WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

Care of Women in Labour
(Including clinical risk assessment in labour)

Amendments			
Date	Page(s)	Comments	Approved by
Nov 2009	6	Monitoring section amended Appendix 1 added to comply with CNST requirement	Women's Health Guideline group
August 2010	2	30 minute waiting time standard on admission to Labour ward added	Women's Health Guideline group
July 2012	Whole document review	Risk assessment updated to include lifestyle changes	Supervisors of Midwives
Jan 2014	6	Additional guidance added re ARM and fetal observations	Women's Health Guideline group
June 2015	Whole document review	Updated following NICE guidelines; table added for maternal observations; appendices added	Women's Health Guideline group
Aug 2017	7	Suspected delay management clarified	Women's Health Guideline group
April 2019		Amended to incorporate Badgernet & NICE 2017 updated references	Women's' Health Governance Group
Aug 2019	3	Addition of invite to unit when requesting care outside clinical guidance	Women's health & guidelines group

Compiled by: Women's Health Guidelines Group (WHGG)

In Consultation with: Obstetric and Anaesthetic Consultants
Women's Health Guidelines Group
Supervisors of Midwives

Ratified by: Women's Health Guidelines Group

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Target Audience: All Healthcare Professionals Working within the Maternity Service

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Comments on this document to: Women's Health Guidelines Group

Care of women in labour

See also:
Epidural and CSE Labour analgesia (including accidental Dural Puncture)
Waterbirth guideline
Fetal Monitoring guideline
Induction of Labour guideline
Use of Oxytocin (Syntocinon) to induce/augment labour
Management of Retained Placenta guideline
Bladder Care guideline
Perineal Trauma, Management & Repair guideline
Referral to Maternity Services, Booking Appointments and Maternity Care Pathway including Missed Antenatal appointments
GBS/Sepsis guideline
Meconium stained liquor guideline
Abbey Birth Centre Operational and Clinical guideline

1. Place of Birth

The intended place of birth should be recorded clearly on the notes from booking. If a woman's risk status changes at any point in the antenatal, intrapartum or postnatal period, her suitability to continue under midwifery led or consultant care must be clearly documented and a management plan recorded - to include a review by a senior obstetrician, referral to a Consultant clinic or the ABC assessment clinic at 36/40, if appropriate. The woman needs to be fully informed of the reasons for the change with documentation in the notes reflecting the discussion.

2. Introduction

This guideline is based on: *Intrapartum care. The care of healthy women and their babies during childbirth. (NICE*, 2017) The over-riding principle is that care should be based on a model of partnership working between the woman and her care providers. Women should be supported in making informed choices at every stage of the care pathway. The ultimate aim to ensure that women and their partners are kept safe during their experience of labour and birth, and, emerge feeling positive and empowered 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 interprofessional team. Please refer to the following document for further guidance http://www.nice.org.uk/guidance/cg138/chapter/1-Guidance

1. Risk assessment in labour

At the time of admission in labour, the woman's pregnancy Notes must be reviewed on badgernet. The risk assessment is a continuous process noting that the clinical risks can change at any time during labour; the action planning must, therefore, be reviewed and updated according to clinical findings (National Patient Safety Agency (2007), NICE (2017))

Where risks have been identified as part of the clinical risk assessment process an individualised care plan must be developed and documented, in consultation with the woman and her family. Each woman must be aware of the associated risks, benefits and alternatives of any proposed plan of care.

Women who plan to receive intrapartum care in the community setting will have a risk assessment undertaken by the community midwife who attends her in labour.

The following risks should be assessed when considering whether midwifery led care in labour is appropriate. (NICE 2017) - To be reviewed in conjunction with the ABC Clinical guideline and criteria see Appendix 1 for details;

- Medical conditions requiring ongoing treatment
- Gestation less than 37 weeks;
- Indications for electronic fetal monitoring (EFM) including abnormalities of the fetal heart rate (FHR) on intermittent auscultation. See; Fetal monitoring guideline
- Delay in the first or second stages of labour
- Significant meconium stained liquor
- Maternal request for epidural pain relief
- Obstetric emergency- antepartum haemorrhage, cord presentation/prolapse, breech presentation, postpartum haemorrhage, maternal collapse or an expected need for advanced neonatal resuscitation
- Retained placenta
- **Maternal pyrexia in labour 38˚c on one occasion or ≥37.5˚c on two occasions 60 minutes apart, see table 1 below for escalation and refer to Sepsis Six Pathway and guideline and GBS guideline**
- Malpresentation
- Raised blood pressure
- 3rd or 4th degree tear or complicated perineal trauma requiring suturing by a doctor

NB This list is not exhaustive and each case should be individually assessed and reviewed.

