Maternity Clinical Guideline for Intrapartum Care

Document Control:

For Use In:	Norfolk and Norwich University hospital Maternity Services		
Search Keywords	Care, labour, intrapartum, First Stage, Second Stage, Third Stage		
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Document Owner:	Maternity Clinical Guidelines Committee		
Approved By:	Maternity Guidelines Committee Nursing, Midwifery and Clinical Professionals (NMCP) Forum		
Ratified By:	NMCP Board		
Approval Date:	NMCP Board – 30th October 2024	**Date to be reviewed by:** This document remains current after this date but will be under review	30/10/27
Implementation Date:	As above		
Reference Number:	850 Version 13		

Version History:

Version	Date	Author	Reason/Change
V 9.3	01/05/2020	Mr Charles Bircher	Risk assessment form corrected
V 10	02/11/2020	Mr Charles Bircher	Annual update. Changed MASH to CADS
V 10.1	05/03/2021	Malissa Rayfield	Minor amendment made
V 10.2	26/11/2021	Tracey Miller Miss Beth Revell	Low risk changes – amendment to appendix
V 11	19/10/2022	Mr Georgios Sveronis Mr Charles Bircher	Change of wording – adapt definition of NICE for delay
V 12	25/08/2023	M Rayfield C Bircher A Anderson	New template Meconium and fetal monitoring Communication and language section expanded Change to passive second stage for primips with an epidural to align

			with NICE
V13	15/08/2024	J Simeoni (PDM)	Addition of OASI 2 Care Bundle

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

The following were consulted during the development of this document:

- Charles Bircher, lead for delivery suite
- Tracey Miller, Midwife Led Birth Unit lead
- Carmel Sayer, Midwife Matron for delivery suite and MLBU
- Amanda Anderson, Practice Development Midwife

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

This document is a clinical guideline applicable to Norfolk and Norwich University Hospital; please refer to local Trust's procedural documents for further guidance, as noted in Section 5.

Inclusivity

Within this document we use the terms pregnant women, her/she. However, it is important to acknowledge that it is not only people who identify as women for whom it is necessary to access care. This guideline is also relevant to under and over 18's, even though the term woman is used throughout. Maternity services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals who do not identity with the sex they were assigned at birth.

