Labour - Care and Risk Assessment - Full Clinical Guideline

Reference no.: UHDB/IP/07:21/L2

NULLIPAROUS

	ACTIVE FIRST STAGE OF LABOUR	SECOND STAGE OF LABOUR
Normal progress	• Regular, painful contractions • Progressive cervical dilatation from ≥ 4cm with ≥ 2cm over 4 hours	• Passive second stage lasting < 1 hour • Normal birth within 2 hours of active second stage, apparent progress ≥ 60 minutes active second stage
	Aspects to take into consideration when assessing progress in labour: • station/descent and position/rotation of fetal head • (changes in) strength, duration and frequency of contractions • Presence of moulding and caput succedaneum • Woman's emotional state	
	Do not offer or advise clinical intervention if labour is progressing normally and the woman and baby are well	
Delay suspected	• Progress <2cm dilatation in 4 hours • Other aspects suggestive of delay	Offer VE to assess descent and position if: • no strong urges to push ≥ 1 hour passive stage • ≥ 1 hour active second stage
	Consider: • Amniotomy • Repeat VE to review after 2 hours (advise amniotomy and VE after 2 hours if still no progress) • Obstetric review	Consider: • Amniotomy • Analgesia/anaesthesia • Bladder care/position • Obstetric review • Oxytocin if inadequate contractions at the onset of the second stage
Delay diagnosed	• Progress < 1cm after 2 hours • Other aspects apparent signs of delay	No birth within 2 hours active stage
	Obstetric review to diagnose and manage delay	
	• Consider syntocinon i.v. and advise continuous EFM • VE 4 hourly after starting syntocinon i.v.	• Full obstetric assessment before contemplating use of syntocinon • Obstetric review every 15-30 minutes • Consider instrumental birth or caesarean section • Aim for birth within 3 hours from start active second stage
	Consider Caesarean Section when progress remains < 2cm per 4 hours	

MULTIPAROUS

	ACTIVE FIRST STAGE OF LABOUR	SECOND STAGE OF LABOUR
Normal progress	• Regular, painful contractions • Progressive cervical dilatation from ≥ 4cm with ≥ 2cm over 4 hours	• Passive second stage lasting < 1 hour • Normal birth within 1 hour of active second stage, apparent progress ≥ 30 minutes active second stage

Aspects to take into consideration when assessing progress in labour:
- station/descent and position/rotation of fetal head
- (changes in) strength, duration and frequency of contractions
- Presence of moulding and caput succedaneum
- Woman's emotional state

Do not offer or advise clinical intervention if labour is progressing normally and the woman and baby are well

Delay suspected	• Progress <2cm dilatation in 4 hours • Slowing in progress • Other aspects suggestive of delay	Offer VE to assess descent and position if: • no strong urges to push ≥ hour passive stage • ≥ 30 minutes active second stage without apparent progress
	Consider: • Amniotomy • Repeat VE to review after 2 hours (advise amniotomy and VE after 2 hours if still no progress) • Obstetric review	Consider: • Amniotomy • Analgesia/anaesthesia • Bladder care/position • Obstetric review
Delay diagnosed	• Progress < 1cm after 2 hours • Other aspects apparent signs of delay	No birth within 1 hour active stage

Obstetric review to diagnose and manage delay

• Obstetric abdominal palpation and VE prior to decision on syntocinon • Consider syntocinon i.v. and advise continuous EFM • VE 4 hourly after starting syntocinon i.v.	• Full obstetric assessment before contemplating use of syntocinon • Obstetric review every 15-30 minutes • Consider instrumental birth or caesarean section • Aim for birth within 2 hours from start active second stage
Consider Caesarean Section when progress remains < 2cm per 4 hours	

Contents

1. Introduction

Labour is a normal physiological process characterised by a spontaneous onset between 37 and 42 weeks, in a woman whose pregnancy has been uncomplicated. It relies on good support for the woman in labour, excellent communication between health care professionals and the families and clear identification of those women or babies that need additional care. The woman's personal choices about various aspects of her care in labour must be considered.

2. Purpose and Outcomes

3. Abbreviations

ARM	-	Artificial Rupture of Membranes (Amniotomy)
CLC	-	Consultant-Led Care
CTG	-	Cardiotocography
EFM	-	Electronic Fetal Monitoring
FHR	-	Fetal Heart Rate
MOEWS	-	Modified Obstetric Early Warning Score
MWLC	-	Midwife Led Care
N: S: P	-	Normal: Suspicious: Pathological
PPH	-	Post-Partum Haemorrhage
SBAR	-	Situation, Background, Assessment, Recommendations
SROM	-	Spontaneous Rupture of Membranes
TENS	-	Transcutaneous Electrical Nerve Stimulator
VE	-	Vaginal Examination

4. Documentation

Please ensure all assessments and individual plans of care are documented clearly in the medical records and/or the maternity hand held records and within Lorenzo system.

5. Key Responsibilities and Duties

In all situations it is important that women understand who has responsibility for their care and that they remain informed and involved in decisions concerning them and their babies. Record keeping should reflect discussions that take place regarding the options for their care plan, and should provide an accurate picture of events to enable smooth and safe transfer of care, where that is required with the use of good communication tools. Our trust guideline promotes smooth inter-professional communications and recommends using the SBAR tool.

6. Support for Labouring Women

This includes providing comfort, social and emotional reassurance to enable mothers to work through labour. Continuous, one to one care in active labour should be aimed for, whenever possible, as it has been shown to have positive effects on outcomes. Midwives must endeavour to practice and develop the skills required to help women through their labour and birth. These skills centre round emotional support, information giving, physical support and advocacy but also include positions and movement, water, massage, TENS machine, aromatherapy and coping strategies.
Midwives should be able to enhance and maintain progress in labour with simple non-surgical, non-pharmacological, physical and social support techniques, which have the following advantages:

- Carry less risk of harm or unwanted side effects to mother or baby
- Treat women as the key to the solution, not the key to the problem (woman centred)
- Build or strengthen the midwife-mother relationship as well as with birth-partners
- Reduce the need for more complex interventions, that carry a higher risk and are more costly
- May increase women's emotional satisfaction with her birth experience.

7. Definition of the First Stage of Labour

Latent first stage of labour – a period of time, not necessarily continuous, when:

- there are painful contractions, and
- there is some cervical change, including cervical effacement and dilatation up to 4cm.

Established first stage of labour – when:

- there are regular painful contractions, and
- there is progressive cervical dilatation from 4cm.

Duration of the first stage

Women should be informed that, while the duration of labour varies between women, first labours last on average 8 hours and are unlikely to last over 18 hours. Second and subsequent labours last on average 5 hours and are unlikely to last over 12 hours.

Normal labour: first stage

Clinical intervention should not be offered or advised where labour is progressing normally and the woman and baby are well.

In all stages of labour, women who have left the normal care pathway due to the development of complications can return to it if/when the complication is resolved.