If any of the above are identified either pre labour or intrapartum the woman should be referred to Consultant Led care as she will no longer be suitable for midwifery led care. As such, she must be reviewed by a senior obstetrician, registrar or above, **within an hour** and a plan of management formulated and documented in the woman's notes.

Women must be invited to attend the unit immediately for assessment when requesting care outside of clinical guidance where a management plan is not already in place.

2. On admission

When a woman presents to the birth centre, labour ward triage or labour ward it is expected that she should wait no longer than **30 minutes** for an initial assessment by a midwife. If it is anticipated that the woman will not be seen immediately when she presents to labour ward, she should be asked to wait in the reception area and her notes taken to the team leader. Her name and time of arrival must be written on the **'waiting area board'** this will avoid exceeding the 30 minute waiting time.

Listen to the woman's story; consider her psychological and emotional needs, and upon reviewing her clinical records, **identify and document any risk factors and special instructions for labour from the antenatal notes, this includes any medical conditions to be considered.** See; Appendix 1 for risk assessment

- The fetal heart rate (FHR) should be auscultated for a minimum of one minute following a contraction. The maternal pulse should be palpated and recorded to differentiate between maternal and fetal heart rate.

- Perform an assessment of maternal wellbeing including maternal vital signs, pulse, blood pressure, temperature and respiratory rate and urinalysis – see table 1 below for parameters . Record on the MEOWS chart. Assess her level of pain, including discussing and recording her wishes for pain relief in labour.

- Perform a fetal assessment including abdominal palpation, vaginal loss – show, liquor, blood. (Refer to: Fetal Monitoring guideline).

- Assess the stage of labour based on the frequency, duration and strength of contractions (include palpation of contractions) and woman's behaviour using the Burville score see appendix 3 and/or a vaginal examination (VE) to determine whether the woman appears to be in established labour -**refer to appendix 3 The Modified Burville Score for guidance**

- Document all findings and discussions in labour notes

- All women should have a VTE risk assessment documented on admission and after 24 hours

Table 1 – Maternal Observations

	Parameter	Escalation	Parameter	Escalation
Heart Rate	100-120bpm	Repeat in 30 minutes unless other risk factors/ scoring 1 red and 2 amber on MEOWS **- for senior obstetric review asap**	≥100 with any other risk factors – see sepsis pathway; OR ≥ 120 on repeat with or without other risk factors	**For immediate senior obstetric review**
Respiratory Rate	≥20	Repeat in 30 minutes unless other risk factors/ scoring 1 red or 2 amber on MEOWS **- for senior obstetric review asap**	≥20 on repeat with or without other risk factors	
Blood Pressure	Systolic > 140 or Diastolic > 90	Repeat in 30 minutes or if 1 red or 2 amber on MEOWS and/or++protein in urine/ other risk factors – **for senior obstetric review asap**	Single reading -Systolic >160 **or** -Diastolic >110 or on repeat Systolic >140 **or** Diastolic >90	
Temperature – **to be taken per axilla only**	<36˚c-≥37.5˚c	If ≥ 37.5˚c but <38˚c with no other risk factors repeat in **60** minutes **otherwise for immediate senior obstetric review**; if <36˚c with no other risk factors- as above	38˚c once or ≥37.5˚c on two occasions 60 minutes apart with or without other risk factors	**For immediate senior obstetric review/Refer to Sepsis Six**

				Pathway
Urinalysis	+protein (clean sample) if no SROM	Repeat at next sample if in isolation; for senior obstetric review if any other risk factors	++ protein	Send urgent PCR for senior obstetric review asap if any other risk factors/concerns

If risk factors are identified either in the antenatal period or on admission, the woman is not suitable for midwifery led care in labour and therefore, must be managed by the labour ward obstetric team. The named midwife caring for the woman will notify the labour ward team leader and the obstetric registrar. The obstetric registrar will review the woman at the earliest opportunity, within 1 hour, and will agree and document a plan of care in the labour notes. See: Appendix 1 for risk assessment.

3. Communication

Communication must be clear with explicit and transparent lines of communication with details of the risk assessment and ongoing plan of care communicated, and recorded in the notes, with all relevant members of the Interprofessional team, and the woman and her family, CEMCH (2007), NMC (2015)

- Ensure good communication with the woman and her birth partner. Discuss their birth plan and their expectations of labour. Explain all procedures, seek permission and discuss findings
- All health professionals must ensure that all assessments and reviews undertaken are recorded and provide clear written evidence of any arrangements made for ongoing care or treatment.
- Aim to provide one-to-one midwifery care once labour is established and support the presence of birth partners. Ensure privacy, dignity and confidentiality.