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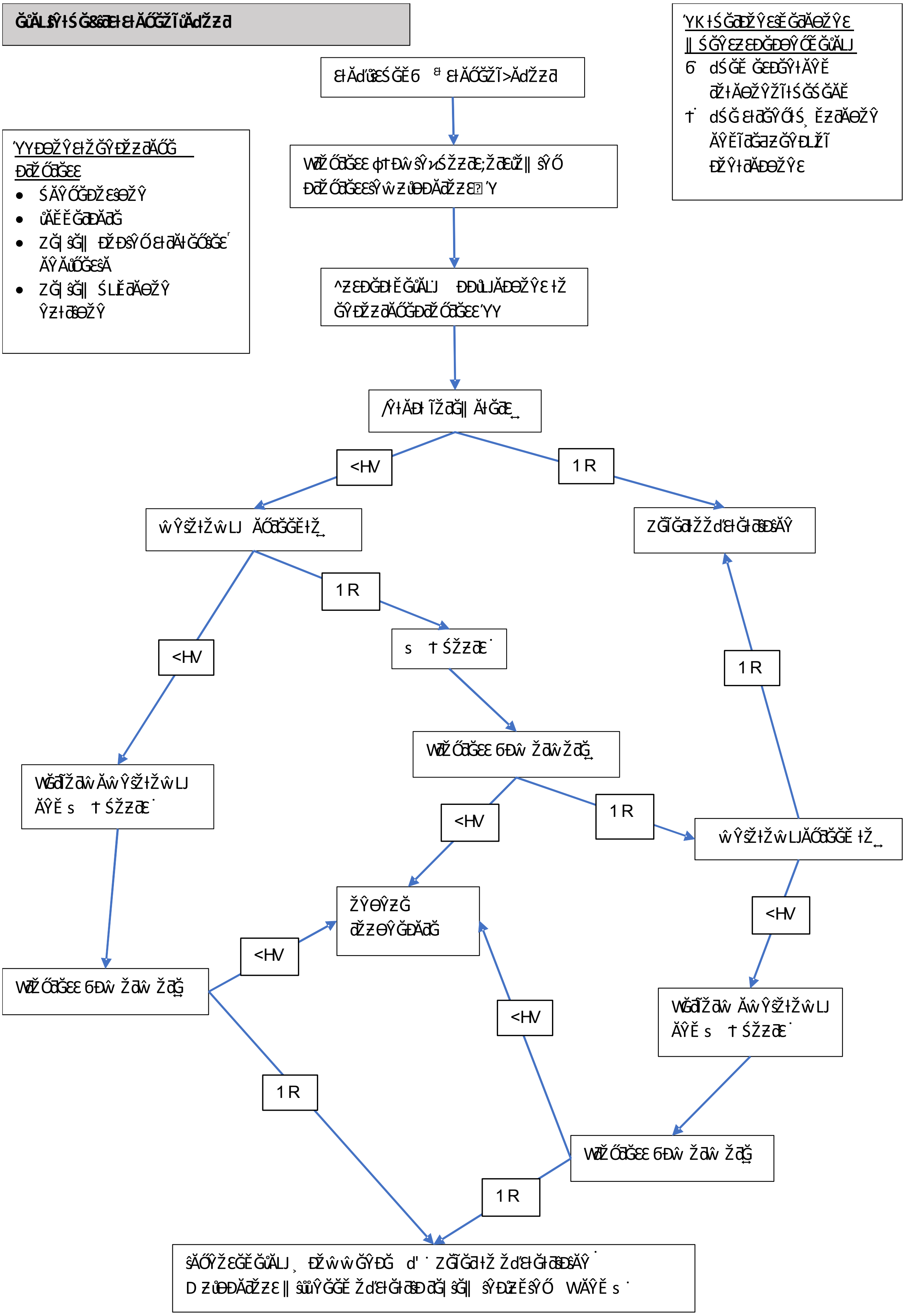
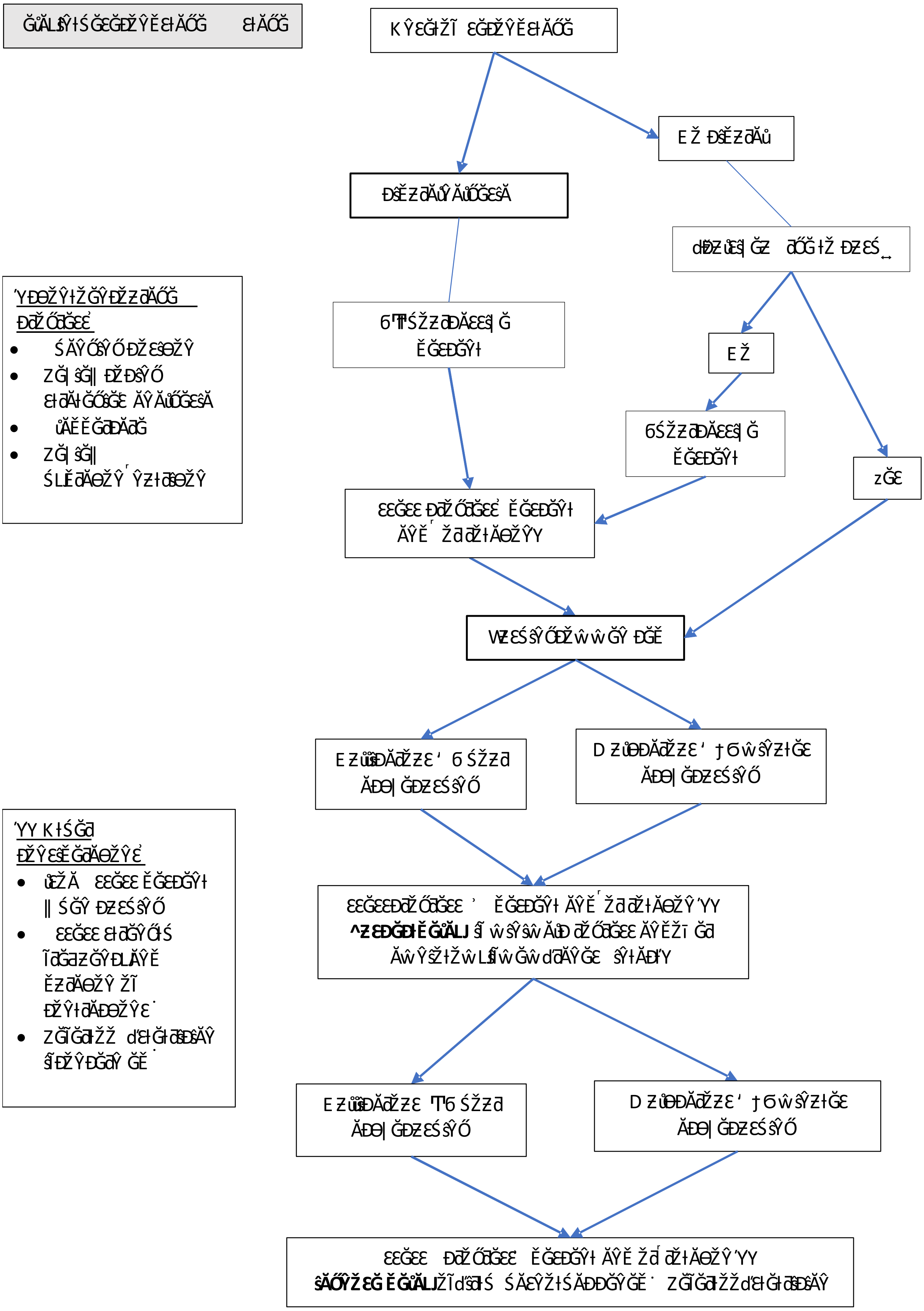


