Frimley Health
NHS Foundation Trust

Care of women in labour

Key Points

- Carry out an initial assessment to determine if midwifery-led care in any setting is suitable for the woman.
- Women should be supported in making informed choices at every stage of the care pathway.
- Explain all procedures, seek permission and discuss findings sensitively. Ensure privacy, dignity and confidentiality.

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Abbreviations

ARM	Artificial rupture of membranes
EPR	Electronic patient record
SROM	Spontaneous rupture of membranes
VE	Vaginal examination

Contents

1. Purpose of the Guideline

This guideline is based on: ***Intrapartum care: The care of healthy women and their babies during childbirth*** (NICE, 2014) updated 2022. Women should be supported in making informed choices at every stage of the care pathway, the ultimate aim being to ensure that women and their partners are kept safe during the experience of labour and birth and emerge feeling positive and empowered and ready to face the challenges of parenting despite any complications that may have arisen. This can only be achieved where there is effective and ongoing communication between the woman, her partner and all members of the multi-disciplinary care team.

2. Care throughout labour

- Use the prepared personalised care support plan as guidance for discussion.
- Ensure good communication with the woman and her birth partner. Discuss their birth plan and their expectations of labour and pain management.
- Explain all procedures, gain full consent and discuss findings sensitively.
- Aim to provide one-to-one midwifery care and support the presence of up to two birth companion(s).
- Ensure privacy, dignity and confidentiality. Knock and wait before entering the woman's room, respecting it as her personal space, and ask others to do the same.
- Show the woman and her birth companion(s) how to summon help and reassure her that she may do so whenever and as often as she needs to. When leaving the room, let her know when you will return.
- Do not leave a woman in established labour on her own except for short periods or at the woman's request.
- Record all documentation as per electronic patient record (EPR)
- Guidance on eating and drinking in labour can be found in “Oral intake in labour and prior to Caesarean section”.
- Give ongoing consideration to the woman's emotional and psychological needs, including her desire for pain relief.

2.1 Initial assessment

Carry out an initial assessment to determine if midwifery-led care in any setting is suitable for the woman, irrespective of any previous plan. When performing an initial assessment of a woman in labour, listen to her story and take into account her preferences and her emotional and psychological needs.

Include the following in any triage assessment of labour:

- give information about what the woman can expect in the latent first stage of labour and how to work with any pain she experiences
- give information about what to expect when she accesses care
- agree a plan of care with the woman, including guidance about who she should contact next, and when, to provide guidance and support to the woman and her birth companion(s).
- The triage midwife should document the guidance that she gives to the woman within the EPR. MAMAS Telephone Triage will record all advice given

- The assessment should comprise the following: ask the woman how she is, and about her wishes, expectations and any concerns she has. A full risk assessment should be carried out at this time.
- ask the woman about the baby's movements, including any changes
- If there is uncertainty about whether the woman is in established labour, a vaginal examination may be helpful after a period of assessment but is not always necessary.
- If the woman appears to be in established labour, offer a vaginal examination. (refer to prelabour rupture of membranes guideline for SROM).
- Measure fetal heart rate as part of initial assessment (refer to fetal monitoring guideline.)

If a vaginal examination is deemed necessary;

- Be sure that this will add important information to the decision-making process.
- Recognise that a vaginal examination can be very distressing for a woman especially if she is already in pain, highly anxious and in an unfamiliar environment.
- Explain the reason for the examination and what will be involved and gain the woman's informed consent.
- Ensure the woman's privacy, dignity and comfort.
- Explain sensitively the findings of the examination and any impact on the birth plan to the woman and her birth companion(s).
- Routine hygiene measures taken by staff caring for women in labour, including standard hand hygiene and single-use non-sterile gloves, are appropriate to reduce cross-contamination between women, babies and healthcare professionals. Sterile gloves should be used for all vaginal examinations.

2.2 Observations of the woman

- Review the antenatal notes (including all antenatal screening results and correspondence) and discuss these with the woman.
- Ask her about the length, strength and frequency of her contractions.
- Ask her about any pain she is experiencing and discuss her options for pain relief.
- Assess her pulse, blood pressure and temperature, respiration rate, oxygen saturation and carry out urinalysis and record in the notes or the partogram if she is in established labour
- Record if she has had any vaginal loss.

2.3 Observations of the unborn baby

- Ask the woman about the baby's movements in the last 24 hours (refer to reduced fetal movements guideline)
- Palpate the woman's abdomen to determine the fundal height, the baby's lie, presentation, position, engagement of the presenting part, and frequency and duration of contractions. Review customised growth chart as part of your assessment.

