Barking, Havering and Redbridge Hospitals NHS
NHS Trust

HAROLD WOOD AND KING GEORGE MATERNITY UNITS

GUIDING PRINCIPLES FOR MIDWIFERY LED CARE FOR NORMAL LABOUR

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GUIDING PRINCIPLES FOR MIDWIFERY LED CARE IN NORMAL LABOUR

INTRODUCTION

Rationale

These guiding principles for midwifery led care have devolved from the original BHR guidelines midwifery led care for normal labour published in 2003 and should be read in conjunction with the RCM's Evidence Based guidelines for midwifery led care in labour (2005). Each labour ward will have at least two copies of these guidelines for reference.

These guidelines are suitable for all those women who are in generally good health following a straightforward pregnancy and without any problems in a previous pregnancy or labour, who enter spontaneous labour at term, expecting one baby in a cephalic presentation. The underlying philosophy of midwifery is that birth is a normal physiological process and that the midwife is the lead professional. However, a woman who is offered midwifery led care may require an obstetric opinion during labour and this may result in her being transferred to consultant led care or agreement made by all parties that midwifery-led care should continue. It is also anticipated that the use of epidural analgesia will not be able to follow the midwifery led pathway, as labour may no longer be physiological, and observations and management of her labour will need to reflect that.

A key principle of midwifery-led care is the right of pregnant women to be provided with good information and to be involved in decisions about their own care and that of their babies. A lack of good quality information and over use of interventions in labour has been shown to have serious consequences in terms of iatrogenic harm, unnecessary costs and increased dissatisfaction among women over their birth experience (Coulter 1998).

The recently revised BHR Obstetric Guidelines will be in use from 5th September 2005 and should be used for women who are not suitable for midwifery led care.

Figure 1 Pathway for determining midwifery-led care

Figure 2 Mechanism of referral for an obstetric opinion

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Fig. 1: Pathway for determining whether women are suitable for midwifery led or obstetric led care

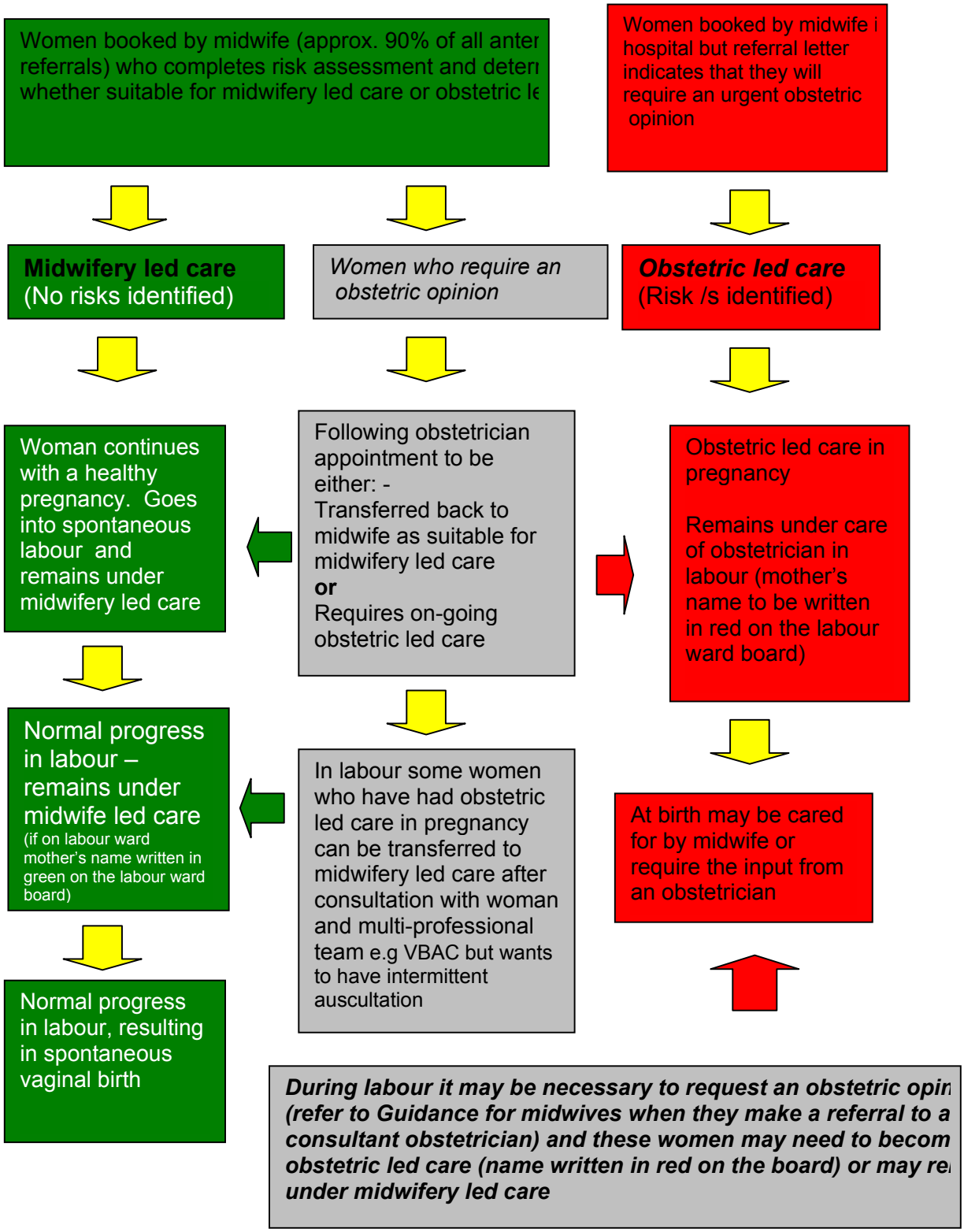
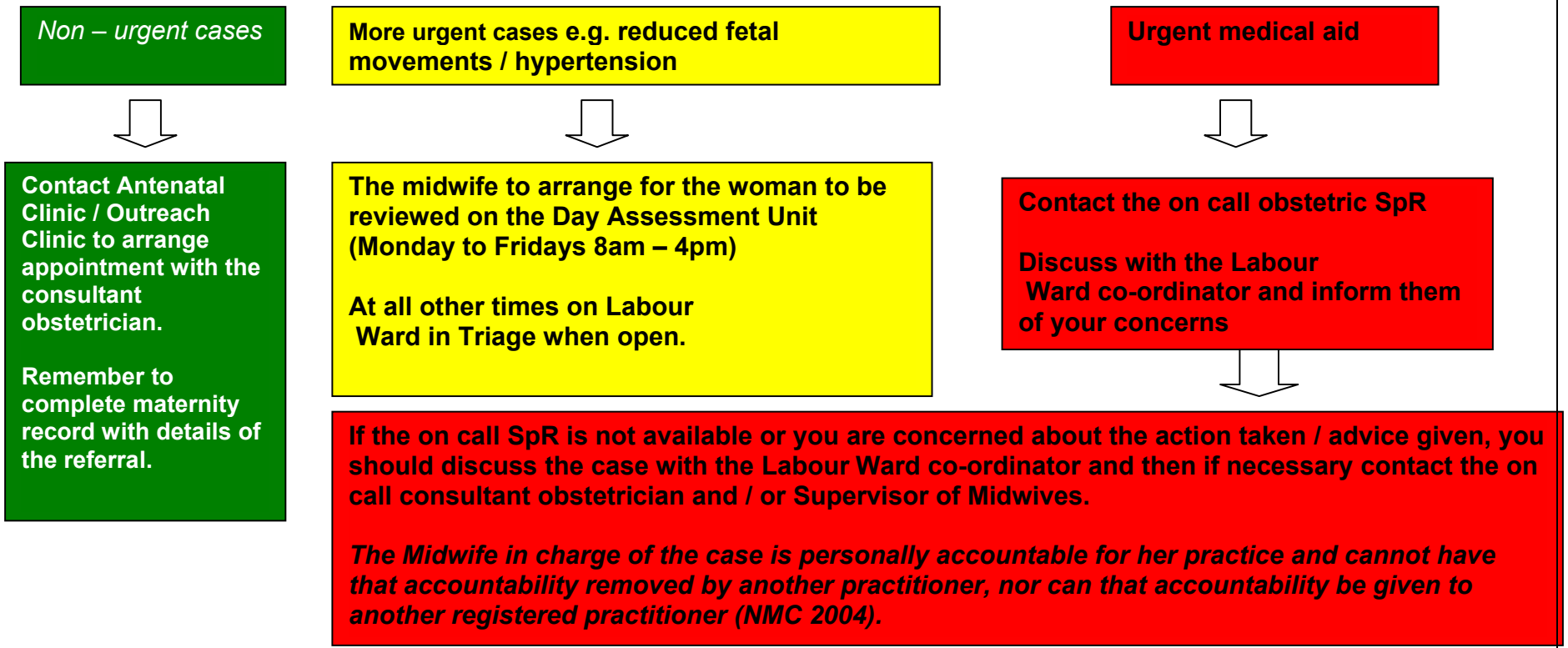