Quick reference 2



1. Introduction

1.1. Rationale

Care in labour should achieve the best possible outcome for mother and baby. This guideline provides standards of care in established labour for women at term in all care settings and is adapted from NICE Intrapartum Care (2022).

Multiple aspects of intrapartum care are covered with their own detailed guideline. In those cases, this guideline aims to signpost to the detailed guideline rather than repeating information as this can lead to different information in different guidelines covering the same aspect of care.

1.2. Objective

To support midwives and obstetricians to facilitate the safest, and the most emotionally fulfilling birth experience possible.

All staff should practice within their recognised scope of practice, and escalate any concerns to more senior staff if action is required out of their scope of practice.

1.3. Scope

For the purpose of this guideline, labour means 'established labour' and is classified as the onset of regular contractions, accompanied by progressive cervical dilatation from 4cm (NICE 2023).

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
MLBU	Midwife Led Birth Unit
NICE	National Institute for Health and Care Excellence
VE	Vaginal examination
IA	Intermittent auscultation
CTG	Continuous Cardiotocograph
MDT	Multidisciplinary Team
CADS	Children's Advice and Duty Service
RCOG	Royal College of Obstetricians and Gynaecologists
CPE	Carbapenemase-producing Enterobacterales
TRA	Thrombosis risk assessment
SRC	Self retaining catheter
PPH	Post partum haemorrhage
MRSA	Methicillin-resistant Staphylococcus aureus
MMAU	Macleod Maternity Assessment Unit
SROM	Spontaneous rupture of membranes
E3	Euroking - Maternity electronic notes system
OASI	Obstetric Anal Sphincter Injury

2. Responsibilities

Leads for delivery suite, MLBU and Community midwifery are responsible for education about and implementation of this guideline

3. Processes to be followed

3.1. Initial Assessment

3.1.1. Telephone Triage

All communication by telephone between a service user or her partner to the Labour Ward or MLBU, must be documented on the E3 telephone contact.

Any information provided should be communicated in a way which is understandable to the service user and take into account the individuals' situation and pregnancy complexities. This aims to enable the woman to make a fully informed choice on the next step on pathway of care, which must subsequently be respected. Documentation is recorded on E3, please refer to the MMAU Standard operating procedure (Trust docs 11525).

3.1.2. Face to Face Assessment

The initial assessment of a maternity service user in labour by a midwife aims to ascertain the wellbeing of both the woman and unborn child and to assess the clinical situation. A review of the service user's birth preferences should form part of this holistic assessment to understand the choices for labour and birth. This allows appropriate plans to be made, in collaboration with the service user for ongoing care. This initial assessment in labour should enable time for the development of trust between the midwife and service user and prioritise a supportive environment allowing the woman time to acclimatise to the situation.

When performing an initial assessment, listen to the woman's story and take into account her preferences. This initial assessment is used to help determine the safest setting for a woman's labour, irrespective of any previous plan. It is a simultaneous review of the woman's emotional, psychological and physical needs, and ensures that the safety both mother and baby are at the heart of the assessment. In order to do this, review previously written birth plans to assess if they are still appropriate and the woman is happy with the plans made.

The intrapartum and fetal monitoring risk assessment tool should be used to determine the most suitable method for fetal monitoring at the initial assessment (Trust Docs 17215).

Any plans made should be in partnership with women. Some women who are high risk may plan to birth in a low risk setting, in these cases a MDT plan is made following the guideline - Care outside of guidance (Trust Docs 20414). Document all discussions and decisions regarding fetal monitoring in the maternity records.

3.1.3. Women who are "Unbooked"

If a woman arrives 'unbooked', please refer to an obstetrician to plan care and liaise with the midwifery manager, safeguarding team, and the Children's Advice and Duty Service (CADs) as appropriate. A CTG is recommended in labour.