4. Overall care

- Encourage mobilisation and the use of equipment such as birthing balls; mats; pool, birth stool
- Whilst it is acknowledged that the majority of pregnant women will be ambulant and self- caring, that state can and may well change during the course of their care. Women with reduced or impaired mobility in conjunction with other risk factors such as increased BMI are at higher risk of pressure trauma. Therefore, women should be encouraged to change their position regularly. All women should have a Waterlow score assessment and a manual handling risk assessment at the beginning of labour and whenever their situation changes.
- Encourage women to empty their bladder regularly (every 4 hours as a minimum).
- Reassure women that making noise is normal.
- Maintain Trust cleanliness and infection control standards.
- Document all care in the woman's notes.

Work on an assumption of normality unless otherwise indicated. Do not offer or advise intervention if labour is progressing normally and the woman and baby's observations are within normal limits. Refer to Appendix 4 – Pathway for Normal Labour

4.1 Nutrition

Ensure hydration and encourage nutrition in early labour.

- Women may drink during established labour; isotonic drinks may be more beneficial than water (Kubli et al 2002).
- Women may eat a light diet e.g.; tea and toast, sandwich, during established labour unless they have received opioids or they develop risk factors that make a general anaesthetic more likely (NICE 2017)
- Ranitidine 150mg and Metoclopramide 10mg should be given orally (8 hourly) to women who receive opioids or who have or develop risk factors that make a general anaesthetic more likely.

Refer to: Epidural and CSE Labour analgesia (including accidental Dural Puncture guideline).

4.2 Analgesia

- Discuss the range of analgesia options available. Reassure the woman she may ask for analgesia at any point in her labour.
- Consider and discuss, but do not rely upon, a vaginal examination (VE) prior to analgesia to assist ongoing care planning, in context to the overall clinical picture.
- Support breathing, relaxation and partner massage techniques. Support the woman's choice of music in the labour room.
- Acupuncture, acupressure and hypnosis are not provided, but women who wish to use these techniques should not be prevented from doing so. (NICE 2017)
- Transcutaneous Electrical Nerve Stimulation (TENS) is of greater benefit when applied in the early stages of labour rather than when in established labour. (NICE 2017)
- Support the use of the pool for analgesia in accordance with the *Waterbirth* guideline. NB: Women should not enter water within 2 hours of opiod administration or if they feel drowsy.
- Offer Entonox. Give clear instructions as to its use and inform women they may feel nauseous and light-headed.
- Pethidine, up to 200mg in divided doses with a maximum individual dose of 150mg can be given by the midwife without consultation with medical staff (under midwives exemptions). The first dose should always be given with an anti-emetic. Inform the woman that this may have side effects for both her (drowsiness, nausea and vomiting) and her baby (short-term respiratory depression and drowsiness which may last several days) and may also interfere with breastfeeding.
- Epidural analgesia is available on request, including to women in severe pain in the latent phase of labour. If a woman is contemplating an epidural, talk to her about the risks and benefits and the implications for her labour, including the arrangements and time involved for transfer of care to an obstetric unit if she is at home or in ABC. Also inform her that having an epidural will be accompanied by a more intensive level of monitoring and intravenous access so her mobility may be reduced i.e.
  -Women should be advised that they will need a continuous CTG during the establishment of regional analgesia and a 30 minute CTG following every administration of a bolus of 10ml or more of epidural solution as per NICE guidance (2007), amended 2014.
  -Women who have an epidural during labour should be catheterised with an indwelling size 12CH Foley's catheter.
  -Epidural anaesthesia should be continued until after the birth and any required perineal repair is complete (refer: to Epidural and CSE Labour analgesia (including accidental Dural Puncture)
  A fluid balance chart should be started with catheterisation of the urinary bladder.

5.3 Definition of the First Stage of Labour

The latent stage is defined as a period of time, not necessarily continuous, when:

- there are painful contractions, and/**OR**
- there is some cervical change, <u>including</u> effacement and dilatation up to 4 cm

Women without complications can go home, with clear information about when to return e.g. SROM, bleeding, increasing contractions. Discuss strategies for coping with contractions e.g. warm bath, mobilisation, simple analgesia, relaxation, massage. The triage midwife should document the guidance and or leaflets that are given to the woman.

