South Eastern Health and Social Care Trust

SOUTH EASTERN TRUST
WOMAN & ACUTE CHILD HEALTH

GUIDELINE: CARE OF LOW RISK WOMEN IN ESTABLISHED LABOUR
(First, Second and Third Stage inclusive)

Title:	**Care of Low Risk Women in Established Labour**	**Ratified by Relevant Executive Directors: Yes / ~~No~~**	
Ownership:	**South Eastern Health & Social Care Trust**	**Status:**	**Current**
Publication Date:	**August 2011**	**Next Review:**	**August 2014**
Author(s)	**V.1 Helen Wallace, HFH Ward Manager/SOM, Practice Development Midwives Maureen Ritchie and Pat Scott, Dr. Caroline Bryson and Dr. Niamh McCabe Consultant Obstetricians** **V.2 M.Byrne, MLU Sister, 2011**		
Version **V1 – Jun 2009** **V1 _ Jun 2011**	**Evidence Base:** **Enkin, M. Keirse, MJNC, Renfrew, M and Neilson, J 1995** **A guide to effectiveness in Pregnancy and Childbirth Oxford: Oxford University Press** **Evidence Based Midwifery 2000 Eds. Munro, J and Spilby H, The Central Sheffield University Hospital** **NICE 2007 Intrapartum Care – care of healthy women and their babies during childbirth. Clinical Guideline London RCOG press.** **Nice July 2008 Induction of Labour Guidelines**		

1.0 INTRODUCTION

This guideline incorporates and replaces former legacy guidelines (UCHT 64, 68, 103,104 [2005]108[2005]105 and 106 and DLT 12, 13 and 14). It provides direction for all health care professionals involved in the care of low risk childbearing women whose gestation is between 37 – 42 weeks, based on current recommendations.

1.1 Childbearing women and their babies are the focus of care and should be offered evidence based information at all stages of their pregnancy to support and help them make informed decisions to manage their labour. Respect for a woman's wishes and her involvement in decision making is essential to her care in pregnancy and labour.

1.2 Women should be informed:

- That the evidence suggests there is a higher likelihood of normal birth with less intervention for women who give birth with midwifery led care, less use of pharmacological pain relief and increased satisfaction for the woman (Hodnett et al, 2005)

- Of the possibility of the need for transfer to Obstetric Care in the unlikely event of any deviation from normal in their condition.

1.3 If the woman is not established in labour, she should be given the opportunity of going home to her own environment until labour is established. She should be given advice on when to return i.e. established labour, spontaneous rupture of membranes or vaginal bleeding.

2.0 DEFINITION AND SCOPE OF GUIDELINE

2.1 Definitions

For the purpose of this guideline, the following definitions of labour are recommended:

Latent first stage of Labour – a period of time, not necessarily continuous, when there are:
- Painful contractions, and
- Some cervical change, including effacement and dilatation up to 4 cm

Established first stage of labour – when there are:
- Regular painful contractions, and
- There is progressive cervical dilatation from 4cm

Second stage of Labour
- The phase between full dilatation of the cervix to the birth of the baby

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

2.2 Scope

- To maintain optimal care throughout labour, respecting each woman's individual needs and expectations but maintaining vigilance to ensure that a safe environment and high clinical standards are maintained.

3.0 ROLES AND RESPONSIBILITIES

3.1 Where possible, care should be provided by a midwife known to the woman. All procedures should be fully explained and consented to, before being carried out, with every effort being made to relieve anxiety. If possible the midwife attending her antenatally should be informed of her admission.

3.2 Midwives should keep up to date with both pharmacological and non pharmacological methods of pain relief including water, position, movement, massage, coping strategies and alternative therapies (refer to Midwives Rules and Scope of Practice). A pain free labour does not guarantee satisfaction with child birth

3.3 On going assessment of the woman in labour will enable the midwife to respond to any risk factors, which may arise. The majority of women will proceed in labour without the need of further assistance.

3.4 On presenting in spontaneous labour, and in the absence of other risk factors, the midwife is responsible for assessing maternal and fetal condition and suitability for Midwife Led Care. Findings should be recorded in the Normal Birth Pathway

Or

Home from Home - UHD site only
When contractions commence following the administration of vaginal PGE_2.
Women may have no more than 2 PGE_2 pessaries prior to and in admission to Home from Home and must be post mature.