8. Observations and risk assessment on Presentation in (Suspected) Labour

All women should have a full assessment performed by a midwife on admission in suspected labour (or first contact with a midwife at home birth)

The admission assessment of a woman by a midwife should include:

- taking a history, considering her emotional and psychological needs, and reviewing her clinical records,
- physical observations – temperature, pulse, blood pressure and urinalysis,
- contractions - length, strength and frequency,
- abdominal palpation – symphysis-fundal height, fetal lie, presentation, position and relationship to the pelvic brim,
- fetal movement pattern
- vaginal loss – show, liquor –including colour and/or blood,
- assessment of the woman's pain, including her wishes for coping with labour along with the range of options for pain relief,
- Clear documentation in notes.

In addition:
The FHR should be auscultated for a minimum of 1 minute immediately after a contraction. The maternal pulse should be palpated to differentiate between maternal and FHR. This should be followed by a CTG monitoring for women with risk factors identified in pregnancy or during assessment (i.e. for all women that are suitable for CTG monitoring during labour under consultant led care). Any woman who has had altered fetal movements in the 24 hours prior to the onset of regular contractions should have a continuous CTG in labour.

If the woman appears to be in established labour, a vaginal examination should be offered, this may be helpful but not always necessary.

If a woman has any risk factors for increased risk of infection please follow the Obstetric Antibiotic guideline. Click here for link to obstetric antibiotics guideline

Discuss the woman's birth plan and check for women under consultant led care if labour advice is documented. Please remember; being eligible to birth on the low risk ward ***Birth Centre*** does not exclude a woman to choose to be cared for on labour ward.

A full clinical risk assessment will be performed when confirmed onset of labour or when a woman attends for Induction of labour. The Risk Assessment tool (Appendix A) is to be used in all settings whether at home, in the low risk birthing unit or clinical labour ward. ***Tool maybe used for women attending for induction of labour***

Information to be documented on the Risk Assessment Tool:

- Medical conditions, anaesthetic history, lifestyle and obstetric risk factors (see list, Appendix B) must be considered and documented
- Refer to the Maternity Risk Alert form at the front of the medical records for any new risks identified in the current pregnancy (Appendix C)
- The PPH proforma should be completed for all women attending in labour, for induction of labour or for caesarean section.
- Document if women accept or decline blood and blood products
- Document VTE risk assessment
- If NO risks are identified at the onset of labour, indicate Midwifery Led Care (MLC) in the appropriate box and detail NONE in the Significant Risks Factors Box. Document if the woman has been assessed antenatally as suitable for Home Birth.
- If risks are identified during the assessment in a planned home birth and indicate a need for Consultant - Led Care (**CLC**), transfer to Labour Ward and inform the Obstetric Specialist Registrar (SpR)/Consultant and the Labour Ward Co-ordinator
- Management plan of care, including plans for labour should be documented, ideally in the 'Plan of Care Box', Consideration for method of fetal surveillance i.e. Continuous Electronic Fetal Monitoring or Intermittent Auscultation (see Fetal Monitoring in labour guideline (**F2**), should be made.
- Written plans of care must reflect a change in risk status if there are changes in labour
- Change from MLC to CLC or vice versa must be altered documented in the health records at the time of change and if possible updated on Lorenzo/***meditec***
- If risks are identified then the woman should be referred to the on call obstetric labour ward team for review
- Identified risks should also be communicated at each handover of care and clearly documented using Situation, Background, Assessment, Recommendations (SBAR) process (refer to Handover of Care Guidelines).

If CLC in pregnancy but no apparent risks for labour identified on risk assessment:

- Have a discussion with the woman. This should include:
- Findings on risk assessment and possible options to change care pathway
- Benefits and considerations of place of birth (including birthing pool if applicable) and fetal monitoring
- Wishes of the woman
- If following this discussion the woman would like to change her care pathway, have a discussion with the most senior doctor available (Senior registrar or higher) and request a review
- If a woman is in advanced labour on admission and a discussion to make an informed decision is not appropriate, a change in care pathway should not be made. CLC should be provided during labour.
- Changes in care pathway should never be made without involving the woman.

Do not perform cardiotocography (CTG) on admission for low-risk women in suspected or established labour in any birth setting as part of the initial assessment, unless there is a clear indication for a CTG/identified risks e.g. fetal heart found abnormal during intermittent auscultation, reported reduced fetal movements or abnormal findings on abdominal palpation (NICE 2014). Always document the indication for undertaking a CTG.***EG Significant Meconium or APH (Ante-partum haemorrhage)***

For women at increased risk of PPH click here for full PPH guideline

- commence PPH tool booklet with labour notes

- consider early IV access
- If antibodies present, for 2 units cross match
- measure and record blood loss
- active 3rd stage management

9. Management of the Latent Phase of Labour

It is recognised that good quality antenatal information and preparation regarding the latent phase of labour can increase the likelihood of women arriving at hospital in established labour. This should include advice regarding:

- How to differentiate between Braxton Hicks contractions and active labour contractions
- How to recognise amniotic fluid (waters breaking)
- How to recognise normal vaginal loss
- Who to contact if the movements of your baby stop or alter from their normal pattern
- The potential length of the latent phase and the physiological processes that are occurring
- Coping with the associated discomfort and exhaustion

The community midwife should discuss the topic of how to manage this latent phase of labour with women at their Antenatal clinic 36/40 appointment.

See appendix D Latent phase

10. Vaginal Examinations

Midwives and doctors who conduct vaginal examinations should be sure that the examination is appropriate and will facilitate information to the decision-making process.
They must:

- explain the reason for the examination and what will be involved,
- the indication for performing the examination must be documented
- be aware that for many women who may already be in pain, highly anxious and in an unfamiliar environment, vaginal examinations can be very distressing,
- obtain and document the woman's verbal consent, ensure privacy, dignity and comfort,
- always carry out an l abdominal palpation prior to VE and document findings
- ensure the bladder is empty.

Ref to FGM guideline

Allow the woman to position herself where she is most comfortable.
Relaxation techniques / Entonox should be offered if appropriate.
Avoid the supine position as this may cause aorto-caval compression.
During the vaginal examination assess and document:

- external genitalia if any abnormalities,
- effacement and dilatation of the cervix,
- state of the membranes,(present or absent/not felt)
- document the presence or absence of significant meconium, this is defined at dark green or black amniotic fluid that is thick or tenacious, or any meconium stained fluid containing lumps of meconium (NICE 2015)
- position and station to the ischial spines of the presenting part,
- presence of moulding and caput succedaneum if present,

Explain the findings and their impact sensitively to the woman.
When a student (midwife /doctor) carries out a vaginal examination, the midwife responsible for the woman must confirm the vaginal examination findings. The midwife must countersign the student's signature.

Some women have pain without 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 attend hospital with painful contractions but who are not in established labour should be offered individualised support, and encouraged to remain at or return home.

11. Observations During the Established First Stage of Labour

A partogram should be started to document observations once labour is established, in all cases of IUFD >24 weeks.(cross reference IUFD guideline please).

