Intrapartum Care – Normal Labour & Birth

Overview

Document Type	Guideline
Function	Clinical Service Delivery
Directorates	National Women's Health
Department(s) affected	Maternity
Patients affected	All maternity patients
Staff members affected	All clinicians in maternity including access holder Lead Maternity Carers (LMCs)
Key words (not part of title)	n/a
Author – role only	Clinical Director of Obstetrics
Owner (see ownership structure)	Owner: Service Clinical Director – Secondary Maternity Services Issuer: General Manager – Women's Health
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Content This document covers the following topics:

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Overview, Continued

Objective

Labour and birth is a normal physiological event.
To ensure staff members are aware of the recommended best practices to follow for intrapartum care in normal labour and birth.

A midwife should

- Understand and implement life saving skills, including the use of technology, in a timely and appropriate manner when there is a clear and present danger to the health of pregnant women and/or their babies
- Take measures to avoid unnecessary interference in the progress of normal labour and birth

(Ref: International Confederation of Midwives Council, May 1999)

- Recognise deviations from normal labour and birth and refer appropriately

Associated documents

The table below indicates other documents and sources associated with this guideline.

Type	Document Titles
ADHB Policies and Guidelines Library	• Admission - Labour & Birthing Suite • Bladder Care Postpartum & Urinary Retention Management • Cord Blood Haematology • Count Policy for Surgical Procedures • Fetal Heart Rate - Intrapartum - Surveillance • Group and Screen Requirements - Inpatients • Hepatitis B Vaccination • Identification of Patients (including Newborns) • Informed Consent • Postpartum Haemorrhage • Resuscitation of Newborns • Retained Placenta Management • Vitamin K prophylaxis and Vitamin K Deficiency Bleeding – Newborn website

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Overview, Continued

Type	Document Titles
ADHB Clinical Forms (some available on Clinical Forms site)	• CR3895: National Women's Partogram • CR5636: Rooming In Record • CR2547: Body Parts /Tissue Release • CC029: Delivery Summary • S291: Newborn Record
References	• British Journal of Midwifery, January 1998, Vol 6 No1. A trial of cetrimide/chlorhexidine or tap water for perineal cleaning • Cochrane Review: Syntocinon vs Syntometrine intramuscularly • 2002 Medline Review: Pushing vs. delayed pushing in second stage • 2000 Cochrane Review: Active vs. expectant management third stage • World Health Organisation, Geneva, 1996. Care in normal birth: A practical guide • 2002 Cochrane Review: Episiotomy for vaginal birth • MOH Guidelines for Consultation with Obstetric and Related Specialist Medical Services • British Journal of Midwifery, July 1997, Vol 5 No1. Restriction of oral intake for women in labour • Royal College of Obstetricians and Gynaecologists. The Use of Electronic Fetal Monitoring

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Observations in labour

Follow the steps below to document labour details on CR3895: National Women's Partogram.

Please note: Hand hygiene is an important part of intrapartum care.
Partogram is to be:

- Commenced when labour is established
- Completed with the woman's name and NHI number, dated and to include EDD, gravida and parity
- Legibly documented, name printed and signed by caregivers

Step	Action
1.	Document admission details in the Progress Notes In Labour section. Include: • Source of admission • Reason for admission • History of contractions, show, rupture of membranes, any other PV loss, and fetal movements • Abdominal palpation findings Thereafter continue to document progress and ongoing care throughout the labour.

2.	Observations - record and document the following:
	Fetal heart
	• On admission then:
	  • ¼ hourly in first stage (immediately after a contraction for one minute)
	  • after every contraction in second stage, or more often if indicated
	• Document method of auscultation
	• If being monitored with a CTG machine, document baseline ½ hourly. Retain the CTG in the clinical record in an appropriate manner
	Temperature
	• On admission and then 4 hourly
	• 2 hourly if membranes ruptured
	• Hourly if temperature greater than 37.4°C
	Pulse
	• On admission and then hourly
	BP
	• On admission and then 4 hourly
	• If diastolic ≥ 90mm Hg, ½ - 1 hourly

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Observations in labour, continued

Step	Action
	Fluid input/output • Urinalysis for ketones on admission, then if indicated • Document on CR3895: National Women's Partogram unless Fluid Balance Record indicated (refer to Bladder Management – see associated documents section) • Commence Fluid Balance Record (CC2354) as indicated
3.	**Liquor** • Document date and time of rupture of membranes, method of rupture and colour of liquor • Continue to document evidence of amount, colour and consistency of liquor, and indication for artificial rupture of membranes
4.	**Contractions** • Palpate and record strength, length and frequency of contractions over a 10 minute period every ½ hour • Follow guide described on Partogram to record