5.4The established first stage of labour is defined as when:

- there are regular painful contractions and/**OR**
- there is progressive cervical dilatation from 4cm

5.5 When confirmed established in the first stage as described above:

- Begin the partogram and continue to document all observations during established labour – to include a MEOWS (modified early obstetric warning score)risk assessment to be completed on vital Pac.
- Assess the woman's wellbeing by recording:
  - pulse hourly (or every 30 minutes where continuous EFM is used)
  - blood pressure and temperature every four hours (temperature to be recorded hourly in 1st stage and ½ hourly if in the pool)
  - the frequency of bladder emptying, they should be encouraged to void every 4 hours
- Assess the baby's wellbeing by recording:
  - fetal heart rate every 15 minutes for one minute following a contraction
  - colour of amniotic fluid hourly or if it changes.
  - NB If meconium present refer to meconium stained liquor guideline.
- Assess indications for continuous electronic fetal monitoring (EFM) in accordance with the fetal monitoring guideline.
- Assess the progress of labour by palpating and recording:
  - Strength, frequency and duration of contractions every 30 minutes
  - changes in the woman's behaviour
  - abdominal palpation every four hours, and prior to every VE
  - VE, if appropriate, to assess descent of the fetal head and cervical dilatation every four hours (NICE 2014). If there is concern about progress or at the woman's request, a VE may be performed more frequently, **consider clinical indication for repeated VE if SROM**, any concerns re infection. Fetal position must be documented after 7cms dilatation. If unable to define position, the team leader/senior midwife will need to perform a further VE.

In women whose most recent haemoglobin measurement is less than 100g, take blood for haemoglobin and group and save.

5.6 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: (NICE 2017)
  - the strength, duration and frequency of uterine contractions
  - 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
- If there has been <2cm dilatation over 4 hours this is 'suspected delay in labour'. The midwife should consider ARM and encourage midwifery interventions (mobilisation or change of position, bath or birth pool, analgesia, hydration and urination).
- In labour with 'suspected delay' the midwife should repeat the VE in 2 hours. If there has been <1cm further dilatation then 'delay in labour' has been confirmed and augmentation with syntocinon should be advised (if no clinical contraindication) and the woman discussed with the obstetric staff (see below).
- Note: In a recent study, only 11% of women had 'confirmed delay' after 2 hours of midwifery interventions (BJOG 2013)

5.7 Delay in the first stage of labour

The use of oxytocin to augment labour refer to: Use of Oxytocin (Syntocinon) to induce/augment labour

- Prior to starting Syntocinon 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
- Nulliparous women should be discussed with the shift leader and obstetric registrar/ SHO. Syntocinon must be prescribed as per guideline.
- Multiparous women should be seen and assessed abdominally and vaginally by the obstetric registrar before Syntocinon is considered.
- Inform the woman that the use of oxytocin:
  - will bring forward the time of birth but not influence the mode of birth
  - is an indication for continuous EFM
  - will increase the strength and frequency of contractions
- Discuss analgesia and offer epidural analgesia before starting Syntocinon
- Commence continuous EFM as soon as Syntocinon is commenced (if not already started)

6. Definition of the second stage of labour (NICE 2017)

- 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. If full dilatation of the cervix has been confirmed in a woman without an epidural and she is not involuntarily pushing after one hour, a vaginal examination must be carried out and the position of the presenting part defined and documented. Continue to assess the strength and frequency of contractions. Inadequate contractions may indicate the need for Syntocinon augmentation.

- The **active second stage** of labour begins when:
  - the baby is visible
  - there are expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix
  - there is active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions.

Observations during the second stage of labour:
- Assess the woman's wellbeing by recording:
  - pulse every 15 mins to differentiate between the two heart rates blood pressure hourly (or maternal pulse every 30 minutes when there is continuous EFM)
  - continue 4 hourly temperature
  - the frequency of bladder emptying
- Assess the baby's wellbeing by recording:
  - fetal heart rate every 5 minutes for one minute following a contraction
  - Colour of amniotic fluid hourly or if it changes. If meconium present refer to Meconium Stained Liquor guideline.
- Assess the progress of labour by recording:
  - Palpation of the strength frequency and duration of contractions every 30 minutes
  - changes in the woman's behaviour
  - the effectiveness of pushing
  - abdominal palpation (prior to any VE)
  - VE to assess descent of the fetal head and position every hour.
- Avoid supine position. Encourage the woman to adopt a position she finds comfortable.
- Empower the woman to be guided by their own urge to push. At the woman's request or if pushing is ineffective, offer encouragement, change of position, bladder emptying.
- Use the 'hands on' (guarding the perineum and gently controlling the birth of the baby's head) or the 'hands poised' (with hands off the perineum and baby's head but poised in readiness for changing to hands on) technique at birth.

6.1 Progress in the second stage of labour

Birth would be expected to occur within three hours of the start of the second stage in nulliparous women and within two hours of the start of the second stage in parous women.

