugees) *	Yes
PROM >24 hours	Yes		
Risk Factors – Not requiring continuous fetal monitoring but requiring obstetric opinion and I A			
Grand multiparity >5	Yes	Clotting abnormality	Yes
Declines Blood products	Yes	Increased VTE risk	Yes
Fetal macrosomia (>90th centile)	Yes	Significant fibroids	Yes
Blood borne virus (HIV / Hep B)	Yes	Anaemia Hb <90g	Yes
GBS risk	Yes	Intrauterine death	Yes
Complication in previous delivery* (3rd/4th degree tear, MROP, shoulder dystocia, PPH >1L)	Yes	Other significant medical history*	Yes
Planned for low risk midwifery led care with **intermittent fetal auscultation**			
Low Risk pregnancy at term	Yes	Risk Identified, but already considered in ANC and midwifery led care planned	Yes

Risk factors highlighted in green are able to deliver on MLBU as per guideline

**Continuous Monitoring and consultant unit may not be required following consultation with the Obstetric Team or if plan clearly documented antenatally*

Date of risk assessment *dd/mm/yyyy*	……./……../……..	Time: *24 hours …..*	
Risk assessment undertaken by			
Name		Signature		Designation	

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Intrapartum and Fetal Monitoring Risk Assessment Tool continued

Complete within one hour of labour admission to MLBU or Delivery Suite or arrival of midwife at home.
(This tool may be used to hand over care in labour)

Name
Hospital Number

or add patient identifier label

Circle all that apply

Anaesthetic Risk – **Alert Anaesthetic team on bleep 0011 if triggers a risk**			
Anaesthetic Alert	Yes	BMI 40 or above on admission	Yes
Severe Latex or relevant allergy	Yes	Spinal abnormality	Yes
Previous anaesthetic problems	Yes	Declines blood products	Yes
Poor venous access/needle phobia	Yes	Co-Morbidities (renal/cardiac/clotting)	Yes

Summary of any modifications to management of labour – if none, write “none”	
Detailed plan for high risk women or where to find details on E3 or COAC form:	
Midwifery co-ordinator aware of management plan if high risk:	

Name		Signature		Designation	
Date *dd/mm/yyyy*		Time *24 hours*			