## Guidelines for Labour Management

<table>
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<tr>
<th>Policy Code</th>
<th>Date</th>
<th>Version Number</th>
<th>Planned Review Date</th>
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<tr>
<td>PtLHB / MAT 004</td>
<td>Oct 2003</td>
<td>1st Issue</td>
<td>August 2012</td>
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<td></td>
<td>Feb 2009</td>
<td>This Issue: Amalgamated first, second, third stage of labour guidelines and Premature Labour. Updated with NICE 2007 guidance</td>
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### Document Owner

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<tr>
<th>Approved by</th>
<th>Date</th>
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<tr>
<td>Head of Midwifery. Operations Directorate</td>
<td>July 2009</td>
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<tr>
<th>Clinical Governance &amp; Healthcare Standards Committee</th>
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Guidelines for Labour Management

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Appendices
VALIDATION & RATIFICATION
To be completed by the Author – no policy, procedure or guidance will be accepted without completion of this section which must remain part of the policy

<table>
<thead>
<tr>
<th>Title: Guidelines for Labour Management</th>
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<tbody>
<tr>
<td>Author: Cate Langley, Lead Midwife, North Powys</td>
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<td>Directorate: Operations: Women &amp; Children’s Service</td>
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| Approved for submission by: Andrew Cresswell, Head of WCH Services |
| Date: May 2009 |

Evidence Base

Are there national guidelines, policies, legislation or standards relating to this subject area?
If yes, please include below:
  - All Wales Labour Pathway

If No, please provide information on the evidence/expert opinion upon which the policy has been based.

Consultation

Please set out the arrangements undertaken and stakeholder groups involved in the development and consultation process:
  - Discussed with all Midwives
  - All referring DGHs
  - Head of Midwifery

Implications

Please state any training implications as a result of implementing the policy / procedure.
No specific training available but staff may need assistance with new process.

Please state any resource implications associated with the implementation.
Increased involvement of Clinical Governance Team

Please state any other implications which may arise from the implementation of this policy/procedure.
N/A
**Equality Assessment Statement**

Please complete the following table to state whether the following groups will be adversely, positively, differentially affected by the policy or that the policy will have no affect at all.

<table>
<thead>
<tr>
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<td>Midwife specific document</td>
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<td>Race</td>
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<td>Sexual Orientation</td>
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**Risk Assessment**

Are there any new or additional risks arising from the implementation of this policy?

NO

Do you believe that they are adequately controlled?

N/A
MANAGEMENT OF LABOUR

Purpose
Local guideline for all Midwives working in Powys.

Responsibilities
The overall aim must be ensure safe and effective care is provided to mother and baby whilst allowing women to make an informed choice. To initiate and implement the rapid transfer of the mother into a district general hospital where any deviation from normal occurs.

Qualifications/Training
All Midwives working within Powys hold a recognised midwifery qualification, no additional qualifications are required to carry out this policy. Midwives will be required to attend yearly obstetric emergency drills as part of their midwifery updates.

Monitoring
This policy will be monitored through clinical midwifery supervision, issues raised through training days and the Datix reporting system.

General Principles
Prior to birth all women will have received, ideally at birth plan visit and the All Wales Clinical Pathway for Normal Labour information leaflet for women. During the antenatal period all women will have discussed place of birth with their named midwife (WAG 2002). For those women who are low risk and suitable for a Powys birth the decision about whether the birth is to be at home or within a Birth Centre can be made once the woman is in labour.

Birth Centres are not an appropriate environment for women in the latent phase of labour. It is best experienced in the woman’s own home, with the support and reassurance of a contactable midwife, who has time to listen and provide sympathetic support. Early admission to labour wards can increase the need for analgesia and oxytocics (All Wales Clinical Pathway for Normal Labour, 2003).
Women who Present in Labour with No Booking or Antenatal Assessment

In the event of a woman attending a birth centre with no evidence of booking or antenatal care they should be referred to a DGH, after a full assessment by the midwife. In the incidence of such a woman being in advanced labour the Normal Labour Pathway MUST NOT be used and full documentation of the labour completed.

Premature Labour

Introduction
Premature labour may be defined as regular uterine activity with or without spontaneous rupture of membranes before 37 weeks completed gestation.

Transfer should be initiated to the nearest DGH where the client can be stabilised and transferred on if necessary.

