

Care in Labour Protocol			
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Related documents	<p><u>Wiltshire Community Health Services Maternity Policies and Procedures:</u></p> <p>140 Bladder Care in the Postnatal Period 180 Transfer and Discharge 156 Handover of Care and Communication 234 Fetal Concern 265 Augmentation of Labour 390 Waterbirth 300 Management of the third stage of labour 245 Obstetric Haemorrhage 360 Protocol of the Repair of Perineal Trauma</p> <p><u>Wiltshire Community Health Services General Policies and Procedures:</u></p> <p>GP047 Health Records Management Procedure</p>		
Equality & diversity	<p>This protocol has had an impact assessment against race, disability, gender, age, sexual orientation and religion and belief equality and diversity criteria in line with current legislation and the requirements of the Single Equality Scheme.</p> <p>NHS Wiltshire is committed to promoting equality and respect for the people of Wiltshire and for our staff. Our aim is to ensure that the way we work with individuals and communities - and their representatives - and with our staff, challenges inequality and affirms difference. This means all our services are accessible, appropriate and sensitive to the needs of individuals.</p>		
Monitoring Method	B - Annual Audit		

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Consultation route

Date of Issue	Version	Distribution	Amendments
August 2010	18	Clinical Effectiveness Forum	Amendments have been made to the following sections: 3 – Documentation 7 – Initial Assessment 9.1 – Established First Stage Labour: Observations must include.

Care in Labour

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1. Introduction

Birth is a life-changing event and the care given to women during labour has the potential to affect them both physically and emotionally in the short and longer term. Women and their families should always be treated with kindness, respect and dignity. Good communication is essential, supported by evidence –based information to allow women to reach informed decisions about their care. The views, values and beliefs of the woman, her partner and her family in relation to her care and that of her baby should be sought and respected at all times. (NICE 2007)

Birth is not a medical event but a ‘normal’ process and as such clinical intervention should not be offered or advised where labour is progressing normally (NICE 2007). If there are any concerns regarding maternal or fetal well being or the progress of labour then it is the responsibility of the midwife to seek a medical review.

2. Purpose

- To provide safe, individualised, one to one care for mother and baby.
- To provide informed choices for the mother and her partner relating to;
 - Place of delivery
 - Positions in labour
 - Monitoring fetal well-being
 - Pain relief
 - Episiotomy
 - Management of the third stage of labour
 - Haemorrhagic disease of the newborn (vitamin K preferences)
 - Contact with the baby immediately post partum
 - Feeding intentions

3. Documentation

- All records should be contemporaneous
- The name of the midwife caring for a woman should be clearly documented in the maternity health records.
- If there is a change of midwifery staff during the labour then a clear handover must be documented in the maternity health records by the presence of both midwives signature.
- All student midwives records must be countersigned. (NMC 2005)

4. Communication

- Greet the woman and her partner in a professional manner, introduce yourself and explain your role in her care
- Knock and wait before entering her room
- If the woman has a written birth plan, document that you have read and discussed it with her

- Discuss her plans for labour and birth. Assess her knowledge of strategies for coping with pain and provide balanced information to find out which available approaches are acceptable to her
- Encourage the woman to adapt the environment to meet her individual needs
- Ask her permission before all procedures and observations ensuring that adequate information has been given and understood
- Show the woman and her birth partner how to summon help; she may do so as often as she needs to. When leaving the room, let her know when you will return.
- Involve the woman in any handover of care to another professional
- Document in the maternity record any discussion, consent gained and name and designation of any health professional providing care for the woman

5. Normal labour and birth

Tell the mother:

Nulliparous women

The first stage of labour lasts on average 12 hours to 18 hours.

Parous women

Second and subsequent first stage of labour lasts 6 hours to 12 hours.

Nulliparous women

Birth would be expected to take place within three hours of the start of the active second stage in most women but a diagnosis of delay should be made when it has lasted two hours.

Parous women

Birth would be expected to take place within two hours of the start of the active second stage in most women but a diagnosis of delay should be made when it has lasted one hour.