- Auscultate the fetal heart rate for a minimum of 1 minute immediately after a contraction. Palpate the woman's pulse to differentiate between the heart rates of the woman and the baby *(refer to fetal monitoring guideline.)*

2.4 Mobilisation and Support

- Encourage mobilisation and the use of optimal equipment such as birthing balls.[2]
- Ensure hydration and encourage nutrition in early labour.[2] Isotonic drinks or honey reduce maternal ketosis without increasing gastric volume.[4]
- Encourage the woman to empty her bladder regularly.[5]
- Document all care in the woman's EPR.
- Work on an assumption of normality unless otherwise indicated. Do not offer or advise intervention if labour is progressing normally and the woman's and baby's observations are within normal limits.[1]
- Encourage the woman to have support from birth companion(s) of her choice.

Principles in making the diagnosis of labour

1. **Listen to the woman.**
2. **The diagnosis of labour should not be based on cervical dilatation alone.**
3. **In nulliparous women, regular painful contractions, at >1 in 5, in the presence of cervical effacement, labour should be considered.**
4. **Women with regular painful contractions at >1 in 5, and spontaneous rupture of membranes (SROM) are likely to be in labour.**
5. **A low station of the fetal head is a sign that progress in labour may be very quick, whatever the parity.**
6. **The diagnosis of 'active phase' of labour according to cervical dilatation from 4cms alone should be abandoned.**
7. **Intrapartum care, indeed, 1:1 midwifery care, is intended to support both the woman and her unborn baby at a time of need. These needs differ.**

2.5 Latent first stage of labour

This is a period of time, not necessarily continuous, when:

- there are painful contractions **and**
- there is some cervical change, including cervical effacement and dilatation up to 4 cm. (Women may be in established labour before reaching 4cm dilatation- see above). Women would be considered to be in labour if contracting and 4cms dilated or more.
- Following a complete risk assessment, women without complications can go home with clear information about when to return, e.g., SROM, bleeding, increasing contractions.
- Women with more than one attendance in the latent phase should be reviewed by the obstetric team or offered admission to the antenatal ward.
- Discuss strategies for coping with contractions, e.g., warm bath, mobilisation, simple analgesia, relaxation, massage.
- Consideration of length of latent stage of labour is required when care planning, adverse outcomes are more common in latent phases over 18 hours.

- **Other issues to consider**
  - **Take into account her social circumstances, her access to healthcare (e.g., language barriers), the time of day, and the distance that she will travel when deciding whether admission is appropriate.**
  - **In higher risk women, including where there is a uterine scar, the threshold for advising admission should be lower, and electronic fetal monitoring (EFM) should be offered.**

2.6 Pain relief in Latent Phase

- Advise the woman and her birth companion(s) that breathing exercises, immersion in water and massage may reduce pain during the latent first stage of labour.
- Do not offer or advise yoga or acupressure for pain relief during the latent first stage of labour. If a woman wants to use any of these techniques, respect her wishes.
- Aromatherapy is available on the midwifery led units at Frimley Health with midwives who have undergone training.
- Support the use of TENS machines in the latent phase of labour if available.
- Preferences for analgesia can be considered.

2.7 Criteria for Obstetric Care

Woman will require obstetric-led care and an obstetric review will need to be arranged, if any of the following are observed on initial assessment:

2.7.1 Observations of the woman

- Pulse over 120 beats/minute on 2 occasions 30 minutes apart.
- A single reading of either raised diastolic blood pressure of 110 mmHg or more or raised systolic blood pressure of 160 mmHg or more.
- Either raised diastolic blood pressure of 90 mmHg or more or raised systolic blood pressure of 140 mmHg or more on 2 consecutive readings taken 30 minutes apart.
- A reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (90 mmHg or more) or raised systolic blood pressure (140 mmHg or more).
- Temperature of 38°C or above on a single reading, or 37.5°C or above on 2 consecutive readings 1 hour apart (refer to sepsis in pregnancy & puerperium Guidelines).
- Any vaginal blood loss other than a show.
- Rupture of membranes more than 24 hours before the onset of established labour.
- The presence of significant meconium. This is defined as dark green or black amniotic fluid that is thick or tenacious, or any meconium-stained amniotic fluid containing lumps of meconium.
- Pain reported by the woman that differs from the pain normally associated with contractions.
- Any risk factors recorded in the woman's notes that indicate the need for obstetric led care.