5.	**Progress in labour**
	• Descent of presenting part
	  • Abdominally palpate and document descent of presenting part 3 hourly, and before vaginal examinations (VE)
	• Cervical dilatation
	  • When membranes are ruptured VE should be minimised to avoid infection
	  • Where possible the same practitioner should perform the VE at each assessment
	  • The practitioner who performs the VE is to document as many details as possible of the VE findings
	  • Plot cervical dilatation and descent of presenting part on the Partogram

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Observations in labour, continued

Step	Action
6.	**Birth plan and labour management plan** • Review the woman's choices regarding her labour and birth and any advice given, and document accordingly • Midwife or LMC is to review and document management plan for labour and birth on CR3895: National Women's Partogram and update plan throughout labour • Ongoing informed choice and consent in labour
7.	**Pain relief/medications/other management** • Document all medications administered on Medication Chart (CC1583) and Partogram (CR3895) • Document any other pain relief measures and effectiveness • When on Syntocinon® infusion, record increasing milliunits on Partogram in space provided • All women receiving intravenous fluids should have a Fluid Balance Chart • Intravenous access and/or group and hold and full blood count should be taken only when medically indicated • Women should be encouraged to take oral food and fluids in normal labour

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Equipment for normal birth

Delivery pack

- 1 hand towel
- 1 plastic cord clamp
- 2 galli pots
- gauze swabs size 10 x 10mm XRD
- tailed swab (throat swab 42 x 7 mm XRD) (if used, attach Spencer Wells to tail)

Instruments packed separately

- 1 cord scissors
- 2 Spencer Wells forceps
- 1 episiotomy scissors

Note: all swabs must be counted upon opening the pack, and after any suturing is completed. Swab count must be documented on the Labour and Birth Summary.

Suture pack

- Needle holder
- Suture scissors
- Pickup forceps

Requirements for ecbolic administration

- 2 mL syringe and 22g needle for giving of ecbolic
- 2 medi-swabs
- 10 units Syntocinon® (oxytocin) or 1 ampoule Syntometrine® (oxytocin 5 units/mL plus ergometrine 500micrograms/mL) . Both stored in fridge.

Baby's clinical record and labels

Collect from reception area.

Emergency equipment

Resuscitaire table: ensure oxygen, suction, laryngoscope and Laerdal bag are functional.

Bedside cabinet: check 30 units Syntocinon®, 10 units Syntocinon® and 1 ampoule Syntometrine® are available.

For care of baby

- Ensure overhead light and heater on resuscitaire are functioning
- Ensure that cot and towels are warm and available for baby

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Equipment for normal birth, continued

Requirements for vitamin K administration	• 1 mL syringe and 25g needle for giving of intramuscular vitamin K • 1 ampoule vitamin K 2mg/0.2mL (for intramuscular or oral use) – not to be drawn up until immediately prior to administration • Vitamin K dropper
Equipment for cord bloods	• 10 mL syringe with 20g needle • 3 blood tubes (1 red top and 2 purple tops) • Cord blood labels • Laboratory request form

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Recommendations for normal birth practices

Effective practices

The following practices have been shown to be effective, demonstrably useful and should be encouraged:
(Ref: WHO Technical Working Group on Normal Birth)

1. A birth plan;
2. Risk assessment antenatally and throughout labour;
3. Respecting the woman's informed choice and consent;
4. Respecting the right of women to privacy in the birthing place;
5. Empathetic support by caregivers during labour and birth;
6. Respecting the woman's choice of companions during labour and birth;
7. Giving women as much information and explanation as they desire;
8. Non invasive, non pharmacological methods of pain relief during labour, such as massage and relaxation techniques;
9. Fetal monitoring with intermittent auscultation;
10. Freedom in position and movement throughout labour;
11. Encouragement of non-supine positions in labour;
12. Early skin to skin contact between mother and child.

Practices which should <u>not</u> be routinely used

1. Use of enemas;
2. Perineal shaving;
3. Rectal examination in labour;
4. Routine intravenous infusion in labour;
5. Routine prophylactic insertion of intravenous cannula;
6. Routine use of supine position or stirrups during labour or delivery;
7. Sustained, directed bearing down efforts (Valsalva manoeuvre) during second stage of labour;
8. Massaging and stretching the perineum during second stage;
9. Routine continuous electronic fetal monitoring;
10. Bladder catheterisation;
11. Routine or liberal episiotomy;
12. Routine augmentation of labour;
13. Routine suctioning of baby at delivery.

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Recommendations for normal birth practices, continued

Practices for which there is insufficient evidence to support use

1. Routine amniotomy in first stage;
2. Manoeuvres related to protecting the perineum;
3. Active manipulation of the fetus at the moment of birth;
4. Restriction of food and fluid during labour.