Table 1: Initial assessments on admission in labour

Risk assessments on admission	**History Taking**
• Intrapartum and Fetal Monitoring Risk Assessment Tool. Discuss with the service user the recommendation for monitoring and place of birth and refer to an obstetrician as indicated in the tool. • Admission paperwork and risk assessment, including Pressure Areas, MRSA, TRA, CPE, Safeguarding as appropriate for area.	• Listen to her story – ask how she is, what are her wishes, expectations and concerns • Review handheld notes and E3 including alerts and growth charts, and discuss sensitively with the woman • Establish if there is/has been any vaginal loss, including any bleeding
Observations and maternal wellbeing	**Fetal wellbeing**
• Ask her about the length, strength and frequency of her contractions. • Ask her about any pain she is experiencing and discuss options for pain relief. • Record her temperature, pulse, Oxygen saturations, blood pressure (BP), respiratory rate and urinalysis. • MEOWS and follow Modified Early Obstetric Warning Score Guideline (Trust doc 817) • Weight (not for homebirths). • Record whether she has any vaginal loss (SROM/bleeding/meconium), and comment on colour. It is good practice to look at any vaginal loss (on a pad) so that a better assessment is made. • If there is uncertainty about whether the woman is in established labour, a VE may be helpful after a period of assessment. If she appears to be in established labour, offer vaginal assessment.	• Ask her about the baby's movements over the last 24 hours • Palpate the woman's abdomen to determine the fundal height (if appropriate), the baby's lie, presentation, position, engagement of the presenting part. • V Scan • Auscultate the fetal heart with Pinard's stethoscope or handheld Doppler for at least one minute after a contraction, with simultaneous palpation of maternal pulse to differentiate the two. • Monitor the fetal heart according to the Intrapartum and Fetal Monitoring Risk Assessment Tool.

3.2. Place of birth

3.2.1. Criteria for MLBU or homebirth (low risk women)

This section has been removed from the Intrapartum guidelines. Please refer to The Midwifery Led Birthing Unit guideline, Trust docs 7181.

3.2.2. Referral to an Obstetrician / Transfer of care

When a review is needed, discuss the reasons with the service user so that the review is made in partnership and with their consent. The date and time should be documented in the notes and the delivery suite co-ordinator informed. Any transfer to obstetric led care should consider whether the risks of transfer outweigh the benefits (NICE, 2022).

Many of the reasons for referral to an obstetrician are listed in the Fetal Monitoring Assessment Tool. Referral to an obstetrician should also take place if:

Observation	**Refer to obstetric led care**
Maternal Pulse	Over 120 bpm on 2 occasions 30 minutes apart. Palpate with FH to ensure two separate heart beats
Blood Pressure	Single reading of a systolic of 160 mmHg or more, or a diastolic of 110 mmHg or more. 2 consecutive readings taken 30 minutes apart of either a raised systolic of 140 mmHg or more, or diastolic of 90 mmHg.
Proteinuria	+2 or more proteinuria and raised Blood pressure ≥140 systolic or ≥90 diastolic.
Temperature	38°C on one occasion 37.5°C on 2 consecutive readings 1 hour apart
Respiratory rate	Respiratory rate of less than 12 or greater than 20. Be aware of any underlying causes (drugs/hyperventilation).
Oxygen Saturation	Below 95%
MEOWS	MEOWs triggers an alert, refer to MEOWS guideline Trust Docs 817.
Fluid balance	Positive fluid balance <1500mls
Vaginal Blood Loss	Greater than a show
Meconium	Any meconium
Pain	Reported by the service user that differs from the pain normally associated with contractions
Fundal Height	Suspected fetal growth restriction, macrosomia,

	oligohydramnios or polyhydramnios.
Presentation	Oblique/transverse/breech/cord presentation or any other malpresentation
Fetal Movements	Reduced in last 24 hours or reduced currently.
Fetal Heart Rate	As per Fetal Monitoring Guideline (Trust Docs 840)
Delay	Confirmed delay in the first of second stage of labour
Regional analgesia	Request for additional pain relief using regional analgesia
Obstetric emergency	APH, cord prolapse, PPH, maternal seizure or collapse or need for advanced resuscitation
Retained Placenta, Third or fourth degree tear or other complicated perineal trauma the needs suturing	

3.3. Ongoing Assessments in Labour

3.3.1. Fetal Heart Rate

Please refer to the Fetal monitoring in labour guideline when assessing the fetal heartrate (Trust Docs 840).

3.3.2. Meconium

There is a difference in national guidance when meconium is seen.

The NICE Fetal Monitoring guideline says “Offer continuous CTG monitoring for women who have or develop any of the following new intrapartum risk factors:…..the presence of meconium”. However later in the guideline it says “Consider the character of the meconium as part of the overall clinical assessment, in conjunction with other antenatal or intrapartum risk factors, and discuss the option of CTG monitoring with the woman.”

The NICE Intrapartum care guideline classifies significant and non-significant meconium and says “If significant meconium is present, transfer the woman to obstetric-led care provided that it is safe to do so and the birth is unlikely to occur before transfer is completed.”