2.7.2 Observations of the unborn baby

- Any abnormal presentation, including cord presentation.
- Transverse or oblique lie.
- High (4/5–5/5 palpable) or free-floating head in a nulliparous woman

- Suspected fetal growth restriction or macrosomia. Refer to customised growth chart in electronic patient record.
- Suspected reduced liquor or polyhydramnios.
- Fetal heart rate below 110 or above 160 beats/minute.
- A deceleration in fetal heart rate heard on intermittent auscultation
- Reduced fetal movements in the last 24 hours reported by the woman. (Refer to fetal monitoring guideline)
- Measuring fetal heart rate as part of initial assessment (refer to fetal monitoring guideline.)

If none of these are observed, continue with midwifery led care unless the woman requests transfer.

- If any of the factors in recommendation 2.7.1, 2.7.2 are observed but birth is imminent, assess whether birth in the current location is preferable to transferring the woman to an obstetric unit and discuss this with the coordinating midwife.

3. General principles for transfer of care

- Transfer of care refers to the transfer between midwifery-led and obstetric-led care.

- Base any decisions about transfer of care on clinical findings and discuss the options with the woman and her birth companion(s). Address any concerns she has and try to allay her anxiety and ensure that her wishes are, respected and her informed consent is obtained.

If contemplating transfer of care:

- Talk with the woman and her birth companion(s) about the reasons for this and what they can expect, including the time needed for transfer.

- When arranging transfer of care at home the midwife should refer to the homebirth guideline. The coordinating midwife on the labour ward should alert the relevant healthcare professionals (obstetric, anaesthetic and neonatal) that a woman is being transferred from a planned home birth and the rationale.

- Women transferring from the birth centre or home for any reason other than epidural request should be reviewed by the obstetric registrar
- Do not delay transfer if complications are recognised, base decisions of clinical need and risk assessment.

4. Established labour

- Do not offer or advise clinical intervention unless clinically indicated.
- Advise women that the length of established first stage of labour varies between women.

5. Monitoring during labour

5.1 Observations during the established first stage

- Once labour is established transfer documentation of care to the partogram.
- Measure fetal heart rate (refer to fetal monitoring guideline)

The established first stage of labour is defined as when:

- there are regular painful contractions, and
- there is progressive cervical dilatation from 4cm
- An individual approach is required to take account of contraction, need for pain relief and the woman's preferences.

Assess the woman's wellbeing by recording:

- pulse hourly (*refer to fetal monitoring guideline)*
- blood pressure and temperature every four hours
- the frequency of bladder emptying. If there is any concern about the woman's hydration and/or progress in labour, urinalysis should be performed to exclude ketones. If haematuria is present obstetric registrar review required.
- If fluid balance is mandated, this should be completed, and any concerns should be escalated.
- Excess fluid intake should not be encouraged.

Assess the baby's wellbeing by recording:

- fetal heart rate every 15 minutes for one minute after a contraction
- colour of amniotic fluid hourly or if it changes.
- assess indications for continuous electronic fetal monitoring (EFM) in accordance with the *fetal monitoring guideline*.

Assess the progress of labour by recording:

- frequency and duration of contractions every 30 minutes
- changes in the woman's behaviour
- abdominal palpation every four hours and prior to every VE
- Offer VE to assess descent of the fetal head and cervical dilatation every four hours. If there is concern about progress or at the woman's request VE may performed more frequently.
- in women whose most recent haemoglobin measurement is less than 100g/l, take blood for haemoglobin and group and save. Consider intravenous cannulation.
- Urine colour – if haematuria present for obstetric registrar review for potential obstructed labour causes e.g. due to Bandl's Ring (constriction between upper and lower uterine segments)/fetal size/malposition

Bladder care in labour:

- Encourage voiding every 2-3 hours of active labour.
- Record the volume and a urinalysis on EPR.
- Volume of urine passed spontaneously or from catheterisation should be recorded on a fluid balance chart.
- Please see 'Guideline for Intrapartum and postpartum bladder care

5.2 Progress in the first stage of labour

Progress in the established first stage of labour needs to take into consideration all aspects of labour and should include:

- cervical dilatation of at least 2cm in 4 hours for first labours
- cervical dilatation of at least 2cm in 4 hours with no slowing of progress for second or subsequent labours descent and rotation of the fetal head
- the strength, duration and frequency of uterine contractions
- Encourage the woman to communicate her need for analgesia at any point during labour.
- If a cervical lip is found on vaginal examination, a one-hour interval should be given, and a further examination should be undertaken. If not fully dilated at this point escalation should be made for a senior obstetric review.