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Restrictive use of episiotomy

Available research does not support the routine use of episiotomy to prevent third degree tears, trauma or reduce the incidence of urinary incontinence.

Restrictive episiotomy is shown to result in less posterior perineal trauma, less suturing and fewer complications, e.g. infection.

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Management in the third stage

Active management should always be encouraged for woman at risk of postpartum haemorrhage. There is good evidence that women who are not at risk also benefit from active management of the third stage. For women at risk of atony, Syntometrine® should be used intramuscularly for active management unless contraindicated. For women at lower risk, intramuscular Syntocinon® should be used.

Recommended best practice

Follow the steps below to actively manage the third stage to reduce the incidence of postpartum haemorrhage and the need for blood transfusion.

Active management

Step	Action
1.	Give 10 units Syntocinon® intramuscularly to the mother after delivery of the placenta. or If high risk of atony, give 1 mL Syntometrine® intramuscularly following delivery of the placenta. Syntometrine®, contains ergometrine and is contraindicated in women with a history of maternal hypertension or pre-eclampsia.
2.	Clamp and cut the cord.
3.	Guard the uterus by providing counter-traction with hand suprapubically. With other hand, provide controlled cord traction by exerting steady downward traction to deliver placenta.
4.	No fundal pressure should be applied.

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Management in the third stage, continued

If after full discussion the woman chooses a physiological third stage, the following is the recommended procedure.

Physiological management

Step	Action
1.	Omit ecbolic.
2.	Postpone clamping and cutting of the cord until the cord has stopped pulsating, or after the placenta has been born.
3.	If the cord is clamped and cut prior to expulsion of the placenta, the placental end must be drained.
4.	Do not use fundal massage or cord traction.
5.	Keep the woman and baby warm and encourage breastfeeding if that is planned.
6.	Wait for signs of separation: • Lengthening cord • Slight blood loss • Strong uterine contraction • Uterus smaller, rounder and firm • Fundus rises to abdomen becoming harder and more mobile • Woman may feel pressure to bear down
7.	Encourage the woman to push in a position that is comfortable.
8.	Where there is any deviation from the expected outcome, active management should be initiated.
N.B.	If at any stage there is a delay in delivering the placenta (> 30 minutes if bleeding otherwise up to 1 hour), ensure that the bladder is empty, either by the woman passing urine or insertion of an in/out catheter if unable to void.

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Management in the third stage, continued

After delivery of placenta

Step	Action
1.	Check the uterus is well contracted following delivery of the placenta and estimate blood loss. Check labia, perineum and vagina for lacerations. Repair trauma as indicated as soon as possible.
2.	Examine the appearance and completeness of the placenta and membranes. Take cord blood samples as indicated. With the exception of cord blood lactates or gases, cord samples should be avoided until after the placenta is delivered to prevent blood accidents. Ascertain number of cord vessels. Confirm whether the woman would like to take her placenta home. Weigh placenta and document findings on Labour and Birth Summary.
3.	Remove soiled linen and ensure that the woman is clean, dry and comfortable. Place sanitary pad in situ.
4.	The practitioner conducting the birth is responsible for cleaning up the delivery equipment/trolley. Instruments and swabs to be accounted for. Dispose of sharps appropriately. Any count discrepancy must be handed over before transfer out of Labour and Birthing Suite, and x-ray arranged as appropriate. Tidy trolley. Clean bowls and kidney dishes in sink. Put placenta into two plastic bags, label plastic bag and return or dispose of according to the woman's wishes.
5.	Blood loss must be estimated by measuring volume and weighing swabs if any concern of post-partum haemorrhage (PPH). Estimated blood loss must be recorded after delivery and any ongoing loss also documented on the Labour and Birth Summary
6.	Complete documentation: • CR3895: National Women's Partogram • CC029: Delivery Summary • CR2547: Body Parts /Tissue Release • Clinical Record. • Enter details on the computer

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Documentation of delivery summary

Documentation

The following forms must be completed:

- CC029: Delivery Summary
- CR3895: National Women's Partogram
- CR2547: Body Parts /Tissue Release
- CR5636: Rooming In Record
- S291: Newborn Record
- Fluid Balance Record
- Clinical Records
  - Baby's
  - Mother's

All clinical records require a date, time, a legible signature and designation of person providing clinical care.

Please note: Delivery Summary is to be commenced once labour established, updated throughout labour and completed following delivery.

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Initial postpartum care of mother

Recommended best practice

Follow the steps below to provide initial postpartum care of the mother in the delivery unit.