3.5 Current evidence does not support the use of an admission CTG in low risk pregnancy.
<u>UHD site only</u>. However, when contractions begin, following administration of vaginal PGE_2 for prolonged pregnancy, fetal well being should be assessed with continuous fetal monitoring. In the presence of a normal cardiotocograph, intermittent auscultation may then be used.

3.6 The midwifes' role is to watch, listen and interpret cues. Monitoring progress in labour will require more than routine assessment of contractions and cervical dilatation. The midwife must use her skills in abdominal palpation as well as her intuition and knowledge of the woman's behaviour in the different stages of labour.

4.0 KEY GUIDELINE PRINCIPLES

4.1 The mother's birth plan should be discussed in detail and adhered to within the realms of safety for both the mother and baby.

4.2 The mother's birth partner will need acknowledgement and be involved in discussions about birth options and practical tasks.

4.3 Nulliparous Women

Birth would be expected to take place within 3 hours of the start of second stage in most women. A diagnosis of delay in second stage should be made when it has lasted 2 hours and women should be referred to a health care professional who is trained to undertake an operative vaginal birth if birth is not imminent.

4.4 Parous Women

Birth would be expected to take place within 2 hours of the start of second stage in most women. A diagnosis of delay in second stage should be made when in has lasted 1 hour and women should be referred to a healthcare professional trained to undertake an operative vaginal birth is not imminent.

5.0 IMPLEMENTATION OF THE GUIDELINE

5.1 An abdominal examination should be performed on initial assessment and prior to all vaginal examinations and findings recorded.

5.2 If not in active labour the woman should be encouraged to return home (if hospital birth planned) to await events with appropriate advice on when to return.

5.3 Studies have shown that women admitted in the latent phase of labour have higher rates of intervention than those who await onset of active labour (Bailit et al, 2005).

5.4 Professional staff should be proactive in demonstrating and encouraging women to remain mobile and when necessary adopt a position that facilitates optimal fetal position.

5.5 Clinical intervention should not be offered or advised where labour is progressing normally and the woman and baby are well, within the agreed limits of low risk care.

6.0 FIRST STAGE OF LABOUR

6.1 Observations by a midwife during the first stage of labour include

- 4 hourly maternal temp, blood pressure
- Hourly maternal pulse
- ½ hourly documentation of frequency, duration and strength of contractions
- Vaginal examination offered 4 hourly once one to one care has commenced or where there is concern regarding progress in labour
- Liquor if present, colour and amount
- Abdominal palpation and assessment of vaginal loss should always precede vaginal examination
- Intermittent auscultation of the fetal heart after a contraction should occur for at least 1 minute, and be recorded at least every 15 minutes, and following vaginal examination.
- Respiration rate hourly - following opiate administration

NB Urinalysis – when possible, but voiding should be encouraged at least 2 hourly.

6.2 The opportunity to labour in water should be offered for pain relief. The woman's temperature and the water temperature should be monitored and recorded hourly to ensure the woman is not becoming pyrexial. (Refer to guideline, 'Labour and Delivery in Water').

6.3 Women may drink in established labour (isotonic drinks may be more beneficial than water).

6.4 Women may eat a light diet in established labour unless they have had opioids or they develop risk factors that make an anaesthetic more likely.

6.5 Antacids should not be given routinely to low risk women in labour. However, an oral antacid should be given following the administration of opioids

6.6 Inhalation Analgesia (Entonox) may be given at the mother's request, providing there are no contra-indications and according to the progress in labour

6.7 Drug administration should be recorded in medicine kardex, partograph, maternity notes and on the NIMATS system.

6.8 Controlled drugs should be recorded also in Controlled Drug Sheet/Register. Analgesia is offered according to relevant patient group directives and the needs/wishes of each mother.

6.9 Risk assessment sheets, as used within these maternity setting (infection, breastfeeding, thromoembolism), should be completed.

6.10 Any deviation from normal must be referred to obstetric care. MLU-complete consultant referral form. Delay in the first stage of labour is defined as <2cm in 4 hours (See Appendix 1) for management of suspected delay.