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

Maternal:

- 4-hourly temperature and blood pressure,
- hourly pulse,
- half-hourly documentation of the strength and frequency of contractions,
- frequency of emptying the bladder – encourage 4 hourly ***(see bladder care guideline***)
- vaginal examination offered 4-hourly, or where there is concern about progress or in response to the woman's wishes and consideration for status of labour progress.
- document the presence or absence of meconium, and specify if it is significant or non-significant (Significant meconium is defined as dark green or black amniotic fluid that is thick or tenacious, or any meconium-stained fluid containing lumps of meconium)
- intrapartum PPH risk factors (see alerts on partogram; suspicion of chorioamnionitis / sepsis, prolonged labour, labour augmented with syntocinon, instrumental delivery, retained products of conception): if any risk identified to commence a PPH management tool and follow guidance on the tool

Fetal:

- Intermittent auscultation immediately after a contraction should occur for at least 1 minute, every 15 minutes. This is to be documented in the labour records / partogram
- When EFM is in progress the FH baseline is plotted on the partogram and the CTG Review box is completed half-hourly. Ensure a 'fresh eye' approach is utilised. Bear in mind that it is not possible to categorise or interpret every CTG trace in which case senior obstetric input is essential.(***Safety Huddle***) Please refer to the Fetal monitoring guideline (F2)

Ongoing consideration should be given to the woman's emotional and psychological needs, including her desire for pain relief. Please ensure the temperature of the room is sufficient for delivery (as per Care for the Newborn guideline: 25°C).

Do not make any decision regarding the care plan based on the CTG findings only.

In the case of caring for women in labour at home, if there is any abnormal change/deviation from the expected norm/changes to the liquor etc – she will require transfer to an obstetric unit

12. Controlling Gastric Acidity

The advice and care given in labour with regards to nutrition is covered in **Appendix E**.

13. Pain Relief in Labour

Women should be encouraged to communicate their need for analgesia at any point during labour. A discussion will take place with the woman regarding the available and appropriate methods of analgesia as required.

14. Delay in Established First Stage of Labour

Delay in established first stage of labour is suspected when all aspects of progress in labour have been considered and should include:

- cervical dilatation of less than 2cm in 4 hours,

- delay in descent and rotation of the fetal head,
- reduction in the strength, duration and frequency of uterine contractions,
- presence of moulding and caput succedaneum.

Women should be offered support, hydration, and appropriate and effective pain relief.
If delay in the established first stage of labour is suspected, women with intact membranes may be offered an amniotomy. A repeat vaginal examination may be recommended 2 hours later if there is still no evidence of progress.

- When a delay in the first stage is diagnosed (Progress < 1cm after 2 hours) a discussion with the senior labour ward midwife and obstetric registrar will be required as well as transfer to CLC. At this point EFM will be recommended.

Wherever possible, vaginal examinations should be performed by the same midwife or obstetrician.

When delay in the established first stage of labour is diagnosed in **nulliparous women**, advice should be sought from the obstetric registrar and the use of oxytocin should be considered following spontaneous or artificial rupture of the membranes and assessment.
Multiparous women with diagnosed delay in the first stage should be seen by the obstetric registrar who should make a full assessment, including an abdominal palpation and vaginal examination, before making a decision about the use of oxytocin. Caution should be taken during augmentation particularly in second or subsequent labours as there is greater risk of uterine rupture, click here for induction of labour and augmentation guideline.
Commence PPH management tool if prolonged labour or in case labour augmented with Syntocinon.

14.1 Amniotomy (ARM)

Verbal consent must be obtained prior to amniotomy following explanation of the procedure and advice given to the woman that it will shorten the labour and may increase the strength and pain of contractions. Note the presence / quantity and colour of liquor at amniotomy. The indication, explanation, consent and procedure must be recorded in the notes.
A midwife can perform an amniotomy as long as the woman is at term and in established labour, the presenting part is engaged, and the cervix is effaced and dilatation is sufficient. . Auscultation of the fetal heart should be made immediately following the procedure and documented.
Amniotomy alone for suspected delay in the established first stage of labour is not an indication to commence continuous EFM.

15. Definition of the Second Stage of Labour

15.1 Passive second stage of labour:

- the finding of full dilatation of the cervix prior to or in the absence of involuntary expulsive contractions.

15.2 Onset of the active second stage of labour:

- active maternal effort following confirmation of full dilatation of the cervix .

16. Observations during the Second Stage

All observations should be documented on the partogram.
Observations in the second stage of labour include:

- intermittent auscultation of the fetal heart should occur after a contraction for at least 1 minute. If contractions are spaced apart > 5 minute intervals then the FH should be auscultated and documented least every 5 minutes,
- If continuous EFM: ***FH recorded and documented every 5 minutes differentiating maternal pulse***
- hourly blood pressure,
- every **15** minutes maternal pulse rate to differentiate between the two heart rates.
- continued 4-hourly temperature,
- half-hourly documentation of the frequency of contractions,

- once ARM/SROM record description of liquor on partogram at least hourly
- frequency of emptying the bladder (see Bladder Care in Labour and the Early Postnatal Period guideline (B4)),
- ongoing consideration of the woman's emotional and psychological needs,
- ongoing consideration should be given to the woman's position, hydration, coping strategies and pain relief throughout the second stage.

Assessment of progress should include maternal behaviour, effectiveness of pushing and fetal wellbeing, taking into account fetal position and station at the onset of the second stage. These factors will assist in deciding the timing of further vaginal examination and the possible need for obstetric review.

17. Perineal protection at crowning to minimise perineal trauma

- The use of warm compresses on the perineum and may be offered to women

- Medio-lateral episiotomy should be considered in instrumental deliveries as this lowers the risk of OASIS significantly

- Where episiotomy is indicated, a medio-lateral episiotomy should be considered to lower the risk of OASIS. This technique is recommended with careful attention to ensure that the angle is **60 degrees** away from the midline when the perineum is distended. (A 60-degree episiotomy from the centre of the introitus results in a post-delivery angle of 45 degrees, a 40-degree episiotomy results only in a post-delivery angle of 22 degrees)

18. Duration and Definition of Delay in the Second Stage

18.1 Nulliparous women:

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

18.2 Parous women:

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

18.3 Confirmed Delay in Second stage:

- Women with confirmed delay in the second stage should be assessed by an obstetrician. Following initial obstetric assessment for women with delay in the second stage of labour, ongoing obstetric review should be maintained and documented at planned intervals.

- Where there is delay in the second stage of labour, or if the woman is excessively distressed, woman's need for analgesia/anaesthesia ***should be considered***

- If full dilatation of the cervix has been diagnosed in a woman without epidural analgesia, but she does not get an urge to push, further assessment should take place after 1 hour.

- In nulliparous women, if after 1 hour of active second stage progress is inadequate, delay is suspected. Following vaginal examination, amniotomy should be offered if the membranes are intact.

- In multiparous women: if lack of progress (rotation/descent) after 30 minutes then a VE and ARM should be offered

- Commence PPH management tool if prolonged labour or in case labour augmented with Syntocinon.