Figure 2: Guidance for midwives when they make a referral to a consultant obstetrician

"A practicing midwife is responsible for providing midwifery care, to a woman and baby during the antenatal, intranatal and postnatal periods….
In an emergency, or where there is a deviation from the norm which is outside her current sphere of practice becomes apparent in a woman or baby during the antenatal, intranatal or postnatal periods, a practicing midwife shall call such qualified health professional as may reasonably be expected to have the necessary skills and experience to assist her in the provision of care." **(Rule 6 – Midwives rules and standards. NMC 2004)**

Midwives at BHR Trust work in a variety of settings both in the hospital and community and the following flowchart clarifies the process for seeking medical aid.



Philosophy of midwifery led care

It is our aim for the maternity services within Barking, Havering and Redbridge NHS Trust to be safe, respectful, personalised and kind to women, their partners and their families. As midwives we are guided by the principle that birth is a normal physiological and social process that respects the woman and her baby's privacy, dignity, religious, social and cultural beliefs.

These guiding principles are evidence based, promoting best practice for midwifery led care, which is women centred holistic and accepts that every childbirth experience is unique to that particular woman, her birth partner and family.

The Aim of Midwifery Led Care

Midwives are considered the experts in normal birth, however all members of the multi-professional team are fundamental in providing an environment that actively empowers women to feel confident in their ability to labour and birth physiologically.

The provision of normal labour care is carried out in a variety of settings, such as home, hospital on the labour ward or in a midwifery birth room and the midwife is accountable for her practice which should be based on the best available current evidence (NMC 2004).

Studies have shown that women who are offered Midwifery led care report greater satisfaction, a reduction in obstetric interventions e.g. caesarean sections, epidurals and episiotomies with no significant increase in perinatal mortality or morbidity (Hodnett 2001a; Saunders et al 2000; Olsen & Jewell 2002)

Thus the aim of midwifery led care in normal labour is to: -

1. Facilitate the physiological process of labour
2. Identify deviations from the normal in the mother, the baby and the progress of labour, birth and early parenting skills and refer to an appropriately qualified health professional
3. Achieve optimal clinical outcomes for the mother and baby
4. Facilitate a rewarding and satisfying experience for both the woman and her partner.

References:

Hodnett ED 2001a Caregiver Support for Women during Childbirth (Cochrane Review) In: *The Cochrane Library, 3,* Update Software, Oxford

NMC 2004 Midwives rules and standards Nursing Midwifery Council

Olsen O & Jewell M *Home versus hospital birth (Cochrane Review)* In: The Cochrane Library, Issue 3 2001. Oxford: Update Software

Saunders D, Boulton M, Chapple J, Ratcliffe J, Levitan J 2000 *Evaluation of the Edgeware Birth Centre* Middlesex., North Thames Perinatal Public Health

DOH 2004 National Service Framework for Children and Young Persons standard 11 Maternity Standard.

RCM (2005) Midwifery Practice Guideline: Evidence bases guidelines for midwifery-led care in labour www.rcm.org.uk/data/education/data/practice_guidelines.htm

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Exclusion Criteria for Midwifery led care

Women with the following conditions should be under the care of the obstetrician (NICE 2003)

Medical Condition	Special information
Cardiovascular	Cardiac disease Hypertensive disorders
Respiratory	Asthma requiring an increase in treatment or hospital treatment Cystic fibrosis
Haematological	Haemoglobinopathies – sickle cell anaemia, beta thalassaemia major History of thrombo-embolic disorders Thrombocytopenia Von Willebrands disease Bleeding disorders in mother Rhesus disease / atypical antibodies
Infective	History of Group B streptococcus Hepatitis B /C with abnormal liver function tests HIV Toxoplasmosis – mother receiving treatment Current action infection of Chicken Pox / Rubella / Genital Herpes in mother Tuberculosis
Immune	Systemic lupus erythrematosus (SLE) Scleroderma Other connective tissue disorders
Endocrine	Diabetes Thyroid disorders
Renal	Renal disease
Neurological	Epilepsy Myasthenia gravis Spinal abnormalities Neurological defects
Gastro-intestinal	Liver disease Crohns disease Ulcerative colitis
Obstetric History	
Previous complications	Previous stillbirth or neonatal death Pre-eclampsia / eclampsia Uterine rupture Placental abruption Primary postpartum haemorrhage Retained placenta Previous caesarean section History of previous baby >4.5kg
Current pregnancy / labour	Multiple pregnancy Placenta previa Antepartum bleeding Pre-eclampsia Prolonged prelabour rupture of membranes Placental abruption Anaemia < 9.5g/dl Obstetric cholestasis Induction of labour BMI >35
Fetal indications	Proven small for gestational age fetus Intra uterine growth restriction Abnormal presentation Abnormal fetal heart heart rate or Doppler studies Oligo/poly-hydramnios Maternal drug/alcohol abuse
Previous gynaecological history	Major gynaecological surgery Cone biopsy (unless full term SVD since treatment) Myomectomy, Hysterotomy, Fibroids

Defining those women who are suitable for midwifery led care in labour

The following criteria applies:

- Normal healthy pregnancy without complication (refer to exclusion list)
- Labouring at term (37 – 42 weeks)
- Singleton pregnancy with cephalic presentation
- Normal fetal heart rate – suitable for intermittent auscultation
- In established labour
- Does not require epidural pain relief

In addition:

- Does not have Group B streptococcus identified in this pregnancy or a previous pregnancy
- Has not had prolonged rupture of membranes for greater than 24 hours
- There is no evidence of meconium stained liquor
- The mother has not had an induction of labour

Remember to complete the Assessment Chart in the BHR maternity record on page 26, which determines whether a woman is suitable for midwifery or obstetric led care in labour.