5.3 Delay in the first stage

- If progress is less than expected encourage mobilisation or change of position, shower, analgesia, hydration and urination. Give the woman positive encouragement and provide more privacy and quiet to optimise oxytocin. This may continue for up to two hours, after which time a further VE should be performed.
- If progress remains slow, consider augmentation by ARM. Explain this should shorten the labour by about an hour but may also increase the strength and frequency of contractions.
- If delay is suspected, repeat the vaginal examination after two hours. If less than 1cm of progress, see ‘Delay in the first stage of labour’ (5.6, below) and refer to the obstetric registrar.
- Consider the use of oxytocin (Syntocinon) see ‘The use of oxytocin’ (see 5.4 below).
- Do not offer or advise clinical intervention if labour is progressing normally and the woman and baby are well
- first labours last on average 8 hours and are unlikely to last over 18 hours
- second and subsequent labours last on average 5 hours and are unlikely to last over 12 hours

If delay in the established first stage is suspected, take the following into account:

- parity
- cervical dilatation and rate of change
- uterine contractions
- station and position of presenting part
- the woman's emotional state
- referral to the appropriate healthcare professional.
- Offer the woman support, hydration, and appropriate and effective pain relief.
- Presence of haematuria

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, and diagnose delay if progress is less than 1 cm.

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

For all women with confirmed delay in the established first stage of labour:

- transfer the woman to obstetric-led care for an obstetric review and a decision about management options, including the use of oxytocin
- explain to her that using oxytocin after spontaneous or artificial rupture of the membranes will bring forward the time of birth but will not influence the mode of birth or other outcomes.

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

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

- Inform the woman that oxytocin will increase the frequency and strength of her contractions and that its use will mean that her baby should be monitored continuously.

- If oxytocin is used, ensure that the time between increments of the dose is no more frequent than every 30 minutes. Increase oxytocin until there are 3–4 contractions in 10 minutes, but <5 in 10 minutes.

Advise the woman to have a vaginal examination 4 hours after starting oxytocin in established labour:

- 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.

5.4 The use of oxytocin to augment labour

Prior to starting oxytocin, consideration should be given to:

- Method of onset of labour.
- Duration and progress of labour.
- Any risk factors.
- Maternal observations.
- Colour of the liquor.
- Strength and frequency of contractions.
- Findings of abdominal palpation and VE including presentation and position of the fetus.
- Presence of haematuria
- CTG classification at present and at all points in the labour process

Before the commencement of oxytocin in either nulliparous or multiparous women, an obstetrician should complete a full assessment of all clinical factors and assess abdominally and consider if a vaginal assessment is required. The commencement of oxytocin without obstetric assessment immediately prior can be considered only in cases of non-labouring inductions/augmentations with a normal CTG, and only if a conversation with the mother regarding the use of oxytocin has already occurred and been documented.

- Discuss analgesia and offer epidural analgesia before starting oxytocin.
- Commence continuous EFM 20 minutes prior to oxytocin starting.
- Continue to monitor maternal and fetal wellbeing as stated earlier in this guideline and fetal monitoring guideline.
- Prolonged use of IV Oxytocin is associated with fluid retention and reduced urinary output, ensure fluid balance is accurately documented on EPR and appropriate escalation occurs.

5.5 Documentation requirements relating to the use of oxytocin

- Assessment prior to commencement of oxytocin
- Individual management plan prior to commencement of oxytocin
- Dosage/changes of increment/stopping oxytocin

6. Second stage of labour

6.1 Definition of the second stage

For the purposes of this guideline, use the following definitions:

Passive second stage of labour:

- The **passive second stage** of labour is defined as the finding of full dilatation of the cervix prior to, or in the absence of, involuntary, expulsive contractions. The passive second stage of labour is not normally expected to last longer than one hour. Maternal and fetal observations should be commenced as per the care of women during the second stage of labour *(refer to fetal monitoring guideline).*

Onset of the active second stage of labour:

- The baby is visible
- Expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix
- Active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions.

6.2 Observations during the second stage

Carry out the following observations in the second stage of labour, record all observations on the partogram and assess whether transfer of care may be needed.