19. Definition of the 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.

- Prophylactic use of uterotonics should be routinely offered in the management of the third stage of labour in all women as they reduce the risk of PPH.

- Uterine massage after birth and either before or after delivery of the placenta is of no benefit in the prophylaxis of PPH and should as such not be practised.

- In the precense of PPH risk factors either AN or IP, physiological management of the 3rd stage or Syntocinon 10IU i.m. is not appropriate

19.1 Active management of the third stage

This involves a package of care which includes all of these four components:

- routine use of uterotonic drugs,
- deferred clamping and cutting of the cord – see section 22 page 8 (After delivery it is not necessary or advisable to wait to give the oxytocin until after delayed cord clamping)
- ensuring the bladder is empty
- controlled cord traction.

For women delivering vaginally:

- Prophylactic use of Syntometrine® 1 ml i.m. after delivery of the anterior shoulder or at the latest immediately after delivery of baby, is the agent of choice to be recommended unless contraindicated

- If Syntometrine® i.m. is contraindicated, oxytocin 5IU i.v. or 10IU i.m should be recommended

- Informed consent needs to include:

    - first line agent of choice according to NICE/RCOG is currently Syntocinon 10IU i.m however, first line use of Syntocinon 10IU i.m. has been proven to increase the risk of PPH>1 litre within our Trust

    - possible side effects of syntometrine® (PIL on Trust website, Appendix A)

For women delivering by caesarean section, oxytocin 5IU by slow infusion should be used to encourage contraction of the uterus and to decrease blood loss. In women at increased risk of PPH the use of intravenous tranexamic acid (0.5-1.0g) in addition to oxytocin should be considered.

Contraindications for use of Syntometrine®:

- hypersensitivity to the active substances or other ingredients
- hypertension, pre-eclampsia, eclampsia
- severe cardiac disorders
- severe hepatic or renal impairment

- occlusive vascular disease
- sepsis

All women with a previous scar must have their placental site determined by USS. MRI may assist in determining the presence of placenta accreta or percreta. These both require Consultant-led, multi disciplinary planning for delivery.

19.2 Physiological management of the third stage

This involves a package of care which includes all of these three components:

- no routine use of oxytocic drugs,
- no clamping of the cord until pulsation has ceased,
- delivery of the placenta by maternal effort.

Expectant management of the third stage, is what the body will do unassisted given time. It is characterised by the placenta being expelled by maternal effort, assisted by gravity and /or putting the baby to the breast without the use of artificial interventions such as oxytocics, cord clamping and controlled cord traction.

19.3 Prolonged third stage

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. Referral to obstetrician required.

20. Observations in the Third Stage

Observations by a midwife of a woman in the third stage of labour include:

- general physical condition, as shown by colour, respiration and her own report of how she feels
- vaginal blood loss.

Record temperature, pulse and blood pressure after the birth on the labour report summary.

21. Physiological and Active Management of the Third Stage

Both management options have risks and benefits (Appendix G), which should be considered within the context of the woman's individual circumstances and preferences.
Women should be informed that active management of the third stage reduces the risk of maternal haemorrhage and shortens the third stage.

Record the timing of cord clamping in both physiological and active management of the third stage.

Some women at low risk of postpartum haemorrhage may express a preference for physiological management. This is only appropriate in an uncomplicated low risk pregnancy and labour, contraindications are listed in **Appendix H**.
Discussions should take place during the antenatal period to enable the woman to understand the management options available and the woman's preference. Where physiological is planned it is important for the woman to be aware that as a result of circumstances during labour or delivery active management may be necessary.

Changing from physiological management to active management of the third stage is indicated in the case of:

- haemorrhage
- failure to deliver the placenta within 1 hour
- the woman's desire to artificially shorten the third stage.
- maternal tachycardia

Traction on the cord or palpating the uterus should only be carried out after administration of Syntometrine/oxytocin as part of active management.

If at any point in the third stage there is poor uterine contraction or tissue trauma resulting in post-partum haemorrhage exceeding 500ml, commence PPH management tool and follow guidance.

22. Presence of meconium (NICE 2014)

Significant meconium is defined as dark green or black amniotic fluid that is thick or tenacious, or any meconium-stained fluid containing lumps of meconium. As part of ongoing assessments during labour, document the presence or absence of significant meconium.

If *significant* meconium is present, ensure that:

- meconium is an indication for Continuous electronic fetal monitoring
- Healthcare professionals trained in fetal blood sampling are available during labour and.
- Healthcare professionals trained in advanced neonatal life support are readily available for the birth.
- If labour is taking place in a low risk birthing setting i.e. Home or Birth Centre and significant meconium is present, transfer the woman to obstetric-led care provided that it is safe to do so and the birth is unlikely before transfer is completed.

Non-significant meconium *in the absence of any other risk factors* is no reason to change to consultant lead care during labour nor to change from intermittent auscultation to continuous monitoring (unless requested by the woman). When at home please consider transfer in to the birth centre depending on circumstances to allow transport. In all cases, use the meconium guideline for neonate following birth including observations at 1 and 2 hours following birth.
Risk factors to be taken into consideration (please keep in mind that clinical judgement allows for additional risks not stated on this list) :

- Maternal tachycardia (>120 on 2 occasions)
- Maternal temperature of ≥38 on a single reading or ≥37.5 on 2 consecutive occasions, 1 hour apart
- Suspected delay in first or second stage
- Suspected small for dates or large for dates
- Fetal heart rate ≤110 BPM or ≥160 BPM ***See FM guideline***
- Any deceleration heard on intermittent auscultation
- Non-significant meconium prior to the onset of labour
- Previous clear meconium recorded in labour

23. Deferred Cord Clamping

After administration of oxytocin:

- Do not clamp the cord earlier than 1 minute from the birth of the baby unless there is concern about the integrity of the cord or the baby has a heartbeat below 60 bpm that is not getting faster.
- Clamp the cord before 5 minutes in order to perform controlled cord traction as part of active management
- If the woman requests that the cord is clamped later than 5 minutes support her in her choice
- Perform controlled cord traction as part of active management only after administration of oxytocin and signs of separation of the placenta.

Deferred cord clamping may not be suitable where either mother or baby is compromised.

24. Management of Retained Placenta

Following all births (irrespective of feeding method) skin to skin should be offered to aid the natural release of oxytocin.

If the placenta remains in situ after 30 minutes following active management of the third stage or after 1 hour following physiological management, the following should be considered:

- Recommend the baby is tried on the breast to aid an additional oxytocin surge (even if the woman intends artificial feeding)
- ensure the bladder is empty,
- inform obstetric registrar – call immediately if heavy blood loss,
- intravenous cannula, blood for FBC and group and save serum
- NICE 2014 guidance recommends the use of intravenous oxytocic agents if the placenta is retained and the woman is bleeding excessively. Therefore, an intravenous infusion of Syntocinon should be commenced if bleeding is considered to be heavy
- Monitor maternal wellbeing and record on MOEWS chart

NB: [NICE 2014] Do not use intravenous oxytocic agents routinely to deliver a retained placenta.