Fig.3 Risk Assessment Tool within the BHR Maternity Record

Assessment for midwifery/obstetric led care	Yes	No
Antenatal complications/obstetric led care antenatally		
Induction of labour		
Meconium stained liquor / fetal problems noted antenatally		
SROM > 24 hours		
Fetal heart abnormalities detected on admission and/or reduced fetal movements		
Group B Strep positive		
Less than 37/40 or greater than 42/40		

If "yes" to any of the above, then for obstetric led care, otherwise for midwifery led care.

Reference:

NICE (2003) Antenatal care: routine care for the healthy pregnant woman

Birth Environment

Aim: *To provide an environment that respects a woman's wishes and her right to make decisions about her care; facilitates good communication, privacy and control.*

- "A woman should receive clear, unbiased advice and be able to choose where she would like her baby to be born" (DOH 1993 p.25; DOH 2004)

- Home birth is a safe option for women who have had uncomplicated pregnancies which continues to be the case when labour commences. (Olsen & Jewell 2001) [*Please refer to the BHR Homebirth guidelines for further information in support of homebirth*]

- For those women, who do not wish to remain at home, but would like the benefits of a home-like environment, both labour wards at King George and Harold Wood have home from home facilities for this purpose.

- It is important to remember that when childbirth occurs in a hospital setting, the environment is unfamiliar, impersonal and governed by routine practices, which contribute to a mother experiencing a lack of control (Enkin et al 2000). This lack of control has been shown to affect the mother's labour and her subsequent emotional well-being. (Simkin 1992; Simkin & Ancheta 2000; Jowitt 2001)

- Trials have demonstrated the benefits to women, of having a low-risk, midwife-led area as alternative to the traditional labour ward. (Hundley et al 1994; Byrne 2000; Waldenstrom 1997)

References:

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Simkin P & Ancheta R (2000) *The Labour Progress Handbook*. Oxford: Blackwell Science

Waldenstrom U, Nisson C, Winbaldh B (1997) The Stockholm birth centre trial: maternal and infant outcome. *British Journal of Obstetrics and Gynaecology* **104**: 408-10

Latent Phase of labour

Aim: *to ensure that those women who experience a prolonged latent phase are cared for appropriately*

- The latent phase of labour is diagnosed when there are uterine contractions, which are painful and frequent without progressive effacement and dilatation of the cervix (Crowther 1995).

- The duration of this phase is not easy to measure, as women experience the onset of labour in a variety of different ways (Albers 2001, Enkin et al 2000)

- The active phase of labour is usually when the cervix has dilated to 4cm and above (Enkin 2000)

- Women may experience difficulty in coping in the latent phase of labour, especially if they perceive a lack of support at this time. Even though labour is not fully established, it may be painful and distressing experience, so it is important that midwives make time to listen and to provide sympathetic support during this time and administer appropriate analgesia as required or desired by the woman. (Simkin and Ancheta 2000; Austin and Calderon 1999)

- Labour wards are not considered to be the appropriate environment for women in the latent phase and they should be encouraged to maintain everyday activity (McNiven et al 1998)

- Before deciding on expectant management of the latent phase it is important to rule out any underlying problems (Mukhopadhyay and Arulkumaran 2002)

References:

Albers L (2001) Rethinking dystocia: patience please *MIDIRS Midwifery Digest* **11**:351-353

Austin D, Calderon L (1999) Triaging patients in the latent phase of labour *Journal of Nurse Midwifery* **44:** 585-591

Crowther C; Enkin M; Keirse M & Brown I (1995) Monitoring Progress of Labour. In: A Guide to Effective Care in Childbirth Oxford: Oxford University Press

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McNiven P, Williams J, Hodnett E et al (1998) An early labour assessment programme: A randomised control trial *Birth* **25**: 5-10

Mukhopadhyay S, Arulkumaran S (2002) Poor progress in labour. *Current Obstetrics and Gynaecology* **12:** 1-7

Supporting women in labour

Aim: *To provide the labouring woman and her family with the appropriate support as required*

Support in labour can be described as being:

- Emotional
- Informational
- Physical
- Advocacy
  (MIDIRS and the NHS Centre for Reviews and Dissemination 1999)

- There is a significant association between the emotional support provided by midwives and the mother's positive experience of childbirth (Tarrka and Paunonen 1996). A conducive and supportive birth environment has been found to reduce the amount of pain relief a mother requires. (Enkin et al 2000)

- Continuous support in labour is associated with a lower use of pharmacological analgesia, fewer epidurals, fewer instrumental deliveries and caesarean sections and fewer 5 minute Apgar scores <7 (Hodnett 2002)

- Women who experience low levels of support from partners and caregivers in labour may be more likely to experience post-traumatic stress disorder (Czarnocka and Slade 2000)

- Midwives should be aware of and familiarise themselves with the use of non-pharmacological methods of pain relief, such as water, positions and movement, the use of gym balls, massage, TENS, coping strategies and alternative therapies. (Mander 1998; Spiby et al 2003)
  [Please refer to the BHR Waterbirth Guidelines for further information about the use of water in labour]

References:

Czarnocka J, Slade P (2000) Prevalence and predictors of post-traumatic stress symptoms following childbirth *British Journal of Clinical Psychology* **39**: 35-51

Hodnett ED et al (2002) Effectiveness of nurses as providers of birth labour support in North American hospitals *Journal of the American Medical Association* **288**: 1373-1381

Mander R (1998) *Pain in Childbearing and its Control Oxford*: Blackwell Sciences

MIDIRS and the NHS Centre for Reviews and Dissemination (1999) *Support in labour. Informed choice for professionals leaflet*

Spiby H et al (2003) Selected coping strategies in labour: an investigation of women's experience *Birth* **30:** 189-194

Tarkka M and Paunonen M 1996 Social support and its impact on mothers' experiences of childbirth. *J Adv Nurs* 23 (1): 70-5

Pharmacological Pain Relief

- Women should be made aware that pharmacological methods of pain relief all have side effects (Enkin 1995). This information should be given during the antenatal period and if not, then the midwife caring for the mother in labour should impart this information.