Action
- Upon receiving a call from a woman with a history of premature labour the midwife should direct an ambulance to the woman's home.
- Once the ambulance is despatched the midwife should attempt to attend prior to transfer. But this should not delay the transfer process and ambulance crews should initiate transfer without the midwife if they are first to arrive.
- The ambulance should then be directed to the nearest DGH and the midwife if present MUST escort the woman in case of birth on route.
- However if it appears that birth is imminent with signs of full dilatation it may be safer to birth the woman at home prior to transfer.
- Once the baby is born it must be transferred as soon as is practical to nearest DGH. (NMC 2004) Midwifery and Paramedic staff should plan the safest and timeliest method of transfer; ensuring the needs of both mother and baby are appropriately met. This may need 2 ambulances; 1 for Mother and 1 for Baby.
- Senior Paediatric Staff should be informed of baby's imminent arrival.
- It may not be possible for the mother to accompany the baby immediately but arrangements should be made as soon as possible.
Admission Procedure and Assessment of Term Labour

When a woman contacts a midwife by telephone Part One of the Pathway for Normal Labour documentation must be completed

All women should ideally be offered an initial assessment of progress in labour within their home environment. (WAG 2006)

On assessment, whether this be at home or in a Powys Birth Centre, a full history and examination will be carried out and documented in Part Two of the Pathway for Normal Labour. The aim is to determine whether a Woman is in labour and if midwife managed care remains appropriate. Should a woman appear to be in advanced labour Part Two MUST still be completed with any inability to fulfill the full assessment recorded i.e. 'maternal observations not done as presenting part advancing rapidly on to perineum'.

Observations and Examination

<table>
<thead>
<tr>
<th>Maternal Observations</th>
<th>Abdominal Palpation</th>
</tr>
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<tbody>
<tr>
<td>Temperature</td>
<td>Fundal height</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Lie</td>
</tr>
<tr>
<td>Pulse Rate</td>
<td>Presentation</td>
</tr>
<tr>
<td>Hydration</td>
<td>Position</td>
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<tr>
<td>Urinalysis</td>
<td>Attitude</td>
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<tr>
<td>Vaginal Loss - mucous show</td>
<td>Engagement</td>
</tr>
<tr>
<td>Blood</td>
<td>Fetal heart rate and fetal activity</td>
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<tr>
<td>Liquor – colour</td>
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<tr>
<td>Gestational age</td>
<td></td>
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<tr>
<td>Last recorded Hb</td>
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Uterine Activity

Frequency of Contractions
Strength of Contractions
Duration of Contractions

Antenatal History

Any complications, which may affect the maternal or fetal condition in labour, must be ascertained and recorded. Appropriate action must then be taken.
Assessment of Labour

A vaginal examination should normally be conducted to confirm active labour within four hours of the onset of 1:1 midwifery care, following an explanation of the procedure to the woman and after gaining her verbal consent. (All Wales Clinical Pathway for Normal Labour, 2003)

Record of Examination to include:
- Abdominal palpation and decent of head into pelvis
- Fetal heart rate
- Cervical position, consistency, effacement and dilatation.
- State of the membranes - present or absent – colour of liquor draining.
- Define presenting part, station and if possible its position.
- Fetal heart recorded following examination.
- Discuss findings with woman and partner.

If the woman is not in labour then she should be encouraged to remain at home, with the knowledge that a midwife is available at any time to speak to or visit her.

If there are any potential complications the woman should be referred to the consultant team at a DGH by ambulance (NMC 2004). A midwife is to accompany a woman in transfer.
MANAGEMENT OF ACTIVE LABOUR (FIRST STAGE)

Introduction
Active labour is established when the cervix is fully effaced, more than 3 cms dilated and in the presence of regular, painful contractions (All Wales Clinical Pathway for Normal labour, 2003).

Action Documentation
If labour is established and progressing normally and there are no concerns regarding maternal or fetal wellbeing Part Three of the Normal Labour pathway documentation is to be used. Midwives must ensure that they complete the record of care on the front sheet and any handover of care is also documented. All records must be contemporaneous in accordance with NMC Guidelines for Records and Record Keeping (NMC 2004).

Documentation of variances
Any variations from the Pathway for Normal Labour must be documented in full. Documentation of variances of care should include;

- Variance code
- Reason for variance
- Plan of care
- Actions taken
- Time frame for review
- Initials of caregiver, time and date

Ambulation and Position
Women should be encouraged to adopt upright positions and to mobilise during labour.

Partogram
This will provide a record of the progress of labour, fetal and maternal wellbeing.

Uterine Contractions
Recorded half hourly on the chart immediately below the cervicograph showing strength (mild, moderate, strong), frequency and duration of contractions.

Descent of the Head
Abdominally - fifths palpable per abdomen recorded as a circle on the Partogram. Cervical dilatation (recorded with black cross on Partogram graph).