7.0 SECOND STAGE OF LABOUR

7.1 There is typically a latent or passive phase prior to involuntary expulsive contractions. Women should be supported while awaiting the urge to push.It is not recommended to perform a vaginal examination to confirm full dilatation if other signs present.

7.2 Clear signs that can accompany the onset of active second stage of labour include:

- changes in woman's behaviour voice and posture
- changes in facial expression
- overwhelming urge to bear down
- anus dilates
- vulva gapes
- spontaneous rupture of waters
- anal cleft line (Hobbs, 1998)
- Appearance of the rhomboid of Michaelas
- heavy show

- appearance of the presenting part

7.3 Observations in second stage include:

- hourly blood pressure and pulse
- 4 hourly temperature
- hourly vaginal examination in the absence of visible progress
- ½ hourly record of frequency of contractions
- frequency of emptying of the bladder
- intermittent auscultation of the fetal heart after each contraction for at least 1 minute and at least every 5 minutes, or more often at the midwives discretion

Consideration should be given to a woman's position, hydration, coping strategies and pain relief throughout second stage of labour.

7.4 Women should be discouraged from lying supine or semi supine.

7.5 Women should be guided by their own urge to push and should not require direction. If pushing is ineffective strategies such as change of position and emptying the bladder should be engaged.

7.6 Episiotomy is an emergency procedure and should not be carried out routinely in the second stage of labour. Like any surgical procedure episiotomy carries a number of risks.

7.7 There is no evidence to support the practices of guarding or massaging the perineum (Enkin *et al*, 1995).

8.0 THIRD STAGE OF LABOUR

8.1 Active management of the third stage involves all of the following components:

- Routine use of oxytocic drugs
- Early clamping of the cord
- Controlled cord traction (South Eastern Trust midwives practice Modified Brandt Andrews where the Uterus is guarded by the other hand while performing CCT).

Physiological Management is where there is no prophylactic oxytocic drug, no cord clamping and no cord traction, and the cord is clamped and cut when pulsation has stopped.

8.2 Physiological management is only appropriate for low risk women and then only if they have had a physiological labour and have not received an opioid for pain relief.

8.3 Women at low risk of postpartum haemorrhage who request physiological management of the third stage should be supported in their choice.

8.4 Physiological management must change to active management In the event of:

- Haemorrhage
- Woman's choice to shorten the third stage

And should be considered if the placenta is still retained after I hour.

8.5 A piecemeal approach to the third stage of labour, whereby elements of both methods are used e.g: no oxytocic drug but cord clamping and CCT, should never be employed.

9.0 EXITING THE NORMAL BIRTH PATHWAY

9.1 If a deviation from normal progress in labour (as laid out in the agreed Normal Birth Pathway) is suspected at any stage, or a risk factor is identified, advice from a colleague should be sought immediately and appropriate action taken.

9.2 Transfer to Obstetric care should be discussed with obstetric registrar and arranged with the Labour Ward Sister.

9.3 All findings and care given should be documented clearly in the woman's notes

9.4 For transfers from home from Home to main Labour Ward at UHD the 'Transfer of Woman to Main Labour Ward Summary' in the care pathway should be completed as well as the 'Transfer of Care' form.

9.5 The obstetrician on call for Labour Ward is responsible for reviewing the woman on transfer to Labour Ward and documenting a plan of care in the obstetric notes.

EQUALITY STATEMENT

This guideline has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote Equality of Opportunity.

In line with the duty of equality this guideline has been screened against particular criteria and as a result no major issues requiring further impact assessment have been identified.

This guideline has also been considered and prepared with regard to the Trust's obligation under the Human Rights Act 1998. The Trust is satisfied that the guideline complies with its obligations under the Act.

If at any stage of the life of the guideline there are any issues within the guideline which are perceived by any party as conflicting with his/her rights, that party should bring these to the attention of the Director of Human Resources & Corporate Affairs or raise a complaint through the published complaints procedure.