Consideration for Manual Removal of Placenta

If all the above measures have failed to achieve delivery of the placenta or if there is concern regarding the condition of the mother at any time, the women should be offered assessment to remove the placenta manually. This assessment can be painful without adequate analgesia and suitable analgesia or even anaesthesia should be made available prior to this.

Once the decision for manual removal of placenta has been made, the woman should be transferred to theatre promptly. If epidural anaesthesia is in place, this may be utilised. If not, a spinal anaesthetic or GA may be more appropriate, particularly if bleeding is heavy. Manual removal of placenta should be completed in theatre, using aseptic technique, by an obstetric registrar or suitably trained doctor and /or appropriate supervision. Commence PPH management tool and follow guidance

Following manual removal of placenta the following is required:

- Indwelling urinary catheter, to remain in situ for 12-18 hours
- perineal suturing as required.
- continue IV Syntocinon infusion for 4 hours,
- if significant blood loss (PPH) or other co-morbidity transfer to HDU/Labour ward enhanced care for observation click here for full guideline

Stat dose of Intravenous prophylactic antibiotics should be given as per Antibiotics Guideline: Obstetric Infections: click here for full guideline

25. Post Partum Haemorrhage

Commence PPH management tool in presence of risk factors or if no risk identified but bleeding continues after 500ml loss. Follow guidance on the tool.
click here for full guideline

26. Obstetric Anal Sphincter injury

Women with obstetric anal sphincter injury at birth; grade and manage and initiate use of the perineal trauma booklet. click here to open pathway

27. Referral for Obstetric Opinion should be Instigated in the Following Circumstances

- indications for electronic fetal monitoring (EFM) including abnormalities of the fetal heart rate (FHR) on intermittent auscultation, clinical indication to be documented on the CTG and in the labour notes.
- delay in the first or second stages of labour,
- *significant* meconium-stained liquor, or non-significant meconium in the presence of additional risk factors (see 22)
- obstetric emergency – ante partum haemorrhage, cord presentation/prolapse, postpartum haemorrhage, maternal collapse or a need for advanced neonatal resuscitation,
- maternal pyrexia in labour (38.0°C once or 37.5°C on two occasions 2 hours apart)

- malpresentation or breech presentation,
- either raised diastolic blood pressure (over 90 mmHg) or raised systolic blood pressure (over 140 mmHg) on two consecutive readings taken 30 minutes apart,
- uncertainty about the presence of a fetal heartbeat,
- retained placenta,
- third or fourth-degree tear or other complicated perineal trauma requiring suturing.

28. Home Birth – see separate guidelines

29. Monitoring Compliance and Effectiveness

Monitoring requirement	1% of all health records of women who have delivered either in the maternity Unit or at home will be audited 3 yearly for compliance with this guideline. Additionally 1% of health records of women who have delivered having received oxytocin in labour will be audited.
Monitoring method	Retrospective case note review
Report prepared by	Named individual undertaking audit
Monitoring report sent to:	Labour Ward Forum
Frequency of report	3 yearly

30. References

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Nursing and Midwifery Council, The Code: Professional Standards of practice and behaviour for nurses and midwives. NMC 2015

RCM (2012) Evidence Based Guidelines for Midwifery led care in labour: Latent Phase
Maimburg et al Management of the latent phase 2010

Royal College of Obstetricians and Gynaecologists (2007) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. RCOG. London.

LABOUR RISK ASSESSMENT TOOL

Appendix A

NAME: **HOSPITAL NUMBER:**

Location: ☐ Home ☐ RDH LW ☐ DBC ☐ PAU ☐ Ward 314 ☐ QHB LW ☐ MAU ☐ Ward 11 ☐ SJCH

Named Midwife: Continuity of Carer Team:

Named Consultant:

Date	Time	Grav/Par	EDD	Gestation	Blood group/Rh	Allergies	BMI
		/					

Reason(s) for admission:

Vaginal loss:	Uterine activity:

RISK FACTORS

	Pre-existing	Identified in this pregnancy
Obstetric		
Medical		
Lifestyle (include smoking, alcohol,safeguarding)		

PPH RISK FACTORS—start PPH tool if any factors identified prior to or developing during labour)

☐ Anaemia or bleeding disorder (Hb <95, platelets <100)	☐ Estimated birth weight >4.5kg
☐ Previous Postpartum Haemorrhage >1liter	☐ Polyhydramnious
☐ BMI <18 or >35 or booking weight <55 kg	☐ Previous uterine surgery
☐ Multiple pregnancy	☐ Abnormal placental implantation
☐ ≥ 5 previous vaginal births	☐ Known abruption or Antenatal Haemorrhage
Most recent Hb: ……gm/dL At gestational age:	Declining blood products: ☐ Yes ☐ NO

AN screening blood (HIV, Hep B, Syphilis, SC/T) results: Available and reviewed ☐ Results not known ☐

If screening results not known: screen woman, follow urgent pathway GBS status: Covid-19 status:

OBSERVATIONS AND CARE PLAN

Blood pressure	Pulse:	Resp rate:	Temperature	Saturations:	Urinalysis	Oedema
/	BPM	/min	°C	%		

SFH (if applicable) cm	Pres / lie:	PP to brim:	Fetal movements:	Fetal Heart rate: BPM	VTE score:	Plymouth score:

Fetal monitoring: ☐ I.A. ☐ CEFM: reason: .....
Care pathway: ☐ Suitable for low risk ☐ Consultant led care
☐ Obstetric review required ☐ Anaesthetic review required

Plan if at increased risk of PPH:
☐ Measure/record blood loss ☐ PPH booklet
☐ Active 3rd stage management ☐ Early IV access
☐ Antibodies; If yes for cross match ☐ 2 units Xmatch

Name: Designation: Signature:

Appendix B

The following list indicates conditions or situations where there is an increased risk to mother or baby and as such must be identified and documented on risk assessment in labour.

Disease Area	Medical condition
Cardiovascular	• Confirmed cardiac disease • Congenital heart disease (in woman) • Hypertensive disorders
Respiratory	• Asthma requiring an increase in treatment / hospital treatment • Cystic fibrosis
Haematological	• Haemoglobinopathies: sickle cell disease • Beta thalassaemia major • History of thromboembolic disorders • Thrombocytopenia, platelet disorder or platelet count <100 • Von Willebrands disease • Bleeding disorder in the woman or unborn baby • Atypical antibodies which carry a risk of haemolytic disease of the newborn.
Infective	• Group B streptococcus; associated risk factors whereby antibiotics in labour would be recommended • Hepatitis B/C • Carrier of / infected with HIV • Toxoplasmosis – receiving treatment • Current active infection with chicken pox/ rubella/ genital herpes • Tuberculosis under treatment
Immune	• Any auto-immune disease, including: • Systemic lupus erythematosis • Scleroderma
Endocrine	• Thyroid dysfunction • Diabetes
Renal	• Abnormal renal function • Renal disease requiring supervision by a renal specialist
Neurological	• Epilepsy • Previous cerebrovascular accident • Myasthenia gravis