Step	Action
1.	Immediately postpartum assess and document the following: • Fundus • Lochia • Temperature, pulse, BP (within the hour postpartum) • Bleeding from site of any laceration or episiotomy
2.	Prioritise the following cares according to the woman's and baby's immediate needs: • Calls to family/friends • Time with baby/partner/family • Fluids/food • Analgesia • Initiation of skin to skin contact within 5 minutes of delivery • Empty bladder (report to midwife on warding if the woman has been unable to void completely prior to transfer) • Shower/sponge
3.	If IV in situ, evaluate need for further fluids or Syntocinon® infusion. If not required, luer or remove (unless woman has not passed urine).
4.	If woman has had an epidural, evaluate need for further epidural anaesthesia and remove epidural catheter unless otherwise instructed by the anaesthetist.
5.	Use opportunities as they arise to educate the woman regarding: • Bladder care • Care of perineum • Initiation of breastfeeding and breast care

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Initial postpartum care of mother, continued

Step	Action
6.	Transfer/discharge: according to woman's postnatal plan, i.e: **EITHER** Transfer mother and baby to ward and give verbal handover to postnatal staff members **OR** Arrange transfer of mother and baby to outlying hospital and give verbal handover to postnatal staff members **OR** Discharge mother and baby home (see Early Discharge folder)

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Initial postpartum care of newborn

Recommended best practice

Follow the steps below to provide initial postpartum care of the newborn in the delivery unit.

Step	Action
1.	Initiate skin to skin contact between the mother and baby.
2.	Give the baby to the mother as soon as possible after delivery, ensuring the baby is kept warm.
3.	Ensure initial examination of the baby is performed. Ensure vitamin K is given if consented by parents. The recommended route of administration is intramuscular (IM), being given at birth, and that this should be as a single IM injection: 1. Term babies 0.5-1mg IM soon after birth 2. Preterm 0.5mg IM soon after birth Parents should be advised that with intramuscular injection, the risk of haemorrhagic disease of the newborn is extremely low. If parents do not consent to IM but consent to oral vitamin K, this needs to be given in 3 separate doses according to the following regime: 1. 2mg oral soon after birth 2. 2mg oral at 3-7 days 3. 2mg oral at 6 weeks Parents should be advised that even with full compliance with this regime, cases of Haemorrhagic Disease of the Newborn (HDN) are rare but still occur. Surveillance and reporting of any bleeding is therefore important. The at risk time is up until the infant is receiving something other than breastmilk in their diet.
4.	Observe baby regularly for colour and breathing.

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Initial postpartum care of newborn, Continued

Step	Action
5.	Prioritise the following cares according to needs of the mother and baby: • Fasten on 2 ID bracelets after verifying baby details with one of the parents, ASAP after birth • Weigh baby • Assist with initiation of feeding • Take axilla temperature within an hour of delivery
6.	Documentation: • S291: Newborn Record • Cot card • Outcome of initial feed(s) and the baby's temperature on CR5636 Rooming In Record
7.	If at any stage there are concerns about the baby's condition notify the LMC and/or National Women's Health paediatric staff members. If the baby is under paediatric care, implement a management plan as directed.
8.	For babies with a hepatitis B positive mother, complete the following additional cares: • Bath baby in delivery unit - if temperature satisfactory ($\geq 36^{5}$) • Prescribe and give baby hepatitis B vaccination and immunoglobulin as per Hepatitis B Regime for Newborn once consented by parents • Complete documentation for hepatitis B vaccination and immunoglobulin

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Indications for testing on cord blood

Full blood count

Full blood count to be done for following indications:

- Maternal rhesus negative blood group
- Rhesus isoimmunisation and isoimmunisation with other significant antibodies
- Current or past history of maternal thrombocytopenia
- Antepartum haemorrhage (APH)
- Twin pregnancy
- Intrauterine Growth Restriction (IUGR)
- A previous baby with neonatal thrombocytopenia
- Previously clinically significant jaundice, including ABO incompatibility in the newborn period
- Premature birth

Group and Coombes

Group and Coombes to be done if maternal Rhesus negative blood group.
Hand over that if the baby's blood group is Rhesus positive then Kleihauer must be done on the mother and the result chased to determine dose of anti-D.

Extra cord blood

Extra cord blood may be required for the following reasons:

- Current or past history of maternal thyroid disease (5mL in red tube)
- Rhesus antibodies
- Anticonvulsant drug levels
- Specific study/trial that the woman may be participating in
- Other reasons, as requested by LMC/medical staff members

Please note: Any remaining blood is held in Blood Bank for 7 days in case further investigations are required.

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Disclaimer, Corrections & Amendments

Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this ADHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

Corrections & Amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or the Clinical Policy Advisor without delay.