Nulliparous women and parous women

The third stage of labour is diagnosed as prolonged if not completed within 30 minutes of the birth of the baby with active management and 60 minutes with physiological management

6. Care throughout labour

- Do not intervene if labour is progressing normally
- Ensure supportive one to one care in established labour
- Encourage involvement of birth partner
- Encourage the woman to mobilise and adopt comfortable positions

7. Initial assessment

- Each woman should be seen by a midwife within ten minutes of arrival (the reason for any delay should be clearly documented).

- On admission to the labour ward the initial assessment should include as a minimum;
 - a review of the maternity records including the antenatal history, the birth plan and the booked place of delivery
 - assess risk factors for thromboembolism
 - assess the need for an anaesthetic review
 - record maternal temperature, pulse, respirations, BP and urinalysis
 - abdominal palpation – fundal height, lie, presentation and engagement of presenting part
 - auscultation of the fetal heart rate
 - length, strength and frequency of contractions
 - assessment of pain and coping strategies should be discussed
 - ask about vaginal loss
 - assessment of liquor if membranes are ruptured
 - vaginal examination* should be offered
 - assessment of cervical effacement, dilatation and position
 - presentation and descent of the presenting part
- Explain the reason for the examination and what is involved
- Tap water may be used for cleansing prior to examination
- Explain findings sensitively
- All observations should be documented in the maternal health records, in the designated boxes where available, in the notes section of the maternal intrapartum health records and if in established labour (cervical dilatation of $\geq 4\text{cm}$) a partogram should be commenced.

*Vaginal examination – ensure the procedure is really necessary, obtain consent, ensure privacy, dignity and comfort. An abdominal palpation must be undertaken prior to all vaginal examinations and fetal heart auscultation must be undertaken prior to and following a vaginal examination and documented in the maternal health records by the obstetrician or midwife conducting the examination.

High risk women should be referred to medical staff as appropriate. Refer to other guidelines/policies as needed.

8. Coping with pain

8.1 Supporting women

- Consider your attitude to coping with pain in labour
- Ensure your care supports the woman's choice
- Offer support and encouragement
- Encourage her to ask for analgesia at any point

8.2 Pain – relieving strategies

- Encourage labouring in water to reduce pain
- Support women's use of breathing/relaxation techniques, massage, music
- Acupuncture, acupressure and hypnosis are not provided, do not prevent women if they wish to use these

- Provide information to enable women to make an informed choice regarding their choices for pain relief
- Ensure access to Entonox, opioids (such as pethidine or diamorphine) and epidural
- Provide anti emetics if opioids used
- No birthing pool or bath within 2 hours of opioids or if drowsy

8.3 Latent phase

Some women have pain without significant cervical change. Although these women are described as not being in established labour, they may well consider themselves 'in labour' by their own definition. Women who seek advice or who attend hospital with painful contractions but who are not in established labour should be offered individualised support and occasionally analgesia, and encouraged to remain at or return home. (NICE 2007)

9. Established first stage of labour

Definition - Regular painful contractions, progressive cervical dilatation from 4 cms.

For a healthy woman in an uncomplicated pregnancy and in any birth setting, intermittent auscultation via a 'dopplex' or pinnard stethoscope should be offered and recommended in labour to monitor fetal well being. The method of fetal heart rate (FHR) auscultation should be discussed with the woman and her partner.

Current evidence does not support the use of admission CTG in a low risk pregnancy and it is therefore not recommended.

Once established labour is confirmed all observations should be documented in the maternal health records and where appropriate on the partogram.

9.1 Observations must include:

- Every 15 minutes auscultate fetal heart rate for a minimum of 60 seconds immediately following a contraction. If a deviation from normal is suspected with the fetal heart rate the maternal pulse should be checked for comparison to differentiate between the two rates. Both rates must be documented in the maternal health records and on the partogram.
- Every 30 minutes: document frequency and strength of contractions
- Every 60 minutes: record maternal pulse.
- Every 4 hours: check BP, temperature and offer vaginal examination. An abdominal palpation must be undertaken prior to the vaginal examination to establish descent of the presenting part.
- Regularly check frequency of bladder emptying (4hrly as a minimum)
- Regular assessment of liquor if membranes are ruptured
- Consider the woman's emotional and psychological needs
- Assessment of pain and coping strategies should be discussed
- For women who are having continuous electronic fetal monitoring the CTG must be observed and the fetal heart rate documented every 15 minutes in the maternity records, if available a maternal pulsoximeter should be used. A full assessment should be completed every hour using the DR C Q BRAVADO

mnemonic and the 'fresh eyes approach' as per the Fetal Concern Policy No 234.