Gastrointestinal	• Liver disease with current abnormal liver tests • Crohn's disease • Ulcerative colitis
Psychiatric	• Psychiatric disorder requiring current psychiatric care • Previous puerperal mental illness requiring hospitalisation

Other factors indicating increased risks to be considered

Factors	**Additional information**
Previous Obstetric complications	• Unexplained stillbirth / neonatal death or previous death related to intra-partum difficulty • Pre-eclampsia • Eclampsia • Placental abruption • Uterine rupture • Primary PPH • Retained placenta • Caesarean section • Shoulder dystocia • Anaesthetic History of complications • Previous baby with encephalopathy
Current pregnancy	• Multiple birth • Placenta praevia • Pre- eclampsia or PIH • Preterm labour or preterm pre-labour rupture of membranes • Placental abruption • Anaemia – haemoglobin < 100 g/L • Confirmed IUD • Induction of labour • Gestational diabetes • Malpresentation • BMI > 35 at booking • Recurrent APH • Grand multip; para 4 or more
Lifestyle History	• Substance misuse • Alcohol dependency
Fetal indications	• Fetal abnormality • IUGR/SGA • Abnormal fetal heart rate/Doppler studies • Oligo-/ polyhydramnios diagnosed on us • Altered fetal movements in the last 24 hours prior to the onset of regular contractions.
Previous gynaecological history	• Fibroids • Myomectomy

	• Cone Biopsy

Other factors indicating individual assessment when planning place of birth and care lead

Factors	**Additional information**
Previous Obstetric complications	• History of previous baby more than 4.5kg • Extensive vaginal, cervical, or third- or fourth-degree perineal trauma • Previous term baby with jaundice requiring exchange transfusion
Current pregnancy	• APH of unknown origin (single episode after 24/40) • BMI at booking of 30-35 or over • Clinical or ultrasound suspicion of macrosomia • Recreational drug use • Age over 35 at booking

Appendix C

DERBY HOSPITALS NHS FOUNDATION RISK ALERT FORM

Patient details/sticker NAME DOB HOSPITAL NUMBER

Community Midwife: ……..……

Team Base name: ……

Consultant: ……

EDD: ……

Gravida / parity …… / …….

TO BE READ IN CONJUNCTION WITH CONSULTANT GP LETTER and any SPECIAL INSTRUCTIONS

TO BE COMPLETED WHEN ANY NEW RISK FACTORS ARE IDENTIFIED DURING PREGNANCY

Date/Time	Gest	CLC/MLC	NEW Risk identified (See key below)	Action/Plan of care
				Print name Signature Designation
				Print name Signature Designation
				Print name Signature Designation

				Print name Signature Designation
				Print name Signature Designation

Obstetric risk factors / Thromboembolism (see VTE risk assessment tool) / Medical risk factors / Social Complexities

Appendix D

Management of the Latent Phase of Labour

The latent stage of labour can be defined as

A period of time, not necessarily continuous when

- There are painful contractions **and**
- There is some cervical change, including cervical effacement and dilatation up to 4 cm (NICE 2014)

It is recognised that good quality antenatal information and preparation regarding the latent phase of labour can increase the likelihood of women arriving at hospital in established labour (Maimburg et al 2010). This should include advice regarding

- How to differentiate between Braxton Hicks contractions and active labour contractions
- How to recognise amniotic fluid (waters breaking)
- How to recognise normal vaginal loss
- Who to contact if the movements of your baby stop or alter from their normal pattern
- The potential length of the latent phase and the physiological processes that are occurring
- Coping with the associated discomfort and exhaustion

Women should be provided with advice on The Latent Phase of Labour at their 36/40 appointment with their community midwife (a leaflet can be provided when available).

Continuity of advice from a named midwife may improve the woman's experience and ability to cope with latent labour.

Telephone Triage should be available to all women:

Women under Consultant Lead care (high risk) will contact the 24hour Assessment Unit

Women under Midwifery lead care (low risk) will contact the Birth Centre Coordinator

Planned Homebirth women will contact the 24hour assessment unit in the first instance and the on call community midwives will be contacted by the Triage midwife. Women must not be given the telephone numbers of the Community Midwives.

All Discussions with women who ring for advice should include:

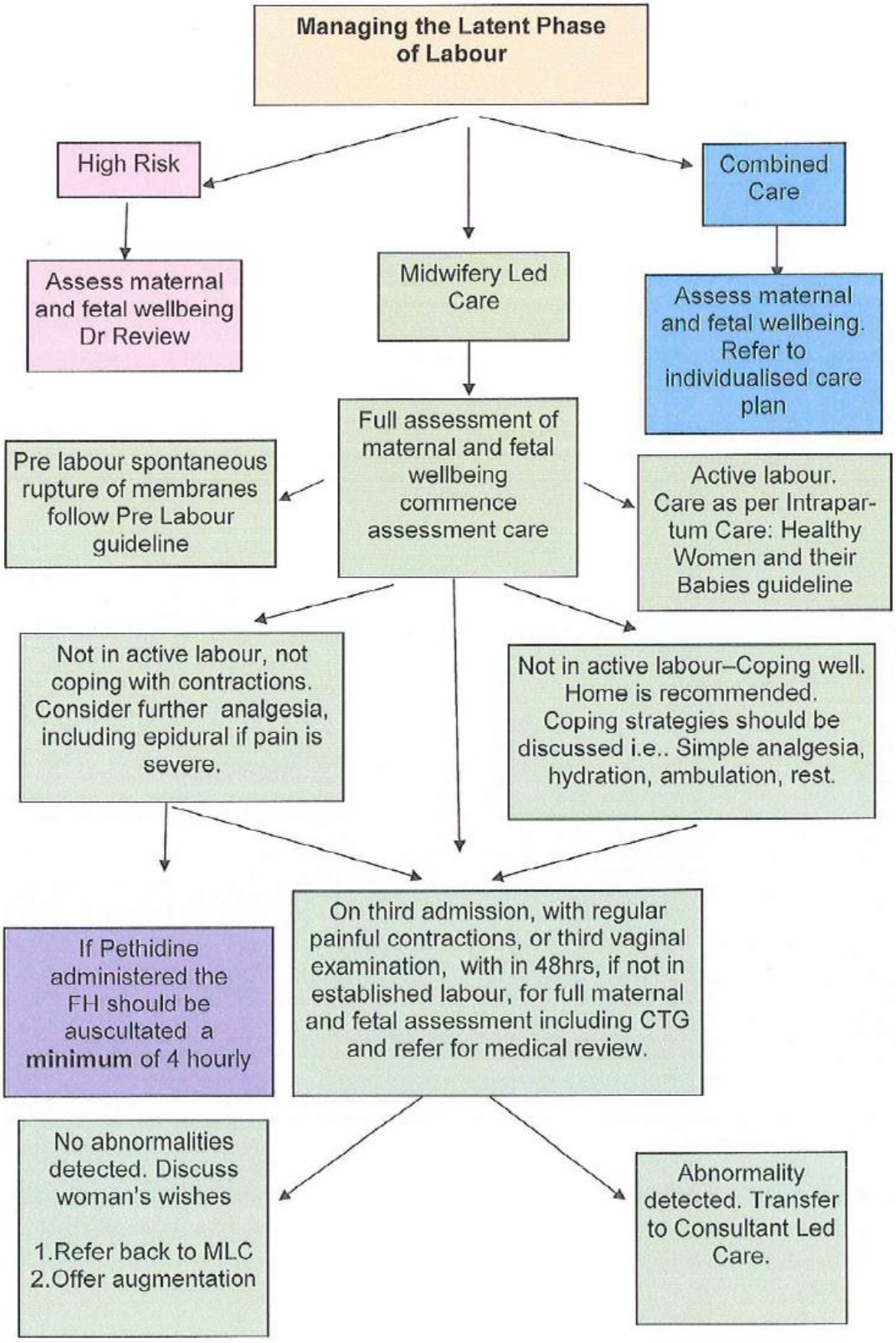
- Recognition of the woman's wishes, expectations and any concerns she may have
- Ask the woman about the length, strength and frequency of her contraction
- Ask the woman about any vaginal loss ie. blood, liquor, mucous
- Ask the woman about the baby's movements, including any changes
- Offer support and guidance to both the woman and her birth companion
- Agree a plan of care, including who she should contact next and when.