Therefore, the guidance at NNUH is:

- If significant meconium is seen, a continuous CTG for the remainder of labour is recommended, which will require transfer to delivery suite if not birthing in a different location.
- If non-significant meconium is seen, this should prompt a holistic review of a woman’s care in labour. If other risk factors such as poor progress or a maternal pyrexia are noted, then a CTG recommended (and transfer to delivery suite if not in this location). If there are no other developing risk factors and other maternal and fetal observations are normal, the woman

should still be offered a CTG and transfer to delivery suite, but if she declines she can remain on MLBU with intermittent auscultation, with a low threshold to transfer if other risk factors develop or the woman changes her mind.

- If at home and meconium is seen, a transfer to delivery suite is recommended

3.3.3. Vaginal Examinations – general principles

It is important to be sure that the examination is necessary and will add important information to the decision making process, mindful that there is strong evidence to say that there is a direct correlation between number of VEs and a rising maternal temperature (Gluck et al 2020).

Some women experience intense pain during a VE, it is important to offer pain relief during the procedure if needed, and to let the woman know that she may withdraw consent at any time. Recognition is also important that some women may have experienced sexual abuse as and not disclosed this fact, therefore sensitivity and respect must also be prioritised to all women.

It is also good practice to use a VE pack to cleanse the labia beforehand. Abdominal palpation should happen immediately before a VE in order to gain a better understanding of descent of head and position. Check when the bladder was last emptied and refer to Bladder Care and Fluid Balance Guideline (TrustDoc 12617)

A VE sticker is recommended. (Trust Docs ID: 23648) once approved.

Ensure privacy, dignity and comfort and explain the findings sensitively. If there is uncertainty about whether the woman is in established labour, a VE may be helpful after a period of assessment. But if she appears to be in established labour, offer vaginal assessment.

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.

3.3.4. Bladder Care

Please refer to Bladder Care and Fluid Balance Guideline (TrustDoc 12617) for full guidance. Women should be encouraged to pass urine at least every 2-3 hours during labour and all women with an epidural should offered a SRC. A fluid balance chart should be commenced on admission to delivery suite, MLBU or at home.

3.3.5. Skin Integrity

Please complete the Pressure Areas assessment once per shift, and ensuring women change position at least every two hours, document skin integrity on a turns chart.

3.4. Principles of Care in Labour

It is important to review previously written birth plans at the initial presentation in labour to make sure they are still appropriate and the woman is happy with the plans made. Changes should be in conjunction with the woman and her choices should be respected.

3.4.1. Support in labour

Women who receive continuous labour support may be more likely to give birth vaginally without assistance (Bohren et al, 2017). Do not leave a woman in established labour on her own except for short periods or at the woman's request. If the midwife is not present for a short time, the call bell should be given.

3.4.2. 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. Any emergency equipment including neonatal resuscitation equipment should be prepared and checked in all birth settings and documented in the handheld records and log books. It should also be re-checked at each handover of care.

3.4.3. Communication and language

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 2022).

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).

Many women read their hospital notes after birth via PALS and Birth reflections and therefore thoughtful and sensitive record keeping is crucial.

By thinking about and carefully choosing the language we use to patients/pregnant people, it can help with them feeling a sense of empowerment over their labour (Mobbs, et al, 2018). Key language examples were produced which were found to cause patients/pregnant people anxiety; not respectful; didn't aid in assisting with their own autonomy or decision making; language which was deemed too medicalised and hard to interpret and did not make them feel as though they were individuals. From there, suggested alternatives were produced to have the contrary affect to assist in reducing anxiety, and showing patients/pregnant people that they are individuals who are respected decision makers. Examples are included in Appendix 1.

3.4.4. 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. 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.

3.4.5. Controlling gastric acidity

Women should be considered for Omeprazole or Ranitidine if they receive opioids or who have or develop risk factors that make a general anaesthetic more likely. Omeprazole 40mg 12-hourly or Ranitidine 150mg 6-hourly may be given orally during labour.

3.5. Pain relief in labour

3.5.1. Pain-relieving strategies

If a woman chooses to use breathing and relaxation techniques in labour, support her in this choice. If a woman chooses to use massage techniques in labour that have been taught to birth companions, support her in this choice. Support the playing of music of the woman's choice in labour. Offer low risk women the woman the opportunity to labour in water for pain relief, referring to the Waterbirth Guideline (Trustdocs 804).

3.5.2. Inhalational analgesia

Ensure that Entonox (a 50:50 mixture of oxygen and nitrous oxide) is available in all birth settings as it may reduce pain in labour, but inform the woman that it may make her feel nauseous and light-headed.

3.5.3. Intravenous and intramuscular opioids

Ensure that pethidine, diamorphine or other opioids are available in all birth settings. Inform the woman that these will provide limited pain relief during labour and may have significant side effects for both her (drowsiness, nausea and vomiting) and her baby (short-term respiratory depression and drowsiness which may last several days). Inform the woman that pethidine, diamorphine or other opioids may interfere with breastfeeding. If an intravenous or intramuscular opioid is used, also administer an antiemetic. Women should not enter water (a birthing pool or bath) within 2 hours of opioid administration or if they feel drowsy. Do not offer Pethidine to women with a history of epilepsy.