- Sometimes midwives can underestimate the intensity of pain experienced by women in labour and over estimate the relief offered by analgesic drugs (Niven 1994; Rajan 1993). Labour pain can only be partially relieved by the use of analgesic drugs such as Pethidine and Entonox (Mander 1997)

- When using Pethidine the mother should be aware of its side effects (Elbourne and Wiseman 1998), which include neonatal respiratory depression, depression of reflexes including impaired suckling, lassitude, and drowsiness (Priest and Rosser 1991). Side effects for the mother include nausea, vomiting, dizziness, and drowsiness (Mander 1998).

- Epidural analgesia is a commonly used method of pain relief in labour. However, there are some unwanted consequences and side-effects associated with epidurals. These are: longer first and second stages of labour (Thorp & Breedlove 1996; Bogood 1995); an increased incidence of fetal malposition; an increased use of oxytocin and instrumental delivery; risk of intrapartum fever; and significant perineal trauma (Howell 1999; Robinson et al 1999; Donnelly et al 1998). Potentially life-threatening complications occur in about 1:4000 cases. Dural taps occurs in about 1% of women (MIDIRS & the NHS Centre for Reviews 1999). Therefore, the anaesthetist prior to insertion of an epidural should counsel all women. Also during the antenatal period the midwife should discuss the subject of pain relief and the variety of methods that are available. (Howell 1999)

- Therefore it is important that women are well informed about their choices in using pharmacological pain relief, and that midwives are aware of the benefits of providing continuous support in labour in an environment that offers privacy and safety for the woman.

References:

Bogod D (1995) Advances in epidural analgesia for labour: progress versus prudence Lancet 345: 1129-1130

Enkin M: Kierse MJN; Renfrew M & Neilson J (1995) A Guide to Effective Care in Pregnancy and Childbirth. Oxford: Oxford University Press

Donnelly V, Fynes M, Campbell D (1998) Obstetric events leading to anal sphincter

damage Obstet Gynecol 92:966-961

Elbourne D Wiseman R A (1998) Types of intra-muscular opioids for maternal pain relief in labour (Cochrane Review) In: The Cochrane Library, Issue 4**.** Oxford Update Software Enkin M, Keirse M, Renfrew M, Neilson J (1995) A Guide to Effective Care in Pregnancy & Childbirth Oxford: Oxford University Press

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Fairlie F, Marshall L, Walker J, Elbourne D (1999) *Intramuscular opiods for maternal pain relief in labour: a randomised controlled trial comparing pethidine with diamorphine* Br J Obstet Gynaecol 106:1181-1187

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Rajan, L (1993) Perceptions of pain and pain relief in labour: the gulf between experience and observation *Midwifery* 9:136-145

Robinson J, Norwitz E, Cohen , McElraith T, Lieberman E (1999) Epidural analgesia and the occurrence of third or fourth degree laceration in nulliparas *Obstet Gyne* (In Press)

Thorp J & Breedlove G (1996) Epidural Analgesia in Labor: An Evaluation of Risks and Benefits Birth 23 (2): 63-83

Fetal heart rate monitoring

Aim: *To ensure the well-being of the fetus during labour*

- Fetal assessment in labour involves auscultation of the fetal heart using different methods. For women who are deemed as low risk and receiving midwifery led care, the method of choice for fetal monitoring is intermittent auscultation, using a Pinard stethascope, or a hand held Doppler (MIDIRS 2003; NICE 2001).

- ***It is important that the fetal heart is auscultated towards the end of a contraction and for up to one minute afterwards: -***

    - First stage of labour – every 15 minutes for a full minute
    - Second stage of labour – every 5 minutes or after each contraction

- Maternal pulse must be taken in conjunction with the fetal heart to distinguish between the two.

- All values should be documented contemporaneously and if the fetal heart rate gives reason for concern, or if any intrapartum risk factors develop, then a continuous record should be obtained using electronic fetal monitoring (NMC 2004)

- Electronic fetal monitoring should not be offered to women in normal labour as it leads to an increase in operative delivery and no improvement in outcomes (MIDIRS 2003)

Reference:

MIDIRS and the NHS centre fro reviews and dissemination (2003) Fetal heart rate monitoring in labour *Informed choice for professionals leaflet*

NMC (2004) Midwives rules and standards: rule 6

NICE (2001) Inherited Clinical guideline C. *The use and interpretation of cardiotocography in intrapartum fetal surveillance* London

Initial Assessment to confirm whether labour has commenced

Aim: *To diagnose the onset of labour and confirm that labour is established*

- This assessment may take place at home or the hospital. A verbal history should be taken and a review of the woman's birth plan and her antenatal notes. A physical examination should be undertaken – abdominal palpation and baseline observations (Temperature, pulse and blood pressure).

- It is important to make a clear diagnosis of established labour. A woman is considered to be in established labour when experiencing regular, painful contractions together with cervical dilatation 4cm and above with full effacement.

- From this assessment a discussion with the mother should take place as to whether labour has commenced or not and the agreed plan should be documented in the woman's maternity record.

Assessing progress in labour

Aim: *To monitor the progress of labour and take appropriate action where a deviation from normal progress is detected*

- Simkin & Ancheta (2000) suggest there are six ways to progress in labour:
    1. cervix moves from the posterior to an anterior position
    2. cervix ripens and softens
    3. cervix effaces
    4. cervix dilates
    5. fetal head rotates,flexes and moulds
    6. fetus descends.

- Vaginal examinations remain the most accepted method of measuring progress in labour (Crowther et al 1995). Any vaginal examination that is performed should be done for a clinical necessity and after discussion with the woman and gaining her consent. There is no evidence about the optimal frequency of undertaking vaginal examinations, but a flexible guide is to carry out an assessment every four hours, but it may be appropriate to do this sooner if slow progress is suspected.

- Many women find vaginal examinations painful and sometimes traumatic (Menage 1996): sensitivity to this issue and privacy may make them less so. Where possible, assessments should be carried out by the same midwife.

- Assessing the progress of labour requires more that the monitoring of cervical dilatation and uterine contractions. Midwives should use other skills such as abdominal palpation, to assess descent of the fetal head in the pelvis, and a knowledge of women's changing behaviour (Leap 2000; Burvill 2002; Gross et al 2003)

The following parameters suggest good progress in labour:

- Changed vocalisation and breathing patterns (grunting and groaning)
- Progressive cervical dilatation of approximately 0.5-1cm per hour
- Descent and increasing flexion of the baby's head
- Increasing length, strength and frequency of contractions
- Passing of heavy mucoid show near to full dilatation

Some examples that may indicate deviations from the normal progress of labour and thus requires an obstetric opinion:

- Maternal tachycardia; pyrexia
- Poor descent of fetal head
- Decreasing contractions
- Meconium stained liquor
- Fetal heart rate abnormalities

Please refer to Figure 4 for following the normal labour pathway.