A telephone log sheet should be commenced at the initial triage, maintained at each contact and the above discussions clearly documented.

The triaging midwife must access the maternity system in order to exclude an indication for prompt admission, for example a previous precipitate delivery.

Following telephone triage consider a face to face assessment within the hospital or home setting. If necessary,
Women in the high risk category will be asked to attend Labour ward for assessment.

Women in the low risk category will be asked to attend the Birth Centre.



ADVICE TO WOMEN THOUGHT TO BE IN LATENT PHASE WITH NO INDICATION FOR ADMISSION

Women in the latent phase of labour should be encouraged to remain at home unless doing so leads to a significant risk that she could give birth without a midwife present (NICE 2014).
Consideration should be given as to the level of social support, past experiences and level of distress.
Both women and their Birth Partners require good quality support & advice in order to cope effectively.

NUTRITION: Women should be advised to maintain food and fluid intake "little and often". Isotonic drinks may be beneficial (NICE 2014)

MOBILITY: Women should be encouraged to remain mobile and find positions comfortable for them

PAIN RELIEF: Non pharmacological methods of pain relief should be discussed. This may include

- the use of Birthing balls &/or beanbags
- adopting various positions for example kneeling or squatting
- The use of warm baths or showers
- The use of massage, particularly to back and shoulders
- The use of relaxation music and or techniques
- The use of TENS machines

If ineffective women can be assured that it is safe to take regular standard doses of Paracetamol (no more than 4g in 24hrs)

BIRTH SUPPORTERS: Recognition should be given to the fact that it is difficult seeing someone you care about in discomfort and distress. The process of the latent phase of labour should be reiterated including practical methods of support such as massage, provision of refreshments, environmental comfort and the running of baths for example. The responsibility to remember bags, have telephone numbers within easy access and to bring hand held records can also be emphasised.

REST: During periods of less frequent or absent tightening's and pain women should be encouraged to rest and try to sleep. Latent phase can be an exhausting time for many women.

Maintaining contact with the triaging midwife should be encouraged in order to provide effective support. Assessment should be offered to those women who

- Appear in active labour
- Remain very anxious or sound distressed despite reassurance and support
- SROM
- Report blood stained PV loss not associated with a show or sweep
- Call for advice on more than 3 occasions
- Have a history of precipitate birth
- Are booked for a caesarean section.

INITIAL FACE TO FACE ASSESSMENT

The midwife must carry out an initial assessment to determine if midwifery led care is suitable for the woman, regardless of her antenatal care pathway.

A labour risk assessment tool must be commenced and completed in full.

Observations of the Woman

- Review the antenatal notes including antenatal screening results.
- Ask her about the length, strength and frequency of her contractions
- Acknowledge her perception of pain noting any methods of pain relief already used
- Record her temperature, pulse, blood pressure and urinalysis
- Ask her about any vaginal loss

Observation of the unborn baby

- Ask the woman about the movements of her baby in the last 24hrs
- Perform an abdominal palpation to ascertain the fundal height, the babies lie, presentation, position, engagement of the presenting part and frequency and duration of contractions.
- Auscultate with a pinnard or sonicaid the fetal heartrate for a minimum of 1 minute after a contraction.

VAGINAL EXAMINATION

- If there is uncertainty as to whether the woman is in established labour a vaginal examination may be helpful after a period of assessment, but is not always necessary.
- If the woman appears to be in established labour, offer a vaginal examination.

CARDIOTOCOGRAPH

A CTG must not be commenced unless there is a clear indication for its usage. Those women under consultant care with no clear intrapartum risk factors should be discussed with a senior registrar or Consultant in order to ensure the correct care pathway is selected. This must be documented.

Following assessment those suitable for low risk care should be cared for in the midwifery-led birth centre. Those women appropriate for high risk care should be cared for on labour ward.
Women who remain in latent phase and with no indication for admission should be encouraged to return home and offered guidance and support as above.

WHEN TO SEEK MEDICAL REVIEW

It is advised that a medical opinion is sought for low risk women who

- Attend of 3 or more occasions in latent phase of labour
- Have 3 or more vaginal examinations in latent phase of labour with minimal changes to effacement & dilatation.

If she chooses not to go home -12hrly observations to be undertaken

Nutrition in Labour

Practice Statement

Withholding food and drink inappropriately from women in labour can increase levels of stress which in turn can affect the delicate neuro-hormonal balance that enables labour to progress unhindered. Fasting may result in dehydration and ketosis which, combined with starvation and fatigue, is associated with the active management of labour. Although it is not clear whether this association is an indication of cause or effect, the presence of ketonuria should be considered as a signal of metabolic imbalance. To facilitate women's decision-making and informed choice, midwives need to be aware of the evidence and history behind withholding food and drink from women in labour. They must also be cognisant of when it is appropriate to offer light diet and when advising food restriction is believed to be in the woman's best interest.

Recommendations for practice

Where a labour is considered **low risk** and continues to be progressive:

- Offer women light, low residue, low fat snacks and drinks (see charts below) but do not force food where it is declined
- Offer free access to fluid to maintain hydration / isotonic drinks may be more beneficial than water (NICE (2014)
- Routine antacids do not need to be administered
- Women who require opiates should be offered clear fluids only, due to reduced gastric emptying (see chart 2)
- When risk status changes, so should dietary advice, in line with medical opinion.

Suggested drinks for **low risk** women in labour
Low fat yoghurts drinks Fresh fruit juices (avoid long life apple, pineapple and lemon as they tend to be more acidic) Tea/coffee with skimmed milk Soups (tomato, chicken or vegetable etc) Squash drinks – not too concentrated Water and ice Naturally carbonated mineral water

Women that are **low risk** and expected to remain so throughout labour may wish to eat.