3.5.4. Regional analgesia

Please refer to Epidural Analgesia in Labour Guideline (Trustdocs 1305)

3.6. Positions in labour

3.6.1. 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).

3.6.2. 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). 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 2022).

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).The RCOG Greentop Guideline for Assisted Birth 2020 states 'Encourage women using epidural analgesia to adopt lying down lateral positions rather than upright positions in the second stage of labour as this increases the rate of spontaneous vagina birth' (Murphy et al, 2020).

Perineal trauma can be minimised by gentle birth of the baby's head. The method used and the maternal position at the time of birth should both be clearly documented in the records. If the legs are in lithotomy, and it is safe to take them out of lithotomy for the birth, this may reduce perineal trauma.

3.7. First Stage of Labour

3.7.1. Definition of established labour

The established first stage of labour is when there are regular contractions and there is progressive cervical dilatation from 4 cm.

3.7.2. Observations in the first stage of labour

Observation	Frequency
Maternal Pulse	1 hourly
Blood Pressure	4 hourly if BP normal
Temperature	4 hours if < 37.5
Respiratory rate	4 hourly
Contractions	30 minutes Palpate and document the length strength and frequency of contractions every 30 mins
AP	4 hourly and prior to VE

VE	4 hourly. May also perform VE in response to women's wishes or if there are concerns about progress/cord. If delay suspected follow Quick Reference 1
Pass Urine	2-3 hourly
Fetal monitoring	See Guideline for Intrapartum fetal monitoring Trustdocs ID 840. In all cases, the maternal pulse must be palpated alongside the fetal heart and documented to confirm two separate heartbeats.
Partogram	Use a partogram once labour is established and if an action line is used, a 4 hour action line is recommended
Pressure care	Assess 2 hourly. Use a Turns chart
Regional analgesia	Fill in the epidural chart (TrustDocs 1305)
Women's needs	Consider the woman's emotional and psychological needs and her desire for pain relief, document her wishes and any referrals made. Encourage the woman to communicate her need for analgesia at any point during labour.

3.7.3. 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

3.7.4. Suspecting delay in the first stage

See Quick Reference 1 at the beginning of this guideline.

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

- cervical dilatation of less than 2 cm in 4 hours for first labours
- cervical dilatation of less than 2 cm in 4 hours or a slowing in the progress of labour for second or subsequent labours
- descent and rotation of the baby's head
- changes in the strength, duration and frequency of uterine contractions

Take into account the service users emotional state – offer support hydration and effective pain relief as this may influence progress.

3.7.5. Managing delay in first stage

Amniotomy should be considered for all service users with intact membranes if there is delay in the active first stage of labour after explanation that it will shorten their labour by approximately an hour, and may increase the strength and pain of contractions.

Whether or not a woman has agreed to an amniotomy, advise all women with suspected delay in the established first stage of labour to have a vaginal examination 2 hours later.

If delay is diagnosed, inform the woman and refer to on obstetrician for a collaborative discussion about management options.

Consider the woman's emotional state, offer support, hydration and appropriate and effective pain relief as they may hinder progress.

3.7.6. Oxytocin for confirmed delay in the first stage

With a confirmed delay in the established first stage of labour, advise women oxytocin will bring forward the time of birth, but not influence the mode of birth. In multiparous women, an obstetrician should perform a full assessment including abdominal palpation and vaginal examination before a decision is made about oxytocin (Please refer to Oxytocin infusion for induction or augmentation of labour following amniotomy or SROM guideline (TrustDoc 891).

Offer all women with delay in the established first stage of labour support and effective pain relief. This includes women who consent to oxytocin for confirmed delay.

If cervical dilatation has increased by less than 2 cm after 4 hours of oxytocin, further obstetric review is required to assess the need for caesarean section. If cervical dilatation has increased by 2 cm or more, advise 4-hourly vaginal examinations.

3.8. Signs of Transition between first and second stage of labour

Transition can be an extremely intense experience but it is a normal part of labour. Informing women about transition before it happens can help women prepare for it and sometimes, feel more in control. Signs of transition can be a feeling of restlessness, vocalisation with increasing distress, women may feel very alone at that point in labour. Sometimes a women's abdomen bears down before she is fully dilated, this feeling can be very distressing. It is often a time when she will ask for pain relief. Continuous support and reassurance is very important to women at this time, as it is throughout all of labour.