Monitoring of the Maternal Condition
- Blood pressure and temperature -4 hourly
- Pulse-30 minutes.
• Urinalysis whenever urine is passed, record ketones and protein levels.
• Drugs administered.

Nutrition in Labour
Women may eat a light diet throughout labour unless they have received opioids. (NICE 2007)

Monitoring of Fetal Condition
As labour progresses in the active phase intermittent auscultation should occur after a contraction for a minimum of 60 seconds and at least: every 15 minutes in the first stage

In the event of any decelerations of the fetal heart rate, bradycardia (<110 bpm) or tachycardia (>160 bpm) these should be recorded as a variance. If abnormality of the fetal heart rate is detected transfer to DGH should be considered. (NICE 2007)

Monitoring the Progress of Labour
It is entirely the midwife’s responsibility to ascertain that progress in labour is satisfactory and that delay is detected and acted upon.

Vaginal examinations remain the most accepted method of measuring progress in labour. These examinations, should be offered 4 hourly, or where there is concern regarding progress (NICE 2007)

Cervical Dilatation. In active phase 0.5cm. per hour is adequate progress (NICE 2007)

Strength, length and frequency of contractions — length and frequency are assessed manually. As labour progresses contractions should increase in strength and frequency to effect adequate cervical dilatation.

Descent of the Presenting Part — failure of the head to descend in the first stage may indicate cephalo-pelvic disproportion (CPD). Excess moulding and caput together with other signs of poor progress are strong indicators of CPD and women who exhibit these signs will need to be transferred to consultant care.
Delay in the Established First Stage of Labour

If delay in the established first stage of labour is suspected consider mobilisation or change of position, review of pain relief and hydration. If delay in first stage is confirmed amniotomy should be considered, following explanation of the procedure and advice that it will shorten labour by about one hour and may increase the strength and pain of contractions. Amniotomy is not part of normal physiological labour (NICE 2007).

The decision to rupture membranes should only be taken in direct consultation with the woman, when the evidence is discussed and the intervention is not minimised. This discussion should form part of the birth plan, and not take place just before or during a vaginal examination.

A vaginal examination must be performed after 2 hours to assess effectiveness of artificially rupturing the membranes. If no progress or minimal progress has occurred (<1 cm) advise DGH transfer.

If there is evidence of significant meconium stained liquor following ARM, or concern regarding the fetal heart then transfer to a DGH must be arranged immediately. Regardless of progress there should be no delay in arranging immediate transfer if there is definite concern about fetal or maternal condition.

In the following situations the labour is no longer uncomplicated and the woman should be transferred to consultant care:

- Progress is inadequate
- Intermittent monitoring suggests potential fetal compromise
- Significant meconium stained liquor
- Women requesting epidural analgesia
- Maternal pyrexia 38 degrees on one occasion or 37.5 degrees on two occasions two hours apart.
- Suspected malpresentation in labour
- Raised BP
- Obstetric emergency

Give Ranitidine (Zantac) 150 mg orally to any woman requiring transfer in labour.
MANAGEMENT OF THE SECOND STAGE OF LABOUR

Introduction
All Wales Clinical Pathway for Normal Labour Part Three will be used to document the second stage of labour.

Confirmation of Second Stage
This is defined either by full dilatation of the cervix on vaginal examination or by a visible vertex at the perineum.

External signs may include:
- Expulsive contractions with maternal urge to bear down
- Trickling blood
- Anus pouting and gaping
- Perineum bulging
- Advancement of a purple line in the natal cleft to the nape of the buttocks. (Hobbs, 1998)

THE SECOND STAGE OF LABOUR MAY ALSO CONSIST OF A PASSIVE AND ACTIVE STAGE (NICE 2007)

Passive Stage
The woman is found to be fully dilated but has no urge to push. She should not be encouraged to push at this stage. Monitoring of fetal and maternal wellbeing should continue.

Active Stage
The woman has a strong sensation to push or bear down and she should be encouraged to follow her instincts if full dilatation of the cervix has been confirmed.

Monitoring
Once full dilatation of the cervix has been either confirmed by vaginal examination or appears to be apparent from external clinical signs:
Continue maternal observations:
- Hourly PB and Pulse, four Hourly temperature (NICE 2007)
- Intermittent auscultation of the fetal heart for a full minute after a contraction, at least every 5 minutes. (NICE 2007)
- Commence second stage Partogram of the Normal labour pathway.