A light diet may be offered

Do not give Ranitidine routinely to low-risk women.

9.2 Indication for initiating electronic fetal monitoring (EFM) in low risk women

- Significant meconium stained liquor
- Abnormal fetal heart rate auscultated
- Maternal pyrexia (38.0° c once or 37.5° c on two occasions 2 hrs apart)
- Fresh bleeding
- The woman requests to be continuously monitored
- **Use of syntocinon**
- Increased diastolic BP over 90 mmHg or Increased systolic BP over 140 mmHg twice, 30 minutes apart
- Uncertainty about presence of a fetal heartbeat
- Delay in first stage
 - Nulliparous - < 2cm dilatation in 4 hours
 - Parous - < 2cm dilatation in 4 hours or slowing in progress

Seek obstetric advice and transfer to obstetric unit if appropriate

10. Second Stage of Labour

Definition

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

Observations in Labour

10.1 Observations must include:

- Every 5 minutes auscultate fetal heart rate for a minimum of 60 seconds immediately following a contraction. If a deviation from normal is suspected with the fetal heart rate the maternal pulse should be checked for comparison to differentiate between the two rates. Both rates must be documented in the maternal health records and on the partogram.
- Every 30 minutes: document frequency of contractions
- Every hour : check BP, maternal pulse and offer vaginal examination
- Vaginal examinations should be performed if the presenting part is not visible after 30 mins of pushing in a multigravidae or one hour in a primigravidae
- Every 4 hours: check temperature
- Regularly: check frequency of bladder emptying
- Assess progress, including fetal position and station

- If woman has full dilation but no urge to push, assess after 1 hour, discourage the woman from lying supine/ semi supine.
- Consider the woman's position, hydration and pain relief needs. Provide support and encouragement.

Observations during all stages of labour should be recorded in the maternal notes and if appropriate on the partogram

Concerns and suspected delay in the second stage

10.2 Indication for electronic fetal monitoring (EFM) in low risk women

- Meconium stained liquor
- Abnormal FHR (less than 110 bpm, greater than 160 bpm)
- Maternal pyrexia (38.0° C once or 37.5° C on two occasions 2 hrs apart)
- Fresh bleeding
- Oxytocin for augmentation

Seek Obstetric advice and transfer to obstetric unit if appropriate

11. Birth

11.1 Positions for Labour and Delivery

This should be discussed with the woman and her wishes respected as far as possible. The actual position in which the woman is delivered should be documented in the maternal notes.

11.2 Attendance at Delivery

There should be two professional attendants present in the room at delivery. This may include a student midwife. The names of all professionals attending the delivery must be documented.

Any reason for the non attendance of two professionals should be documented.

11.3 Episiotomy/Perineal Tears

Only carry out episiotomy (right mediolateral) when there is:

- A clinical need such as instrumental birth
- Suspected fetal compromise
- Do not offer routinely following a previous 3rd or 4th degree tear
- The reason for episiotomy must be recorded.
- Use effective analgesia prior to an episiotomy (when practically possible) and for repair of any tear
- Document analgesia on the prescription sheet.

12. Third stage of Labour

Observe physical health

Check vaginal loss

- **Active management** - intramuscular Syntometrine (ergometrine maleate 0.5mg and oxytocin 5units/ml)
 1. Advise that this reduces risk of haemorrhage and shortens the third stage
 2. If there is a history of raised blood pressure (more than 2 readings above 90mmHg diastolic in labour) or if there is a history of severe asthma, 10 units of Syntocinon (oxytocin) IV should be used instead.
 3. Early clamping/cutting of the cord and controlled cord contraction
 4. All drugs must be documented on the prescription sheet.