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Burvill S (2002) Midwifery diagnosis of labour onset *British Journal of Midwifery* **10**: 600-605

Crowther C; Enkin M; Keirse M & Brown I (1995) Monitoring Progress of Labour. In: A Guide to Effective Care in Childbirth Oxford: Oxford University Press

Gross M et al (2003) Women's recognition of the spontaneous onset of labour. *Birth* **30**: 267-271

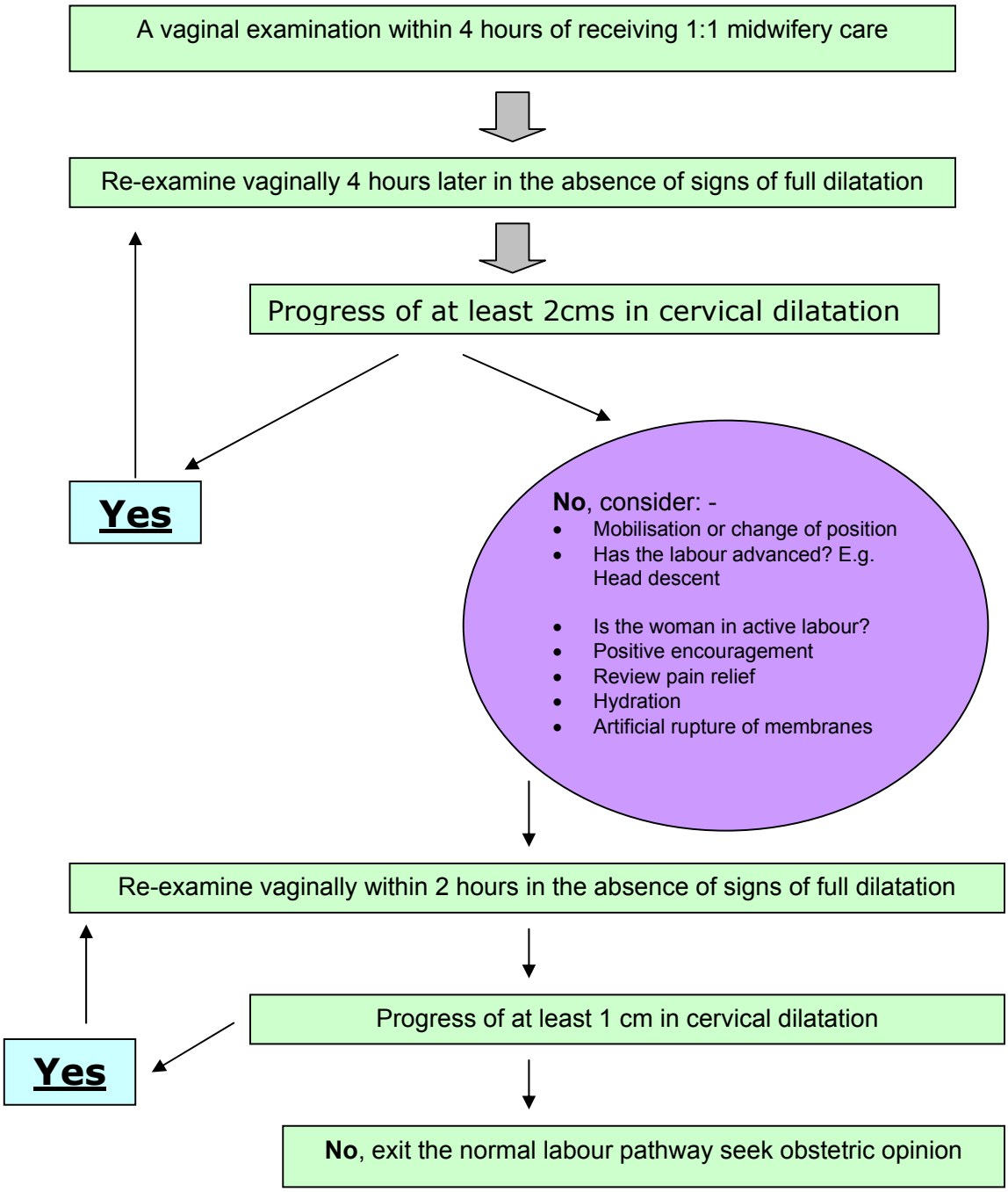
Leap N 2000 Pain in labour: towards a midwifery perspective *MIDIRS Midwifery Digest* vol **10** no 1 March 2000: 49-53

Menage J 1996 Post-taumatic stress disorder following obstetric-gynaecological procedures. *British Journal of Midwifery* **4**(10): 532-3

Simkin P & Ancheta R 2000 *The Labour Progress Handbook*. Oxford: Blackwell Science

Figure 4: Expected progress in normal labour – first stage of labour

Adapted from the All Wales Clinical Pathway for Normal labour (2003)



Summary of care that supports normal labour

Action	Frequency
1:1 care in labour with a midwife	
Maternal temperature and blood pressure	4 hourly
Maternal pulse	Every 30 mins
Intermittent auscultation of the fetal heart for a full minute after a contraction – in the first stage of labour	Every 15 mins
Observe liquor / pv discharge – remains clear or straw coloured	Observe hourly
Encourage eating and drinking as desired	
Encourage mobility, use of birth props e.g. gym ball	
Provide psychological support to ensure the woman is coping with her labour	Continually

Please note that: -

- Rupturing of membranes does not significantly augment normal labour
- The insertion of an epidural catheter takes a woman out of the realms of normal labour

Rupturing Membranes (Amniotomy / ARM)

- Rupturing membranes should be reserved for women with abnormal labour (Fraser et al 2000) and is not part of normal physiological labour (RCM 1997).

- Rupturing membranes is an intervention that can cause an increase in pain, which makes labour unmanageable (Fraser 1993). Any intervention that interferes with a woman's ability to cope in labour can have long term implications for her own well-being and her relationship with her baby (Robson & Kumar 1980)

- There is no evidence that routine ARM is of benefit for all women and has no place when labour is progressing normally (Walsh 2000)

- Therefore, an ARM should not be performed unless a clinical indication exists e.g. progress in labour appears to be prolonged; or abnormal features during labour develop.

References:

Fraser WD, Kraus I, Brisson-Carrol G. Thornton J Breart G 2000 Amniotomy for shortening spontaneous labour. *Cochrane Review. Cochrane Library*

Fraser W F 1993 *Methodological issues in Assessing the Active Management of labour* Birth 20: 155-156

Robson K M & Kumar R 1980 *Delayed onset of maternal affection after childbirth* British Journal of Psychiatry 136: 247-353

Royal College of Midwives 1997 *Debating normality in midwifery*. RCM, London

Walsh D 2000 *Part 3: Assessing women's progress in labour* British Journal of Midwifery 8(7) : 432-435

Positions in Labour and Birth and the use of Birth Props

Aim: *To encourage and assist women to adopt the most comfortable and advantageous positions during labour and birth.*

- There are significant advantages for assuming an ***upright posture*** for labour and birth. These are: -

~ less pain
~ shorter second stage of labour
~ less difficulty in pushing
~ fewer assisted and caesarean births
~ fewer perineal and vaginal tears
(Nikodem 1995)

- Women should be encouraged to remain mobile whilst they are in labour. The use of a gym ball in labour enables the woman to cope with her labour and promotes mobility, whilst she remains upright. The use of TENS as pain relief also encourages the woman to walk around and not remain on the bed.