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Mrs. E. McEneaney
Assistant Director
Woman & Acute Child Health

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Dr. D Glenn
Clinical Director
Woman & Acute Child Health

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Dr. K. E. Madden
Head of Midwifery & Gynaecology/SOM
Woman & Acute Child Health

APPENDIX 1

MIDWIFERY LED EXCLUSION CRITERIA

These lists are not exhaustive and midwives must continually risk assess and refer the woman to obstetric care as appropriate.

Table 1 Medical conditions indicating increased risk suggesting planned birth at an obstetric unit (NICE, 2007)

Disease area	Medical condition
Cardiovascular	Confirmed cardiac disease Hypertensive disorders
Respiratory	Asthma requiring an increase in treatment or hospital treatment Cystic fibrosis
Haematological	Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major History of thromboembolic disorders Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100,000 Von Willebrand's disease Bleeding disorder in the woman or unborn baby Atypical antibodies which carry a risk of haemolytic disease of the newborn
Infective	Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended Hepatitis B/C with abnormal liver function tests Carrier of/infected with HIV Toxoplasmosis – women receiving treatment Current active infection of chicken pox/rubella/genital herpes in the woman or baby Tuberculosis under treatment
Immune	Systemic lupus erythematosus Scleroderma
Endocrine	Hyperthyroidism Diabetes
Renal	Abnormal renal function Renal disease requiring supervision by a renal specialist
Neurological	Epilepsy Myasthenia gravis Previous cerebrovascular accident
Gastrointestinal	Liver disease associated with current abnormal liver function tests
Psychiatric	Psychiatric disorder requiring current inpatient care

Table 2 Other factors indicating increased risk suggesting planned birth at an obstetric unit (NICE, 2007)

Factor	Additional information
Previous complications	Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty Previous baby with neonatal encephalopathy Pre-eclampsia requiring preterm birth Placental abruption with adverse outcome Eclampsia Uterine rupture Primary postpartum haemorrhage requiring additional treatment or blood transfusion Retained placenta requiring manual removal in theatre Caesarean section Shoulder dystocia
Current pregnancy Fetal indications	Multiple birth Placenta praevia Pre-eclampsia or pregnancy-induced hypertension Preterm labour or preterm prelabour rupture of membranes Placental abruption Anaemia – haemoglobin less than 8.5 g/dl at onset of labour Confirmed intrauterine death Induction of labour. The exception to this is prolonged pregnancy and becomes established in labour after 1 or 2 PGE2 pessaries (HFH at UHD ONLY) Substance misuse Alcohol dependency requiring assessment or treatment Onset of gestational diabetes Malpresentation – breech or transverse lie Body mass index at booking of greater than 35 kg/m^2 Recurrent antepartum haemorrhage Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound) Abnormal fetal heart rate (FHR)/Doppler studies Ultrasound diagnosis of oligo-/polyhydramnios
Previous gynaecological history	Myomectomy Hysterotomy

Table 3 Medical conditions indicating individual assessment when planning place of birth (NICE, 2007)