- **Physiological management**
 - No Oxytocin/no early cord clamping
 - Delivery by maternal effort
 - Do not pull cord or palpate uterus

12.1 Care and Observations in the 3rd Stage of Labour

- Maternal health and condition should be closely monitored
- Vaginal loss should be closely observed

12.2 Concerns and suspected delay in the third stage

- Active management > 30 minutes
- Physiological management > 1 hour
- Suspected post partum haemorrhage

Seek Obstetric advice and transfer to obstetric unit if appropriate

13. Immediate Postpartum Care

- A full assessment of maternal and fetal well being must be made following delivery. Maternal observations should include;
 - observe physical condition
 - how she feels
 - colour
 - temperature
 - pulse
 - respirations
 - blood pressure
 - well contracted uterus
 - lochia
 - rectal examination should be performed following delivery and following repair of perineum
 - assess maternal emotional and psychological condition
 - consider analgesia prior to systematic assessment of trauma
 - bladder voiding – document time and amount of first void

Pre and Post Suturing

Swabs, tampon and needles must be counted and signed for by the midwife/doctor conducting the repair before and following the procedure. Only large, X-ray detectable swabs are to be used during the repair. Swab, needle, tampon and instrument count is the responsibility of theatre staff for all deliveries and perineal repairs undertaken in theatre.

The placenta and membranes must be examined after the delivery.

- Baby
 - Apgar score at 1, 5 and 10 minutes
 - Keep warm
 - All mothers should be given their babies to hold for an unlimited period with skin to skin contact as soon as possible after delivery in a relaxed, unhurried environment.
 - They should be encouraged to initiate the first breastfeed as soon as the baby is receptive
 - Do not separate the woman and baby in the first hour
 - Record baby's head circumference, length, body temperature and weight

All midwives are encouraged to visit women they have delivered or cared for in labour to give them the opportunity to talk through their experiences.

14. Auditable Standards


- The partogram will be commenced in established labour.
- The fetal heart will be auscultated every 15 minutes in the first stage of labour with maternal pulse comparison if a deviation from normal with the fetal heart rate is suspected
- All women will be asked to empty their bladder regularly (4hrly as a minimum)
- The mothers preferred choice of third stage management will be clearly defined and actioned
- Abdominal palpation will be performed prior to vaginal examination
- A risk assessment is completed at the commencement of care in labour
- Any women with identified risk factors are referred for obstetric opinion

15. References

1. National Institute for Health and Clinical Excellence (2007) *Intrapartum Care Care of healthy women and their babies during childbirth* NICE London
2. Clinical Negligence Scheme for Trusts 2008 *Standard 2 Criterion 4 Care of women in labour*
3. Standards for Better Health July 2004
C13a Patients treated with dignity and respect
C13b Patient consent
C 13b Element 3 Support for patients with communication needs

16. Appendices

Appendix 1 – Equality and Diversity Impact Assessment

Equality & Diversity Impact Assessment 	
Title of Document	Care in Labour
Is the policy new or existing?	Existing
Date policy was created	September 2008, reviewed August 2010
Does this policy contain the Trust's statement on Equality?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Date policy is due to be reviewed	February 2013
Who was/will be consulted over this policy?	Lay input via Labour Ward Forum.
What is the main purpose of this policy	<ul style="list-style-type: none"> • National guidance. • Consistency of practice. • Compliance with CNST. • Evidenced-based practice.
Is this policy contractual?	No
Who is this policy aimed at or who will be affected by it?	PCT staff
What are the likely implications for the Trust of this policy?	Compliance with national standards.
What, if any, are the resource implications of this policy?	Within financial budget
What is the legislation, ethic or other guiding principle behind this policy?	Equality and diversity – Maternity is accessible to all.
Is this policy likely to have an adverse effect on any specific group taking into account: sex, gender, ethnicity, colour, national origin, and disability, physical or mental health?	No
Could this policy discriminate directly or indirectly against any staff group with reference to Sex, Race Disability Discrimination acts or the Regulations on Religion or Belief and Sexual Orientation? If so how?	No
If this policy could be discriminatory in any way, what actions will be taken to remedy this?	N/A
Where will this policy be stored and how will it be accessed?	Electronic storage – access through the PCT's internet and in paper copy by request to the communications team