- Remaining ***mobile in labour*** has been shown to:-

~ Reduce pain
~ Reduce the need for epidural anaesthesia and narcotics
~ Improve placental perfusion

- The use of a birth stool in the second stage can shorten the length of the second stage due to the woman being able to adopt a supported upright position. This is because the horseshoe shape of the stool allows the coccyx and perineum to remain free and unobstructed.

- Perineal trauma has been reported to increase with the use of a birth stool. (Enkin et al 2000 p.292; Jander and Lyrenas 2001) It is therefore advisable for the midwife attending the birth to apply some gentle pressure on the vertex as it is crowning to allow the perineal tissues to stretch.

References:

Enkin M, Keirse M.J.N.C, Neilson J, Crowther C, Duley L, Hodnett E, Hofmeyr J. , 2000 *A guide to effective care in pregnancy and childbirth* 3rd Edition Oxford University Press

Jander C, Lyrenas S (2001) Third and fourth degree perineal tears. Predictor factors in a referral hospital. *Acta Obstetricia et Gynaecologica Scandinavica* **80**: 229-234

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Eating and Drinking in Labour

Aim: *To ensure all women in labour are well hydrated and have sufficient energy for labour*

- There is insufficient evidence to support the practice of starving women in labour in order to lessen the risk of gastric acid aspiration (Baker 1996).
- In early labour, women should be encouraged to eat long lasting carbohydrates, such as bread, toast, cereals, pasta, and rice. This should sustain a prolonged energy release, which should continue into established labour when the appetite may be reduced.
- When in established labour, women can eat light snacks as they wish and drink freely (Grant 1990).
- If a narcotic has been given as pain relief, then it is important that mothers should stop eating and drinking, and be reduced to sips of water. This is because narcotics delay the stomach emptying, especially in pregnant women (Holdsworth 1978).
- Denial of food can be seen as authoritarian and intimidating which may increase feelings of apprehension in the labouring mother (Simkin 1986).

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Second Stage of labour

Aim: *To facilitate a safe birth with the minimum amount of intervention and maximum amount of support and control for the woman*

- There are many signals from the mother about the transition into the active phase of the second stage of labour: change in expression on the face, words, action (Enkin et al 1995)

- A woman should wait until she experiences a strong urge to push, and then encourage pushing. The practice of sustained breath holding in directed pushing is thought to be harmful (Thomson 1993). By providing positive feedback about the effectiveness of their efforts, midwives can facilitate a woman's ability to birth their baby.

- There is no strong evidence to justify arbitrary time limits on the length of the second stage. While the condition of the mother and fetus are satisfactory and there is clear progress with the descent of the fetal head, there are no grounds for intervention (Enkin et al 2000). However, there appears to be an association between maternal morbidity and a second stage of 3 hours. (Saunders et al 1992)

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Care of the Perineum

Aim: Reduce the risk of perineal trauma.

- Perineal discomfort can cause significant problems and distress during the first days, months and years of motherhood. (Enkin et al 2000)

- There is evidence that women, who are taught and encouraged to massage their perineum, increase their chance of an intact perineum (Labrecque et al 1999; Shipman et al 1997) and reduce the chance of an instrumental birth (Shipman et al 1997).

- There is no evidence to support the practice of "ironing out" or massaging the perineum with oils or other lubricants in the second stage of labour. (Enkin et al 2000)

- When the technique of guarding the perineum (by placing the midwife's fingers against the perineum during a contraction) was compared to a hands poised approach, the amount of perineal trauma was found to be the same. (McCandlish et al 1998). The only difference was the increase in reported incidence of mild pain at 10 days in the hands poised group and therefore either technique can be employed depending upon the skill of the midwife and the informed choice of the woman. (Munro and Spiby 2001)

- There is no evidence of short or long-term maternal benefit to support the liberal use of episiotomy (Carroli et al 1997). Women report increased pain and discomfort after episiotomy that interferes with the experience of early motherhood (Kitzinger & Walters 1981). Therefore the practice of episiotomy should be restricted to mainly fetal indications (Sleep 1990).

- Episiotomy is strongly associated with a higher frequency of serious trauma (third and fourth degree lacerations). (Renfrew et al 1998; Albers et al 1999)

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Third Stage of labour

Aim: *To facilitate the third stage in accordance with the woman's wishes while adhering to the principles of safety*

- Midwives should be knowledgeable about the advantages and disadvantages of both active and physiological management of the third stage of labour in order to help the woman make an informed decision about her plan of care (Featherstone 1999)

- Active management – includes a prophylactic oxytocic drug, early clamping and cutting of the cord and controlled cord traction (Gyte 1994)

- Physiological management is where there is no prophylactic oxytocic drug, no cord clamping until after placental delivery and no cord traction but the use of maternal effort, guided by gravity or assisted by the baby being put to the breast. (Rogers and Wood 1999)

- Physiological management is appropriate for women who are thought to be low risk of post partum haemorrhage and who have had a healthy normal pregnancy and physiological labour (RCM 1997).

- The advantages of physiological management include the possibility of a reduction in the incidence of neonatal anaemia if the baby receives his physiological quota of blood at birth when the cord is not clamped (Perez-Escamilla & Dewey 1998)

- The advantage of a physiological third stage for the mother is that she suffers less nausea and vomitting. (Rogers et al 1998)

- If the placenta is retained after one hour, active management should be considered and an obstetric opinion sought if the placenta remains retained (Prendiville et al 1988)

A guide to the physiological management of the third stage

1. The decision to undertake a physiological management of the third stage should be discussed with the mother and clearly documented in the maternity record.

2. Following the birth of the baby, he/she should be given to the mother (providing the neonatal condition permits). The baby should be dried and wrapped and can be placed to the breast "skin to skin" with a towel covering it.

3. Observe the mother, but do not interfere with the fundus to avoid stimulating irregular contractions

4. Signs of separation (gush of blood, cord lengthening, rising, hard fundus and change in shape of uterus) should occur in 10-15 minutes. Do not pull the cord

5. The placenta may become visible at the vulva or the mother feels a heavy sensation or urge to push

6. The placenta can normally be delivered by maternal effort. Use of a bed-pan to facilitate a squatting position is helpful

7. The cord is clamped and cut after delivery of the placenta, or if the baby requires resuscitation

8. If there are no signs of separation and no placenta after 30 minutes, examine to see if it is in the vagina. If the placenta is undelivered by one hour, inform medical staff and consider active management

9. If at any stage bleeding is heavy or the pulse rate rises, then medical staff should be informed immediately, and Syntometrine given and then see if the placenta can be delivered by active management.

A guide to Active management of the Third Stage

1. Syntometrine 1 ampoule is given intramuscularly to the mother following the birth of the baby.

2. Syntocinon 10iu IM or Syntocinon 5iu should be given if the mother has a history of heart disease or hypertension, which should be prescribed by the doctor.