- Half-hourly documentation of the frequency of contractions
- Hourly blood pressure and pulse.
- Continued 4-hourly temperature
- Frequency of passing urine

Assess the baby's wellbeing by recording:

- Fetal heart rate every 5 minutes for one minute after a contraction *(refer to fetal monitoring guidelines)*

- Colour of amniotic fluid hourly or if it changes.
- Assess progress, which should include the woman's behaviour, the effectiveness of pushing and the baby's wellbeing, taking into account the baby's position and station at the onset of the second stage, the frequency and duration of contractions every 30 mins.
- Offer a vaginal examination hourly in the second stage, or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss).
- These factors will assist in deciding the timing of further vaginal examination and any need for transfer to obstetric led care.
- Ongoing consideration should be given to the woman's position, hydration, coping strategies and pain relief throughout the second stage.
- Avoid supine position. Encourage the woman to adopt a position she finds comfortable.

6.3 Duration of the second stage and definition of delay

For a nulliparous woman:

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

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.
- Diagnose delay in the active second stage when it has lasted 1 hour and refer the woman to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.

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

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

6.4 Oxytocin in the second stage

- 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.
- Review by an obstetrician prior to commencement of oxytocin is required.

6.5 The woman's position and pushing in the second stage

- Discourage the woman from lying supine or semi-supine in the second stage of labour and encourage her to adopt any other position that she finds most comfortable. Lithotomy poles should not be used routinely.

- Inform the woman that in the second stage she should be guided by her own urge to push. Women with epidural with no bearing down urge should have uterine contractions palpated and guided to bear down with uterine contractions.

- If pushing is ineffective or if requested by the woman, offer strategies to assist birth, such as support, change of position, emptying of the bladder and encouragement.

6.6 Intrapartum interventions to reduce perineal trauma

- Call for a second person for the birth
- Do not perform perineal massage in the second stage of labour.
- Slow and controlled birth of the head should be encouraged
- Manual perineal protection should be applied throughout the birth
- Warm compression during the second stage of labour reduces the risk of OASI.
- Routine use of lithotomy is not recommended, as this increases risk of OASI
- Do not carry out a routine episiotomy during spontaneous vaginal birth.
- If an episiotomy is performed, the recommended technique is mediolateral originating at the vaginal fourchette and usually directed to the right side. The angle to the vertical axis should be 60 degrees when the perineum is distended.
- Perform an episiotomy if there is a clinical need, such as instrumental birth or suspected fetal compromise.
- Provide tested effective analgesia before carrying out an episiotomy, except in an emergency because of acute fetal compromise.

6.7 Delay in the second stage

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

- An obstetrician should assess a woman with confirmed delay in the second stage (after transfer to obstetric-led care, following the general principles for transfer of care described in section 3.4) before contemplating the use of oxytocin.

- After initial obstetric assessment of a woman with delay in the second stage, maintain ongoing obstetric review every 30 minutes.

6.8 Assisted vaginal birth and delayed second stage

- Consider offering instrumental birth if there is concern about the baby's wellbeing or there is a prolonged second stage *(refer to Assisted Vaginal Birth guideline.)*

- Advise the woman to have a caesarean section if vaginal birth is not possible.

7. Third stage of labour

- Recognise that the time immediately after the birth is when the woman and her birth companion(s) are meeting and getting to know the baby. Ensure that any care or interventions are sensitive to this and minimise separation or disruption of the mother and baby.

7.1 Definition of the third stage

- For the purposes of this guideline, use the following definitions:

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

7.2 Prolonged third stage

- Diagnose a prolonged third stage of labour if it is not completed within 30 minutes of the birth with active management or within 60 minutes of the birth with physiological management. (See retained placenta guideline for care and management during this time)

7.3 Observations in the third stage

Record the following observations for a woman in the third stage of labour:

- Her general physical condition, as shown by her colour, respiration and her own report of how she feels
- Vaginal blood loss.
- If there is postpartum haemorrhage, a retained placenta or maternal collapse, or any other concerns about the woman's wellbeing refer to the appropriate guideline. Carry out 15-minute observations to assess whether resuscitation is needed and record on MEOWS.

7.4 Physiological Management of third stage

Physiological management of the third stage involves a package of care that includes the following components:

- No routine use of uterotonic drugs
- Hands off approach, where signs of placental separation are awaited and the placenta is birthed spontaneously or with the aid of gravity or maternal pushing.
- No clamping of the cord until pulsation has stopped
- Use of natural methods, such as nipple stimulation, warmth and breastfeeding.

7.5 Active management of the third stage

- Document in the records the decision that is agreed with the woman about management of the third stage.