3.9. Second Stage of Labour

3.9.1. Definition of the passive second stage

The findings of full dilatation without involuntary expulsive contractions

3.9.2. Definition of the active second stage

The onset of active second stage of labour:

- The baby is visible
- Expulsive contractions with a finding of full dilation of the cervix
- Active maternal effort following confirmation of full dilation of the cervix

3.9.3. Reducing Perineal Trauma - OASI 2 Care Bundle

The OASI 2 Care Bundle has been developed between the RCOG, the RCM and The Health Foundation to reduce the risk of OASI at vaginal births. All women should be offered the following 4 elements to reduce their risk of injury.

1. Antenatal Education including information on what is pelvic health, what are perineal tears and episiotomy's, individualised risk factors, antenatal perineal massage, promoting spontaneous vaginal birth, and recovery & potential complications following a severe tear. These discussions should be documented on E3.
2. When indicated, episiotomy should be performed mediolaterally at a 60-degree angle (ideally with epi-scissors) at crowning.
3. Documented use of manual perineal protection (MPP) unless declined or birthing in water. Warm compresses should be offered and used in between contraction.
4. Following birth, the perineum should be examined, and any tears graded appropriately. The examination should include a per rectum examination even if the perineum appears intact. Document this clearly in the notes. Adequate pain relief is needed and a mechanism for requesting the examination to stop should be agreed beforehand. Please refer to the Perineal Trauma Guideline (TrustDocs 867).

3.9.4. Observations in the second stage of labour

Observation	Frequency in second stage
Maternal Pulse	5 minutely (palpated with every episode of IA)
Blood Pressure	1 hourly if BP normal
Temperature	4 hourly if < 37.5
Respiratory rate	4 hourly
Contractions	30 minutes. Palpate and document the length strength and frequency of contractions every 30 mins
AP	Prior to VE
VE	To confirm FD and at least hourly in second stage Nulliparous women – 1 hour after active pushing Multiparous – 30 minutes after active pushing
Pass Urine	2-3 hourly
Fetal monitoring	See Guideline for Intrapartum fetal monitoring *Trustdocs ID 840.* In all cases, the maternal pulse must be palpated alongside the fetal heart and documented to confirm two separate heartbeats.
Pressure care	Assess 2 hourly. Use a Turns chart

Regional analgesia	Fill in the epidural chart as appropriate
Women's needs	Consider the woman's emotional and psychological needs and her desire for pain relief, document her wishes and any referrals made. Encourage the woman to communicate her need for analgesia at any point during labour.

3.9.5. Length of passive second stage

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.

The RCOG Greentop guideline for Assisted Birth (2020) recommends 'delayed pushing for 1–2 hours in nulliparous women with epidural analgesia as this may reduce the need for rotational and mid-pelvic assisted vaginal birth'.

3.9.6. Delay in the active second stage – Nulliparous Women

See Quick Reference 2 at the beginning of this guideline.

For a nulliparous woman birth would be expected to take place within 3 hours of the start of the active second stage in most women

Suspect delay for nulliparous women, 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.

Diagnose delay in nulliparous women 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.

3.9.7. Delay in the active second stage – multiparous women

For a multiparous woman birth would be expected to take place within 2 hours of the start of the active second stage in most women.

Suspect delay in a multiparous woman 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.

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.

3.9.8. After diagnosing delay

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 or at home the woman must be promptly transferred to Delivery Suite and an obstetrician contacted as per MLBU and Homebirth guidelines

CTG should be recommended when a diagnosis of delay in second stage is made.

3.9.9. Epidural analgesia in the second stage

It is recommended that we should not discontinue epidural analgesia during pushing as this increases the woman's pain with no evidence in a reduction in the incidence of assisted vaginal birth (Murphy et al, 2020).

After diagnosis of full dilatation in a woman with regional analgesia, agree a plan with the woman in order to ensure that birth will have occurred within 4 hours regardless of parity.

3.9.10. Starting oxytocin in the second stage of labour

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.

Starting oxytocin in a multiparous woman in the second stage must be done with caution and always discussed with the most senior obstetric team member on site.

3.9.11. Datix for length of second stage

An incident report should 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.

3.10. Third Stage of Labour

See Management of the Third Stage of Labour (Trust Docs 818)

3.11. Postnatal Care

3.11.1. Cord Gases

Cord gases should be taken if the baby is born in poor condition, at instrumental delivery, an emergency caesarean birth, preterm birth, breech or if there have been any concerns about fetal wellbeing during labour or birth.

3.11.2. Swabs

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 as per the Swab Count Guideline (TrustDocs 9635)

3.11.3. Initial Assessment of the mother

Carry out the following observations:

- Temperature, pulse, respiratory rate, BP, oxygen saturations, uterine tone and lochia
- MEOWS score.

- The placenta and membranes should be examined for condition, structure, cord vessels and completeness. The placenta should be sent for histology if indicated in Clinical Guideline for Indications for Placental Examination and use of placenta fridge (Trust Docs 869)
- 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).