Commencing Pushing
- As a guide, the midwife will support pushing only when a woman feels expulsive. Directed pushing and the use of the Valsalva manoeuvre are not to be encouraged if the second stage is progressing normally.
- Ensure bladder is empty.
- Women should be encouraged to adopt a comfortable upright
position such as standing, squatting, sitting or kneeling – positions which are most likely to facilitate a spontaneous vaginal delivery. (MIDIRS 1996)

LENGTH OF SECOND STAGE
Progress in the second stage of labour is defined as advancement of the head, in the presence of expulsive contractions with a stable maternal and fetal condition.

Progress in second stage should be assessed hourly and should include abdominal assessment of the descent of the head.

In the absence of descent after one hour of ACTIVE pushing a referral to an obstetrician should be considered.

A routine episiotomy is not recommended for routine vaginal birth and should not be offered routinely at vaginal birth for women who have previously suffered a third or fourth degree tear. (NICE 2007)

If the midwife has any concerns through any phase of the second stage she should arrange transfer to DGH immediately.

Presence of a Second Midwife
For all Powys births a second midwife should be present for the second stage of labour. The midwife caring for a labouring woman should, in view of the possible distance involved that a second midwife may have to travel, ensure that a second midwife is requested prior to a woman experiencing expulsive contractions.
MANAGEMENT OF THE THIRD STAGE OF LABOUR

Introduction
Midwives should discuss with women prior to birth both active and physiological management of the third stage and their choice should be documented in their birth plan. The choice of management should also be discussed and recorded in Part Three of the normal labour pathway documentation.

Management
- Informed consent should be obtained for the proposed management of the third stage ensuring the woman’s understanding of implications of choice.
- Those handling blood products should wear personal protective equipment.
- Preferably the woman should enter the third stage of labour with an empty bladder.
- The placenta and membranes are inspected at the earliest possible opportunity and blood loss is estimated.
- Cord and maternal blood samples obtained if mother is Rhesus negative.
- Appropriate disposal of the placenta (usually by incineration) is arranged, or if required the placenta is sent to the laboratory in a specific container.
- Record mother’s vital signs, palpate her uterus and observe her lochia.

Transfer of the woman should be arranged if:
- At any time maternal blood loss appears excessive and/or maternal condition gives cause for concern.
- There is delay in delivery of the placenta.

Active Management
Defined as the administration of a prophylactic uterotonic, as soon as possible after the delivery of the anterior shoulder, followed by immediate clamping and cutting of the cord and delivery of the placenta by controlled cord traction.

- Reduces the risk of post partum haemorrhage even when midwives are fully competent in delivering physiological third stage;
- On average, takes less time for the delivery of the placenta and membranes; (NICE 2007).

Action
- With the birth of the anterior shoulder an uterotonic drug is given by IM injection. (Syntometrine 1ml or Syntocinon 10iu)
- The cord is clamped and cut taking care to minimise the risk of blood contamination to those present.
If the mother is Rhesus Negative, either early cord clamping should be avoided, or the placental end of the cord should be allowed to bleed freely after cutting. This reduces the risk of feto-maternal transfusion.

- The woman should be asked to adopt the dorsal position.
- Await strong uterine contraction confirmed by abdominal palpation.
- Steady downward traction is applied to the cord with one hand while maintaining upward counter pressure on the lower abdomen with the other hand.
- The placenta and membranes are delivered gently in an outward and upward direction.
- If the placenta is not delivered within 30 minutes: refer to guideline for retained placenta.

Physiological Management
Whereby there is no use of uterotonic drugs, no clamping of the cord until pulsation has ceased, and delivery of the placenta within one hour by maternal effort only, management should never include pulling the cord or palpating the uterus, (NICE 2007)

- Does not change outcomes in babies, except for slight weight gain, probably from the extra blood gained from late clamping of the cord;
- Reduces the risk of maternal vomiting following delivery;
- Requires midwifery expertise and training. (All Wales Clinical Pathway for Normal Labour, 2003).

Action
- Following birth of the baby allow natural cessation of cord pulsation before clamping and cutting. Remove clamp from maternal end of cord to minimise back flow of blood to mother.
- Wait for natural separation and expulsion of placenta and membranes.

The following factors may assist separation or expulsion:
- Putting the baby to the breast.
- The mother adopting an upright position.
- Maternal expulsive efforts.

If maternal observations and condition remain stable, it is possible to wait for sixty minutes in the physiological third stage. Following this time or if maternal condition dictates, consider giving a uterotonic drug by IM injection and follow active management of the third stage.

A piecemeal approach (a mixture of both types of management) is not recommended. (All Wales Clinical Pathway for Normal Labour, 2003).
Also refer to the following policies:

- Management of Retained Placenta
- All Wales Birth Centre Guidelines
References