- Women should be advised that active management of the third stage reduces the risk of postpartum haemorrhage and shortens the third stage. The woman should not be left without the presence of a midwife or obstetrician during the third stage. Throughout the third stage, the midwife should monitor the woman’s general physical condition as shown by her colour, respiration and her own report of how she feels as well as her PV blood

loss. In the presence of maternal collapse, PPH or retained placenta frequent observations to assess the need for resuscitation are required.

Active management of the third stage consists of:

- Injection of 10 units of oxytocin (Syntocinon) IM or 1 ampoule of Syntometrine shortly after birth.
- Deferred clamping and cutting of the cord
- Controlled cord traction
- Syntometrine should be used for women with the following risk factors. For women without these risk factors, oxytocin (Syntocinon) 10 units can be considered as it reduces the risk of nausea and vomiting compared to syntometrine:

    - Previous PPH
    - Multiple Pregnancy
    - Previous retained placenta
    - >35 years old
    - Grand Multip (5th or subsequent babies)
    - Antepartum Haemorrhage
    - Anaemia (< 9g/dl)
    - Polyhydramnios
    - Uterine fibroids
    - Proven or suspected abruption
    - Low lying placenta
    - Asian ethnicity
    - Obesity (BMI>35)
    - Prolonged active labour >12 hours
    - Oxytocin augmentation in labour
    - Precipitate labour
    - Baby >4kg
    - Pyrexia in labour
    - Women who decline blood products

- Support women at **low risk** of PPH who request physiological management. Any woman who has required obstetric intervention during the first or second stage of labour should be advised to have active management of the third stage.

- Recommend a change to active management in low risk women if haemorrhage occurs or the placenta is not delivered after one hour.
- If the placenta is not delivered after 30 minutes of active management or 60 minutes of physiological management refer to the guideline for retained placenta

- After administering the uterotonic, clamp and cut the cord.

- Do not clamp the cord earlier than 1 minute from the birth of the baby unless there is concern about the integrity of the cord or the baby has a heartbeat below 60 beats/minute that is not increasing

- Clamp the cord before 5 minutes in order to perform controlled cord traction as part of active management.

- If the woman requests that the cord is clamped and cut later than 5 minutes, support her in her choice.

- Perform controlled cord traction whilst guarding the uterus as part of active management only after administration of uterotonic and signs of separation of the placenta. Record the timing of cord clamping in both active and physiological management.

- Transfer the woman to obstetric led care and offer a change from physiological management to active management if the woman wants to shorten the third stage.

- Do not use either umbilical oxytocin infusion or prostaglandin routinely in the third stage of labour.

8. Initial Assessment of the Woman Following Birth

8.1 Initial Observations

- Temperature
- Pulse
- Blood pressure
- Uterine contraction
- Lochia

8.2 Ongoing observations

- Temperature
- Pulse
- Blood pressure
- Uterine contraction
- Lochia
- Early assessment of maternal emotional/psychological condition in response to labour and birth
- Successful 1st void of the bladder with documentation of time and volume

9. Auditable Standards

All documentation should be on the Electronic Patient Record.

Documentation of an initial assessment when labour commences in all care settings.

Documentation of an individual management plan when risks are identified during the initial assessment.

Documentation of referral of women when risks are identified during the initial assessment.

Documentation of the maternal observations carried out during established first and second stage of labour and third stage of labour.

Documentation of assessment prior to commencement of oxytocin.

Documentation of when oxytocin is stopped.

10. Monitoring compliance

This guideline will be subject to three yearly audit. The audit midwife is responsible for coordinating the audit. Results presented to the department clinical audit meeting. Action plans will be monitored at the department clinical audit meeting.

11. Reference

National Institute for Health and Care Excellence CG 190 Intrapartum Care of healthy women and their babies during childbirth 2014

Full version control record

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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	Sept 2015	S Coxon, Z Jones, J. Valimohamed, N. Rose-Stone, H Whapshott	Final	Joint guideline development
2.0	June 2019	S. Coxon, Z. Jones	Final	Updated and approved at OGCGC
2.1	July 2021	Z. Jones	Interim	Addition of haematuria observations (action from FPH patient safety and quality meeting). Ratified at OCGC 28/10/2021.
2.2	February 2022	Z. Jones	Interim	Update of section 5.7 (action from FPH patient safety and quality meeting). Ratified at OCG 28/2/2022
3.0	July 2023	C Smith-White, D Simkin	Final	Full review and update
3.1	August 2024	N. Rose-Stone, Consultant Midwife, WPH	Interim	Amendment to section 2. Ratified at OCGC 01/10/2024

Related Documents

Document Type	Document Name
Guideline	Intrapartum Fetal Heart Monitoring