3. The umbilical cord should be clamped within 3 minutes following the birth of the baby

4. Mild controlled traction is applied to the cord and the placenta should deliver, by placing a hand on the symphysis pubis should guard the uterus. Alternatively, controlled cord traction can be applied once the signs of separation have occurred.

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Suturing the perineum

Aim: *To achieve a comfortable and satisfactory repair with minimal delay*

- All repairs to the perineum should be carried out as soon as possible after delivery (Sleep et al 1984) and by a skilled person with adequate pain relief (Green et al 1998)

- There is evidence that women prefer to be sutured by midwives: it can mean a reduction in waiting time and a more sympathetic approach. (Hulme and Greenshields 1993)

- There is little research to date on the non-suturing of second-degree tears. Midwives should clearly discuss the lack of evidence, and the theory of the healing process, when considering this with women (Lewis 1997). However, current recommendation in BHR Trust is that perineal trauma should be sutured.

- The suture material used should be polyglycolic acid (e.g. Dexon or Vicryl, Polysorb) as suturing with this material appears to cause less pain in the early postpartum period than chromic catgut (Enkin et al 1995)

- Subcuticular suturing of the skin is associated with less pain. (Brownlee 1994; Enkin et al 1995)

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Immediate care of the Newborn

- Babies can loose heat quite dramatically after birth (Enkin et al 1995). They should be dried with a pre-warmed towel and placed in contact with the mother's skin.

- Early mother-baby contact should be encouraged in an unhurried environment (Enkin et al 1995)

- "Skin to skin" contact and the opportunity to suckle within the first half-hour of birth are important to the initiation of breastfeeding (WHO 1998). Such early contact also has a positive effect on the duration of breastfeeding at 2 to 3 months. (Perez-Escamilla et al 1994)

- Vitamin K should be administered within the first hours after birth following previous discussion and informed consent. The parents should have been given information about Vitamin K in the antenatal period. (Puckett & Offringa 2002) Refer to Trust policy regarding the route that Vitamin K should be administered

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HOMEBIRTHS:
GOOD PRACTICE AND GUIDING PRINCIPLES

Statement:
"All women are entitled to reach their own decisions about how and where to give birth, with the benefit of midwifery or medical advice..... The role of the midwife is to support the woman's informed decision-making and then to provide the best possible care appropriate to that choice. It is good practice to support and promote home birth, so as well as responding positively to women's requests, midwives should offer home birth as a positive and realistic choice to all women who could benefit from it." (RCM 2002)
All low risk pregnant women should be offered the possibility of considering a planned home birth. (Olsen and Jewell 2000)
Evidence:
The meta-analysis of the safety of home birth demonstrated that women booked for home birth experienced fewer medical interventions, and that their babies had fewer low Apgar scores. (Olsen 1997)

The MIDIRS informed choice leaflet "*Where will you have your baby – hospital or home"* and the in – house leaflet *"Planning for a Homebirth"* are available for distribution to women.

GUIDELINES

Preparation

1. It is a requirement that the principal midwife attending a home birth should be regularly involved in intrapartum care. Midwives should discuss with their supervisor of midwives their updating requirements, and thus suitable arrangements can be made.

2. All midwives should be skilled in managing obstetric and neonatal emergencies. (RCM 2002)

3. Once a mother has decided to have a home birth, clear instructions should be given to the mother on how and when to contact the midwife.

4. A home birth would not be recommended for women with the following:-
   Multiple pregnancy
   Known fetal abnormalities
   Breech presentation
   Unstable lie
   Severe fetal growth restriction
   Pregnancy induced hypertension
   Ante partum haemorrhage
   B.M.I >35 (RCOG 2004)
   This list may not be exhaustive.....

However, if the midwife has advised the mother against home birth and the mother insists that she wishes to have a home birth, this should be discussed with one of the supervisor of midwives. Any discussion that you have with the supervisor of midwives and the woman should be clearly documented in the maternity records. This is clearly supported by the following statement from the NMC (2004): -

"If you judge that the type of care a woman is requesting could cause significant risk to her or her baby, then you should discuss the woman's wishes with her; providing her detailed information relating to her requests, options for care, and outlining any potential risks, so that the woman may make a fully informed decision about her care.

If a woman rejects your advice, you should seek further guidance from your supervisor of midwives to ensure that all possibilities have been explored and that the outcome is appropriately documented. The woman should be offered the opportunity to read what has been documented about the advice she has been given and she may sign this if she wishes. You must continue continue to give the best care you possibly can, seeking support from other members of the health care team as necessary"

Antenatal Care

1. Antenatal care can be provided in the midwives clinic, apart from 37 week check, when equipment can be delivered to woman's home (see attached homebirth list). This gives the opportunity for the midwife to familiarise herself with the route and entry to the home.

2. The midwife who delivers the equipment must ensure that all relevant blood results are available in the notes.

3. Details of all home births booked should be given to the community secretary, so that home birth forms can be generated.

4 We should aim to assess all low risk women at home to maximize opportunity for home birth.

5 Only drugs that have been prescribed specifically for the woman may be left in her home.Women should be discouraged from considering Pethidine or Meptid as forms of pain relief and encouraged to consider Entonox, TENS and immersion in water instead.

6. The following drugs should be carried by each community midwife:

   Syntometrine – replace after 2 months) store in fridge
   Ergometrine - replace after 1 month)
   Vitamin K – oral and i.m.

Lignocaine
Syntocinon 4 x 10 unit ampoules
Entonox should be brought to the home, when the woman is in labour.

Labour

1. Once the mother is in established labour the midwife should remain with her, and she should contact her colleague, who will act as the second midwife. It will not be necessary for the second midwife to attend immediately, unless the mother is in advanced labour.

2. Labour ward should be informed when a home birth is taking place.

Transfer to hospital

1. If the midwife has any concerns at home and in her opinion it is necessary to transfer to hospital, she should contact the labour ward co-ordinator. The ambulance service should be contacted to facilitate the transfer.

2. If a mother is being transferred to hospital,for any reason ,then the midwife should accompany her in the ambulance.

3. If the mother is being transferred to the nearest hospital and this is not part of BHR Trust, then it will be possible for the midwife to remain with the mother. The on call supervisor of midwives should be able to facilitate this, however care will be given by that Trust's midwives; this is because the other Trust will not accept vicarious liability for a BHR employed midwife.

Post birth

1. All birth notifications should be completed within 12 hours following birth and NHS baby number should be generated and homebirth form returned to community secretary.

2. Any rhesus negative mothers – should have the Kleihauer done and cord blood taken as soon as possible and state on the request form that the baby was born at home. The result should be phoned out to the midwives.

3. Once the baby has been born, the midwife should remain with the mother for a minimum of one hour after the completion of the 3rd stage.

4. All placentae to be securely double-bagged and returned to labour ward for disposal unless parents request that they retain same.