6.3 Delay in the second stage of labour

Delay would be diagnosed by:

- After 2 hours active second stage in a nulliparous woman
- After 1 hour active second stage in a parous woman

- Discuss analgesia.
- ARM prior to the active second stage of labour.
- Refer to the obstetric register unless birth is imminent.
- Consider episiotomy

Unless the birth is imminent, referral to an obstetric registrar for delay in the birth of the baby should be made after two hours of the second stage in nulliparous women and after one hour in parous women.

7 Third stage of labour

Recognise that the time immediately after birth is when the woman and her partner are meeting and getting to know their baby. Ensure that any care or interventions are sensitive to this and minimise separation or disruption of the mother and baby. Women should be advised that active management of the third stage

reduces the risk of postpartum haemorrhage and shortens the third stage. If a woman has risk factors for a postpartum haemorrhage, highlight these in her notes, and make and discuss with her a care plan covering the 3rd stage of labour (NICE 2017).
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 and document 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. Document in the notes the decision that is agreed with the woman about management of the third stage

Active management of the third stage consists of:

- IM Syntometrine shortly after birth
- Deferred clamping and cutting of the cord between 1 and 5 mins – **do not clamp the cord earlier than 1 minute unless there is concern about the integrity of the cord or the baby's HR is <60bpm and is not rising**
- Controlled cord traction following signs of separation of the placenta

Physiological management involves:

- No routine use of uterotonic drugs
- No clamping of the cord until pulsation has stopped then, if appropriate, clamping baby's end by the umbilicus and leaving the maternal end unclamped
- Encouraging the mother to be in an upright position
- Encouraging skin to skin and early breastfeeding (if appropriate)
- Delivery of the placenta by maternal effort – **do not attempt to use control cord traction**

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: *Retained Placenta Guideline*).

7.1 Following delivery of the placenta

- Assess and document the woman's condition; pulse, blood pressure, respiration rate, temperature, uterine contraction and vaginal bleeding within the first 30 minutes and subsequently as indicated by her condition (observations to be recorded on the MEOWS chart)
- Check the placental vessels and completeness of the placenta and membranes.
- Provide ongoing emotional support.

- Record the first urine void in accordance with the guideline for bladder care.
- Assess the perineum in accordance with the guideline for *Perineal Trauma, Repair and Management.*

Encourage skin-to-skin contact and breast feeding as soon as possible after birth, ideally within the first hour following birth.

8 Monitoring

Compliance with this guideline will be monitored as detailed in the table below. Where deficiencies are identified action plans will be developed and changes implemented and disseminated as required.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangement	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
2.1 women in labour, at term, in all care settings, which as a minimum must include: a. maternal observations to be carried out on admission b. ***maternal observations to be carried out during established first stage of labour*** c. maternal observations to be carried out during second stage of labour d. maternal observations to be carried out during third stage of labour e. ***documentation of all of the above maternal observations*** f. guidance on duration of all stages of labour g. guidance on referral to obstetric care	**Standard lead** Faris Zakaria- Consultant Obstetrician Arash Bahmaie- Consultant Obstetrician	Review of 1% of health records using audit tool attached in appendix 2 1% or 10 sets of notes of women who have risks identified during a risk assessment	3 yearly 3 yearly	Reported to Labour Ward forum	**Criterion lead** Louise Emmett – Labour ward manager who will disseminate and monitor any action plans required. Theresa Spink -Community and Outpatient services Manager Alison Howker- Maternity Matron Supervisors of Midwives	• Communication bulletin • Bonus days • MDT Educational half days • staff meetings • any other meeting as appropriate • Individual feedback as appropriate One or all of the above
4.7 process for clinical risk assessment when labour commences, which as a minimum must include: a. ***timing of the clinical risk assessment in all care settings*** b. medical conditions to be considered, including anaesthetic history c. factors from previous pregnancies d. lifestyle history to be considered e. risk assessment for appropriate place of birth f. **documentation of an individual management plan when risks are identified during the clinical risk assessment** g. ***process for referral of women when risks are identified during the clinical risk assessment*** h. ***documentation of all the above, where clinically relevant***				As above	As above	As above

Appendices

1 Exclusion criteria/risk assessment
2 Audit tool
3 Modified Burville Score
4 Normal Labour Pathway

References

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APPENDIX 1;

Exclusion criteria for Midwifery Led Care (NICE 2014): History of any of the following

Current Pregnancy

- Confirmed cardiac disease
- Hypertensive disorders
- Cystic Fibrosis
- Haemoglobinopathies – sickle cell disease, beta thalassaemia major
- Platelet disorders or if platelets <140 on repeat
- Von Willebrand's disease
- Bleeding disorders in woman or unborn baby
- History of thromboembolic disorders
- Diabetes
- Hepatitis B/C with abnormal liver function tests
- HIV infection
- Toxoplasmosis infection
- Active varicella/ rubella/genital herpes infection
- TB infection
- Lupus
- Scleroderma
- Abnormal renal function/disease
- Epilepsy
- History of CVA
- Myasthenia gravis
- Liver disease
- Psychiatric disorders – requiring treatment – see depression below
- Hyperthyroidism
- Severe asthma –any woman who is under medical care management for her asthma. E.g. medicated or have had a change/ increase in medication during current pregnancy; or hospital admission for a significant asthmatic episode.