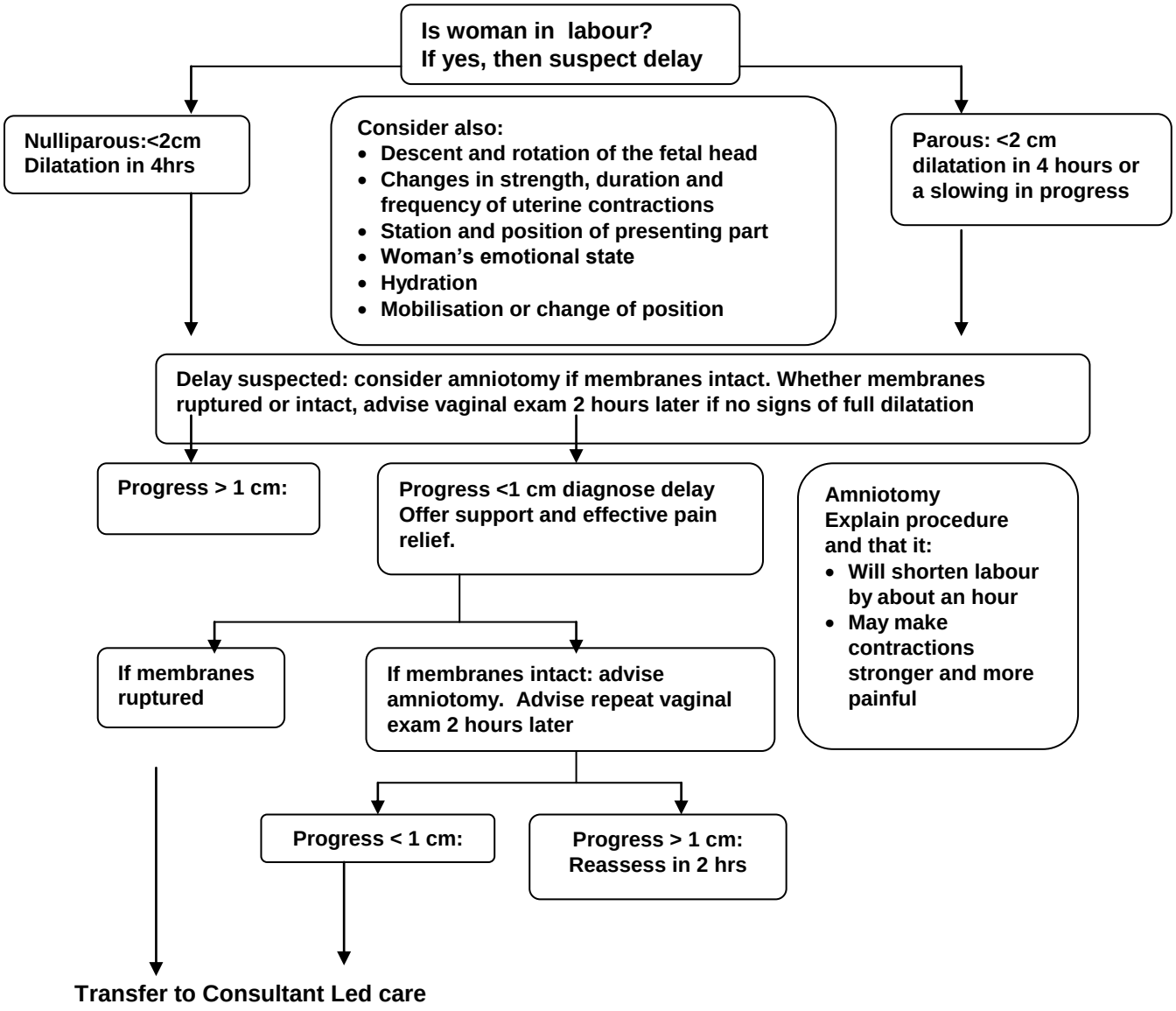
Disease area	Medical condition
Cardiovascular	Cardiac disease without intrapartum implications
Haematological	Atypical antibodies not putting the baby at risk of haemolytic disease Sickle-cell trait Thalassaemia trait Anaemia – haemoglobin 8.5–10.5 g/dl at onset of labour
Infective	Hepatitis B/C with normal liver function tests
Immune	Non-specific connective tissue disorders
Endocrine	Unstable hypothyroidism such that a change in treatment is required
Skeletal/neurological	Spinal abnormalities Previous fractured pelvis Neurological deficits
Gastrointestinal	Liver disease without current abnormal liver function Crohn's disease Ulcerative colitis

Table 4 Other factors indicating individual assessment when planning place of birth (NICE, 2007)

Factor	Additional information
Previous complications	Stillbirth/Neonatal death with a known recurrent cause Pre-eclampsia developing at term Placental abruption with good outcome History of previous baby weighing > 4.5 kgs Extensive vaginal, cervical or 3rd/4th degree perineal trauma Previous term baby with jaundice requiring exchange transfusion
Current pregnancy	Antenatal bleeding of unknown origin (single episode at greater than 24 weeks gestation Body Mass Index at booking of 30-34 kg/m2 BP of 140mm Hg systolic or 90 diastolic on two occasions Clinical or ultrasound suspicion of macrosomia Para 6 or more Recreational drug user Under current outpatient psychiatric care >40 years of age at booking
Fetal indications	Fetal abnormality
Previous gynaecological history	Major gynaecological surgery Cone biopsy or large loop excision of the transformation zone Fibroids