3.11.4. Immediate care of the newborn

- Encourage mother to have skin to skin contact with the newborn(s) for as long as the parent wishes, at least one hour or until after the first feed.
- Assess the Apgar score
- Maintain thermoregulation
- Weigh the baby, record head circumference and initial top to toe newborn assessment
- Assess the NEWS score within the first hour.
- Offer and administer Vitamin K depending on parental choice.
- Encourage initiation of infant feeding, respecting mother's choice.
- Perform observations as required where there are indications for neonatal observations, e.g. meconium liquor (TrustDocs 9999) or Newborns at increased risk of infection (TrustDocs 9998).
- If there are any concerns with the newborn, refer to paediatrician.
- Avoid separation of mother and their newborn within the first hour of birth for routine assessments unless necessary for immediate care.
- Measure oxygen saturations as per the Routine Oxygen Saturations Guideline (TrustDocs 10566)

3.11.5. 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.

3.11.6. Initiation of breastfeeding

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

4. Related Documents

- Macleod Maternity Assessment Unit (MMAU) Standard Operating Procedure (SOP).
- Intrapartum and Fetal Monitoring Risk Assessment Tool
- Modified Early Obstetric Warning Score (MEOWS)
- Midwifery-led Birthing Unit (MLBU) Operational Guideline
- Clinical Guideline for the Use of Intrapartum Fetal Monitoring
- Bladder care and Fluid Balance, Antenatal, Intrapartum and Postnatal
- Epidural Analgesia in Labour
- Oxytocin Infusion for Induction or Augmentation of Labour Following Amniotomy or Spontaneous Rupture of Membrane
- Perineal Tears
- Third Stage of Labour (Trust Guideline) (Management of)
- Newborn babies born to mothers with meconium stained liquor
- Newborn babies at increased risk of developing neonatal infection
- Waterbirth Guideline
- Swabs, tampons and sharps in the maternity services when used for vaginal birth and perineal repair (Management of)
- Clinical Guideline for Indications for Placental Examination and use of placenta fridge
- A Clinical Guideline - Maternity Care Requested out of Guidance
- VE Sticker

5. References

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- NICE Guideline CG190. Intrapartum Care for Healthy Women and Babies. December 2022.
- NICE Guideline NG235 Intrapartum Care, September 2023
- NICE Guideline NG229. Fetal Monitoring in Labour. December 2022
- Odent M (2001) New reasons and new ways to study birth physiology. International of Gynaecology and Obstetrics, 75: S 39-45.
- RCOG Greentop Guideline 26. Assisted Vaginal Birth. April 2020

6. Monitoring Compliance

This guideline is an overview of intrapartum care. Multiple aspects of intrapartum care are audited and detail of these audits are available in the relevant detailed guideline listed in section 4 of this guideline.

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
Completion of partogram	Audit	Appropriate appointed midwife by Delivery Suite Matron	Maternity Clinical Governance	Annual
Prolonged second stage	Datix Reporting trigger	Maternity Risk and Governance	Maternity Risk and Governance	Case by case

The audit results are to be discussed at maternity governance meetings to review the results and recommendations for further action. Maternity Governance will ensure that the actions and recommendations are suitable and sufficient.

7. Appendices

Appendix 1 Suggested language

Associated with increased anxiety	Associated with less anxiety
‘”failure to progress”	“slowed labour”
“room 2 needs and epidural”	“(patient’s/person’s name) in room 2 would like an epidural”
“she’s 7cm”	“(patient’s/person’s name) cervix is 7cm dilated”
“poor maternal effort”	“not finding it easy”
“poor obstetric history/ high risk”	“medical complexities’”
“Trial of forceps’	“To see if we can help the baby out using forceps”
“delivered”	“gave birth”
“she refused”	“they declined”
“I need to”	“would it be okay if I…”
“failed induction”	“unsuccessful induction”
“concealed pregnancy”	“unaware of conception”
“you must have…”	“I would recommend/ suggest…”
“you are putting your baby at risk of”	“there are additional risks”

8. Equality Impact Assessment (EIA)

Type of function or policy	Existing clinical guideline

Division	Women's and Childrens	**Department**	Maternity
Name of person completing form	Charles Bircher	**Date**	21/08/23

Equality Area	Potential Negative Impact	Impact Positive Impact	Which groups are affected	Full Impact Assessment Required YES/NO
Race	No	No		No
Pregnancy & Maternity	No	No		No
Disability	No	No		No
Religion and beliefs	No	No		No
Sex	No	No		No
Gender reassignment	No	No		No
Sexual Orientation	No	No		No
Age	No	No		No
Marriage & Civil Partnership	No	No		No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?		N/A		

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.