Previous Pregnancy

- Previous CS
- 3rd/4th degree tears - if advised by obstetrician not to have vaginal birth
- History of a baby > 4.5 kg
- Eclampsia
- Uterine rupture
- Previous stillbirth or neonatal death of unknown cause
- Previous PPH >1000mls –. If due to uterine atony with no other predisposing factors
- Previous shoulder dystocia
- Previous retained placenta requiring manual removal
- Previous puerperal psychosis
- Previous gynae history of hysterotomy, myomectomy
- Bicornate uterus

Labour

- Abnormal maternal observations
  Significant meconium in at any stage intrapartum
- 2 episodes of reduced fetal movements after 34/40 with no documented obstetric review/ USS/ CTG any woman measuring small or large for dates (> or < 3cms) without 3rd trimester USS for growth and documented obstetric review
- Preterm labour – before 37/40
- Pre-eclampsia/gestational hypertension
- Fetal abnormality
- GBS positive (current pregnancy)

- Confirmed IUD
- Induction of labour – for any reason other than postdates
- Placenta praevia
- Epidural
- Multiple births
- Breech or transverse lie after 36/40
- Placental abruption
- Placenta praevia
- Preterm rupture of membranes before 37/40
- Late booker (greater than 20 weeks)- this does not include transfers from other units
- Concealed pregnancy (from 24 weeks gestation)
- Clinically large baby or USS suspicion of macrosomia
- Small for gestational age with ultrasound measurements <3rd centile/ large for gestational age > 97th centile
- Polyhydramnios/olighydramnios

This is not an exhaustive list; if in doubt seek advice from an experienced midwife, and/or from an obstetric colleague.
Following discussions with the obstetric team, some women may have midwife-led pregnancy care and/ or labour care. The discussion and plan of care must be clearly documented in the woman's hand held records.

1

On admission were the following documented:

Fetal Observations:

Fetal Heart Rate auscultated for minimum of 1 minute ☐ Yes ☐ No

CTG commenced ☐ Yes ☐ No

If yes state reason: _____

Maternal Observations:

Maternal pulse	☐ Yes	☐ No	Level of pain	☐ Yes	☐ No
Blood pressure	☐ Yes	☐ No	Abdominal palpation	☐ Yes	☐ No
Temperature	☐ Yes	☐ No	Vaginal loss	☐ Yes	☐ No
Respiratory rate	☐ Yes	☐ No	Contractions, timing & frequency	☐ Yes	☐ No

2

When confirmed established first stage of labour, were the following documented:

(a) Duration of 1st stage of labour _____

Partogram commenced ☐ Yes ☐ No

(b) Maternal Observations:

Hourly pulse ☐ Pulse every 30 mins if EFM ☐

BP 4 hourly ☐ Temp 4 hourly ☐

Bladder:

Documentation of void ☐

(c) Fetal Observations:

Fetal heart rate, every 15 mins ☐ Hourly assessment of amniotic fluid ☐

Continuous EFM ☐ Yes ☐ No

Intermittent auscultation ☐ Yes ☐ No

Assessment for indications for EFM	☐ Yes	☐ No

PTO

(d) Progress of labour documented :

Strength, frequency & duration of contractions every 30 mins	☐ Yes	☐ No
Change in women's behaviour	☐ Yes	☐ No
4 hourly abdominal palpation	☐ Yes	☐ No
Abdominal palpation prior to every VE	☐ Yes	☐ No
4 hourly VE assessment Including Cervical dilatation & descent of presenting part	☐ Yes	☐ No

3

Second Stage of Labour were the following documented:

(a) Was there a passive second stage ☐ Yes ☐ No

(b) During the active second stage of labour:

Maternal Observations:

Hourly pulse ☐ Hourly BP ☐ Temp 4 hourly ☐

Bladder:

Documentation of void ☐

(c) Fetal Observations:

Fetal heart rate (every 5 mins for 1 min following contraction) ☐ Colour of amniotic Fluid / hourly ☐

(d) Progress of labour:

Strength, frequency and duration of contractions every 30mins	☐ Yes	☐ No
Changes in woman's behaviour	☐ Yes	☐ No
Effectiveness of pushing	☐ Yes	☐ No
Decent of presenting part	☐ Yes	☐ No

What positions were used during the second stage?