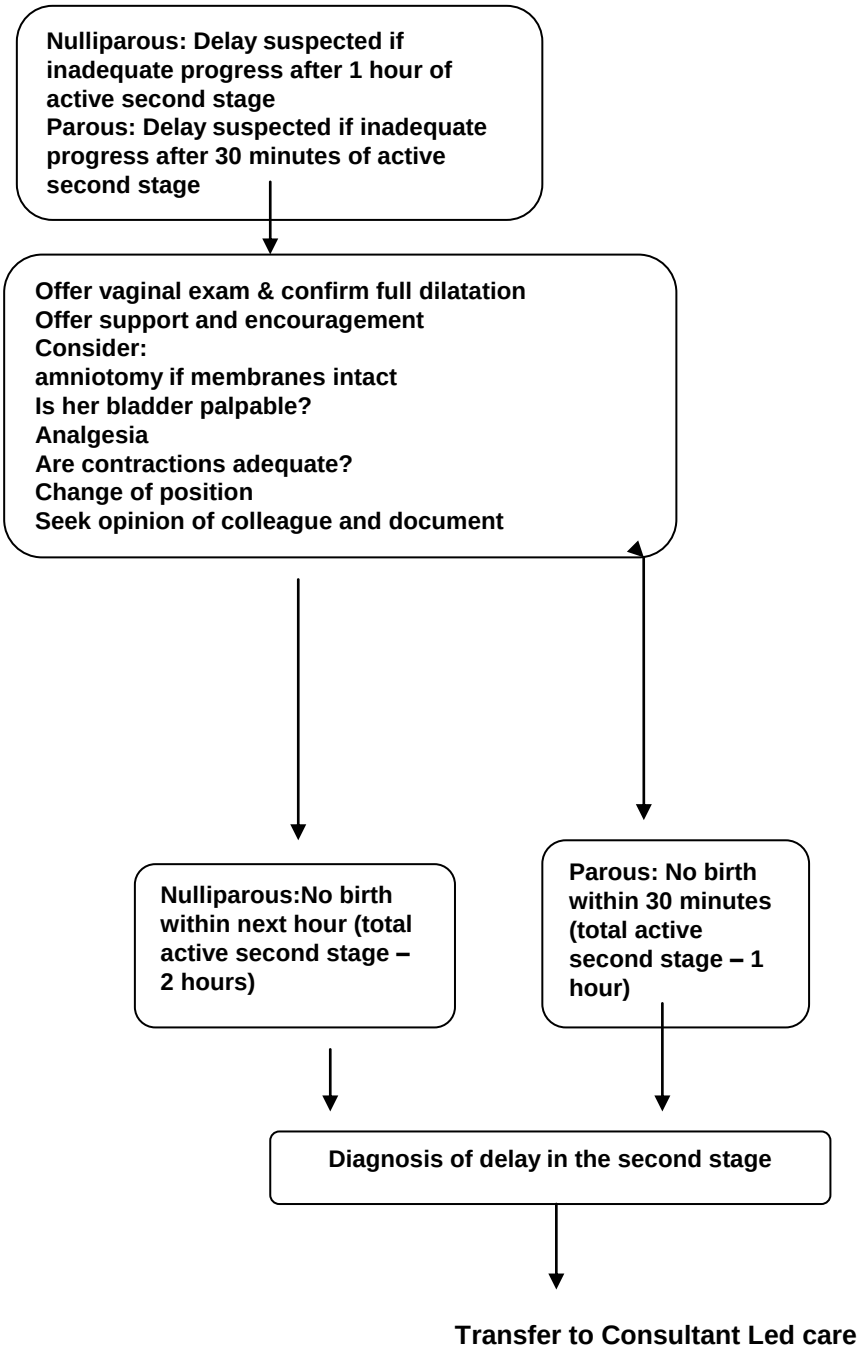
APPENDIX 2

Expected progress in the first stage



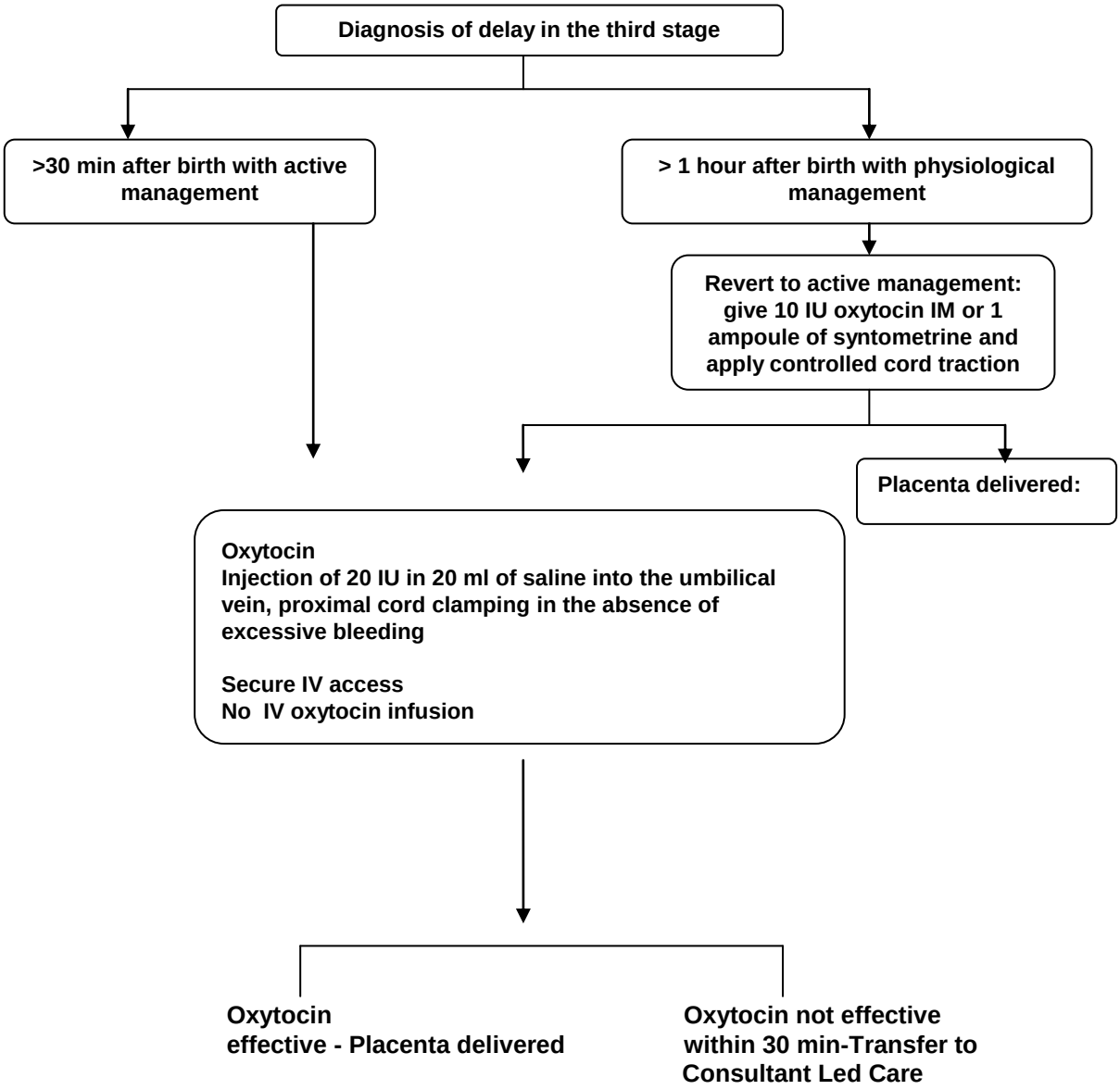
APPENDIX 3

Expected progress in the second stage:



APPENDIX 4

Expected progress in Third Stage



If physiological management is attempted but intervention is needed, management must proceed actively. <u>Do not adopt a piecemeal approach</u>

Physiological measures to aid expulsion of placenta may include:
Ensuring the bladder is empty
Offering the baby a breastfeed
Encouraging maternal effort to expel the placenta

At all times blood loss must be observed and clinical observations monitored