Suggested low fat, low residue foods for **low risk** women in labour:
Toast with low fat spread, jam /honey Cereals with semi/skimmed milk Plain sweet biscuits Smooth soup, Chocolate wafer biscuit Low fat, smooth yoghurt/fromage frais

Where a labour is considered **high risk** the woman should be offered fluids as suggested below, **women in this group should <u>not be</u> offered foods during labour**

Suggested drinks for **high risk** women in labour
Water & ice Tea/Coffee skimmed milk Squash Apple juice Clear soup Bovril/Vegetarian equivalent

Ranitidine should be given to all women at high risk of requiring a Caesarean Section (including all women with epidurals), and the dose is 150mgs orally, 6 hourly, until delivery.

There is no indication for Ranitidine in low risk women as prophylactic use of antacids or reduction of the volume of stomach contents by restricted oral intake has not been shown to be successful in preventing Mendelson's syndrome.

In particular individual cases it may be necessary for the woman to be kept Nil By Mouth at the anaesthetists request.

Clinical decision making and the evidence

The original rationale for the introduction of restricted oral intake in labour was to prevent Mendelson's syndrome (aspiration of acidic stomach contents) if a general anaesthetic was required. There is no evidence that the practice of starving well women in normal labour will influence the incidence of this syndrome. Withholding food and drink during labour will not ensure an empty stomach and for those women for whom a general anaesthetic is not anticipated a light, low residue, low fat diet may be recommended.
Where solid food is not appropriate, isotonic drinks may provide more benefit than plain water, in reducing maternal ketosis without increasing gastric volume.

The administration of opioids appears to be a major factor in delaying stomach emptying.

Pain Relief in Labour

Inhalational analgesia

Entonox (a 50:50 mixture of oxygen and nitrous oxide) should be available in all birth settings as it may reduce pain in labour, but women should be informed that it may make them feel nauseous and light-headed.

Intravenous and intramuscular opioids

Pethidine, is available in all birth settings although not carried by community midwives so needs to be prescribed by GP for home birth.
Women should be informed that this will provide limited pain relief during labour and may have significant side effects for both the woman (drowsiness, nausea and vomiting) and her baby (short-term respiratory depression and drowsiness which may last several days).
Women should be informed that pethidine, may interfere with breastfeeding.
If an intravenous or intramuscular opioid is used, it should be administered with an anti-emetic.
Women should not enter water (a birthing pool or bath) within 2 hours of opioid administration or if they feel drowsy.

For regional analgesia see Guidelines for Management of Epidural Analgesia in Labour **(E4)**

Appendix G

Risks and Benefits of Active and Physiological 3rd Stage of Labour

Active Management	*Physiological* Management
Benefits • A significant reduction in the incidence of primary post-partum haemorrhage (PPH >500ml) • Reduction of PPH >1000mls is significant in women with risk factors • Reduced need for treatments e.g. blood transfusion • Reduction in the length of the 3rd stage of labour (approx 9 mins on average)	**Benefits** • Reduction in side effects related to oxytocics • Associated with a transient continuation of circulation to the baby = approx 80ml auto transfusion
Risks • Transient increase in maternal BP (particularly where ergometrine is used – see instructions on oxytocic use below), tachycardia, nausea, vomiting and headache. • A rise in incidence of retained placenta – not significant when applied to both low & high risk groups	**Risks** • Increased risk of PPH >500mls • Increase in PPH > 1000mls is non significant for low risk women. • Increased need for treatment • Increased length of 3rd stage

Appendix H

Contraindications for Physiological Management of Third Stage

Expectant management is positively contraindicated in the following circumstances:

- previous history of PPH,
- history of antepartum haemorrhage, including in labour,
- haemoglobin <100 g/L prior to birth,
- multiple pregnancy,
- grand multiparity,
- known fetal macrosomia,
- polyhydramnios,
- any known bleeding dyscrasias (eg von Willibrand's disease, haemophilia carrier),
- risk of current coagulation disorder or deranged liver function, includes women with pre-eclampsia, obstetric cholestasis, fatty liver of pregnancy, IUFD and thrombocytopenia,
- women using anti-coagulation treatment,
- uterine anomalies e.g. fibroids,
- induction of labour,
- where labour has required augmentation with syntocinon,
- prolonged 1st or second stage,
- precipitate delivery.

Physiological management of the third stage is **only** appropriate for women who are at low risk of postpartum haemorrhage and who have had **uncomplicated** labour and birth. Intervention with active management should ensue if this situation changes during labour, including during third stage. Any circumstances, which may inhibit the uterus to function normally, such as oxytocin augmentation in labour, repeated doses of opiates, and early clamping and cutting of the cord are contraindications to expectant third stage.

Documentation Control

Reference Number: UHDB/IP/07:2021/L2	**Version:** **UHDB 1**		**Status: FINAL**	
	Royal Derby prior to merged document:			
Version / Amendment	Version	Date	Author	Reason
	3.4	Feb 2018	Maternity Guideline Group	Change Syntometrine to Syntocinon in third stage
	Burton Trust prior to merged document:			
WC/OG/43	8.1	May 2018	Dr M Doohan – Consultant Obstetrician	Syntrometrine instead of syntocinon for first stage
Version control for UHDB merged document:				
Intended Recipients: All staff caring for labouring women				
UHDB	1	May 2021	Kate James - Senior Midwife High Risk (RDH) Sarah Evans – Senior Midwife Delivery Suite (QHB)	Review and merge
	1.1	Aug 2021	Cindy Meijer – clinical risk and governance support	Aligned with PPH tool and guideline
	1.2	May 2023	Cindy Meijer - Digital Midwife Joanna Harrison-Engwell - Lead Midwife for Guidelines, Audit and QI	Guidance on FHR & CTG monitoring for women with risk factors identified in pregnancy or during assessment (Section 8) Amendment to fall in line with new NICE guidance - for continuous CTG in labour if altered fetal movements in 24 hours prior to regular contractions
	1.3	Aug 2023	Joanna Harrison-Engwell - Lead Midwife for Guidelines, Audit and QI	Sentence added to complete PPH proforma on all women
Training and Dissemination: Cascaded through lead midwives/doctors / Published on Intranet NHS mail circulation / Article in BU newsletter				
To be read in conjunction with the following guidelines: Epidural Anaesthesia (E4) / Bladder Care in Labour and the Early Postnatal Period (B4),				
Consultation with:	Obstetricians, Maternity Staff			
Business Unit sign off:	29/06/2021: Maternity Guidelines Group: Miss S Rajendran – Chair V1.2 02/05/2023: Maternity Guidelines Group: Miss S Rajendran – Chair 17/06/2021: Maternity Development & Governance Committee/ACD- Miss S Raouf V1.2 19/06/2023 Maternity Governance Group - Mr R Deveraj			
Divisional sign off: 29/06/2021				

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Key Contact:	Joanna Harrison-Engwell