☐ Standing ☐ Ball ☐ Chair ☐ Kneeling

☐ All fours ☐ Squatting ☐ Sitting on bed ☐ Semi

☐ Right lateral ☐ Left lateral ☐ Buddha ☐ Recumbent ☐ Lithotomy

Was pushing: ☐ Spontaneous ☐ Directed

What position did the women deliver in? _____

4

Third stage of labour

Women's general physical condition documented	☐ Yes	☐ No
PV blood loss documented	☐ Yes	☐ No

1,On Admission

a) Is there a documented risk assessment	☐ Yes	☐ No	
b) Medical conditions to be considered	☐ Yes	☐ No	☐ N/A
c) Anaesthetic history	☐ Yes	☐ No	☐ N/A
d) Factors from previous pregnancies	☐ Yes	☐ No	☐ N/A
e) Lifestyle issues to be considered	☐ Yes	☐ No	☐ N/A
f) Risk assessment for appropriate place of birth	☐ Yes	☐ No	☐ N/A
g) Is there a clear individualised management plan of care following risk assessment	☐ Yes	☐ No	☐ N/A
h) Assessment of stage of labour documented	☐ Yes	☐ No	
i) Findings documented in Labour notes	☐ Yes	☐ No	
j) Discussions documented in Labour notes	☐ Yes	☐ No	

2 Ongoing Risk Assessment and Obstetric referral

a) Was a referral made for obstetric led care	☐ Yes	☐ No	☐ N/A
b) What were the specific risk(s)	_____		
c) Was the process for referral of women when risks are Identified followed	☐ Yes	☐ No	
d) Was a clear plan of care documented	☐ Yes	☐ No	

Appendix 3

Modified Burvill Score

To be completed at the discretion of the midwife for woman beyond 37/40 gestation where the diagnosis or exclusion of early labour is uncertain

	0	1	2
Themes	**Signs may indicate Early Labour**	**Signs may indicate Early Active Labour**	**Signs may indicate Active Labour**
Breathing	Exaggerated, pain like breathing	Deeper breathing, controlled, pronounced, like a sigh	Not shallow, cannot talk, focused on breathing slow with contractions; grunting sounds, cries out with expiration
Conversation	Chatty, excitable, speaks quickly	Speaks less	Becomes quiet, conversation stops with each contraction, takes 20 seconds or more to resume talking; focus goes inward
Mood	Excitement/anxiety, happy, slightly agitated	Ceases to worry about external concerns	Withdraws, focus is on self
Energy	Wants to sort out practicalities	Becoming still. Inward focus on self	Still. Withdrawn into self
Movement & Posture	Grasps abdomen and bends forward with contractions	Less mobile. Stops for contractions and holds onto something/one	Stays in one position with or without contraction. Sways hips during contraction
Contractions without palpation	20 - 40 seconds	50 seconds or more - at least 4 minutes apart	50 seconds or more, 2-3 minutes apart

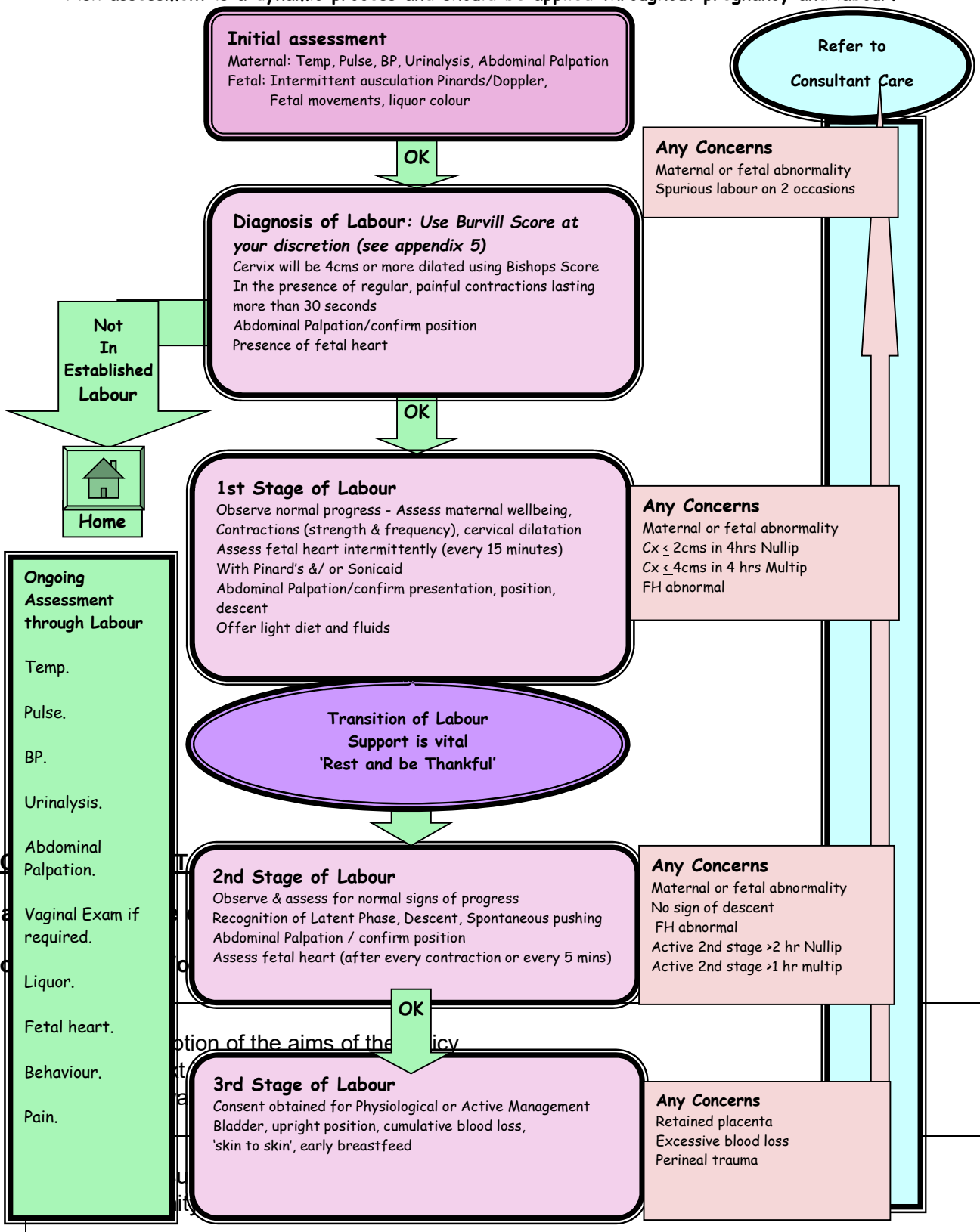
The Burvill score is not intended to replace clinical assessment but is to enhance the assessment process of labouring women. It is suggested that where the Burvill score is 5 or more one to one care should be commenced.

References

NICE Intrapartum Care Guidance CG 55 (2007)

Normal Labour Pathway –Appendix 4

Risk assessment is a dynamic process and should be applied throughout pregnancy and labour.



Methodology

- A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age)

• The data sources and any other information used • The consultation that was carried out (who, why and how?)
Policy widely circulated for comments within the Interprofessional Maternity Team.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
Accepted and understand the relevance of high standards of evidence based LW practice.
Conclusion • Provide a summary of the overall conclusions
Principles of equality have been adhered to.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
Improvement and consistency of LW care provision.

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family	**Social class** (consider ability to access services

relationships and individual care needs)	and information, for example, is information provided in plain English?)

If further assessment is required please see the Integrated Single Equality Scheme.

For advice in respect of answering the above questions, please contact HR Manager, on extension 2552.

PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name:	…Care of Women in Labour
Name of Person completing form:	…Alex Bell
Date:	…June 2015……

Author(s)	Dianne Casey/Alex Bell	
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Dianne Casey/Alex Bell	
Date of final draft	June 2015	
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency?		Yes
By whom:	Alex Bell	
Is this a new or revised policy/guideline?	New	

Describe the development process used to generate this policy/guideline.
Interprofessional dissemination and Guidelines group
Who is the policy/guideline primarily for?
All professional clinical staff working in the Maternity Services
Is this policy/guideline relevant across the Trust or in limited areas?
Limited area - Maternity
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?
Intranet/ Mandatory training/ Newsletters/ Individual circulation to all Midwives & Doctors working within the Maternity Services
Describe the process by which adherence to this policy/guideline will be monitored.
Audit
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?
NICE guideline CG190 2014, NICE guideline cg138, 2012
What (other) information sources have been used to produce this policy/guideline?
See reference list
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?
Yes
Other than the authors, which other groups or individuals have been given a draft for comment?
Interprofessional Dissemination
Which groups or individuals submitted written or verbal comments on earlier drafts?
Consultants/midwives and supervisors of Midwives
Who considered those comments and to what extent have they been incorporated into the final draft?
Women's Health Guidelines Group (WHGG), comments included within guideline
Have financial implications been considered?
No financial implications