5. All equipment should be checked and replaced as necessary before returning to store. Storage centres are;- Fanshawe health centre, Goresbrook Ambulance Station (team midwives have keys) Harold Wood Community Office and St Georges Hospital (via Porter's lodge)

Please note that there is always a supervisor midwives on call and they can be contacted via the switchboard – there is a rota available on the labour ward.

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Authors:
Sue Read Supervisor of Midwives and Team 1 Midwife in September 2002 and updated in July 2005 by home birth group KG and HW.

Water birth: Guidelines for the use of water in labour and birth

Aim

To offer the use of water as a natural method of pain relief whilst ensuring the safety of both the woman and fetus.

Introduction

The evidence from two national surveys of neonatal morbidity and mortality indicates that there is no evidence to suggest that this method of care should not be made available to women (Gilbert & Tookey 1999; Alderdice et al 1995).
Waterbirth should be viewed as an alternative method of care and management in labour, and as one which must therefore, fall within the duty of care and normal sphere of a midwife (RCM, 2000). The available evidence does not justify discouraging women from choosing the use of water for their labour or birth.

Potential beneficial effects of immersion in water during labour & birth:

- maternal relaxation
- less painful contractions
- shorter labour
- less need for augmentation
- less need for pharmacological analgesics
- more intact perinea
- fewer episiotomies

(Schorn et al 1993; Aird et al 1997; Garland & Jones 2000; Otigbah et al 2000, Cluett et al 2004).

Potential adverse effects of immersion in water during labour & Birth:

- unrealistic labour expectations
- restricted mobility
- infection
- inhalation of water by the neonate

(Alderdice et al 1995; McCandlish & Renfrew 1993; Nikodem 2000).

Suggested criteria for the use of water for labour and birth:

- Woman's informed choice
- Normal term pregnancy
- Singleton fetus with cephalic presentation
- Spontaneous onset of labour
- No systemic sedation
- Spontaneous rupture of membranes less than 24 hours

Entering the pool:

There is no evidence to support restricting the duration of use and little to support the imposition of arbitrary points at which the use of water should commence. However, early immersion (before the cervix is 5cms dilated) has been associated with prolongation of labour and increased need for epidural and syntocinon (Eriksson et al 1997).

Observations of the woman in the pool:

- Temperature 4hrly, Pulse half hourly and Blood pressure 2 hourly (unless otherwise indicated)
- Abdominal palpation of uterine contractions
- Observations of vaginal loss
- Vaginal examinations - this procedure may be carried out in the pool
- Fluid intake - women should be encouraged to drink plenty to avoid dehydration
- Women should leave the pool to urinate

Observations of the fetus:

- The fetal heart (FH) should be auscultated every 15 minutes using an underwater sonicaid in the first stage of labour (NICE 2001)
- In the second stage of labour the FH should be auscultated following each contraction

Care of the water/pool:

- Water temperature should be comfortable for the woman (Charles 1998). Recommended range is 35-37.0 degrees centigrade during the first stage of labour and 37-37.5 degrees centigrade in the second stage. The temperature of the water should be checked at intervals and documented on the partogram (Deans and Steer 1995, Garland 1995, Johnson 1996).
- If the water becomes contaminated with maternal faeces there may be risk of cross-infection, therefore the water should be kept clear with a plastic sieve (Burns & Kitzinger 2000)
- Women should be advised against using additives in the water

Health & Safety:

- Universal precautions should be implemented (RCM 1998)
- Health & safety advice on moving and handling should be adhered to at all times (RCM 1999). Leaning over the pool for any length of time should be avoided.
- Any water spillage should be mopped up as soon as possible.
- The pool should be cleaned thoroughly after use.

The woman should be advised to leave the pool for:

- Maternal pyrexia - or a rise of 1 degree centigrade above baseline (Charles 1998)
- Fetal tachycardia
- Fetal bradycardia
- Abnormal Fetal heart rate
- Meconium stained liquor
- Vaginal bleeding
- Hypertension
- Augmentation with oxytocin

Birth in the pool:

- Whenever possible 2 midwives should attend for the birth. This will encourage reflective practice and skill sharing as well as health and safety of mother and baby

- The birth should be a 'hands off' procedure, with verbal guidance from the midwife, to minimise any stimulation for the emerging baby underwater (Johnson 1996)

- Feeling for the cord under water is not necessary as it may stimulate the baby to breathe (Garland 1996)

- The cord should not be clamped or cut when the infant's head is still under the water as this may initiate respiration.

- The baby should be born totally submerged in the water
  The baby should be brought to the surface of the water gently, immediately following the birth of the body (Johnson 1996)

- To minimise the possibility of the cord snapping, avoid undue traction on the umbilical cord as the baby's head surfaces from the water (Gilbert and Tookey 1999)

- Physiological third stage should be an option, as for any other low risk birth. The cord should be left unclamped until the placenta and membranes are expelled by the mother, she may choose to remain in the pool.

Exclusion criteria for third stage in water:

- Heavy blood loss
- Mother feels faint
- Delayed delivery of placenta
- Baby needs resuscitation

- Active third stage should be managed out of the pool and the mother should be asked to leave the pool following the birth of the baby

- Accurate estimation of blood loss is difficult, therefore it should be recorded as <500mls or >500mls (Garland 1995)

Emptying portable pool
- Place pump in the pool
- Hose to suitable outlet – ensure end is securely anchored on pump
- Start pump

Problems/Emergencies:
As when caring for any mother, the midwife is responsible for using her clinical judgement in responding appropriately to problems that may occur during any stage of labour, and for documenting actions taken.

Cord tight around neck
- Help the woman into a standing position

- Ensure the perineum and baby's face are clear of the water

- Clamp and cut the cord

Shoulder Dystocia
- Call for help

- Help the woman into a standing position

- Ask to get out of bath

- Help out of the bath

- Perform usual manoeuvres for shoulder dystocia

Asphyxiated baby/inhalation/drowning
- Call for help

- Clamp and cut the cord immediately

- Commence resuscitation

- Keep baby warm and dry

- Keep parents informed

This guideline was compiled by Claire Homeyard, Consultant Midwives 2003 and reviewed in 2005 by Clare Capito. We would like to acknowledge the use of the waterbirth guideline at Harold Wood Hospital written by Fiona Bennett and the draft St Thomas' home from home birth centre guidelines.

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BARKING, HAVERING AND REDBRIDGE NHS TRUST
HAROLD WOOD AND KING GEORGE MATERNITY UNITS

Reviewing BHR Guiding Principles for Midwifery Led care for Normal Labour

These guidelines have been reviewed in August 2005. They were first written in April 2003 and should be next reviewed in August 2008.

The contents of this document are not exhaustive and will require regular review in light of new evidence being produced. These guidelines should not be treated as prescriptive, and if when providing care to a woman in normal labour, there is a departure from recommended best practice, the actions and rationale should be clearly recorded in the maternity record.

These BHR guiding principles for midwifery led care in normal labour have been reviewed by midwives, midwifery resource managers, consultant midwives, users, user representatives, supervisors of midwives, obstetricians and midwifery lecturers.

Please note: -
These guidelines are available as a hard copy on the labour ward, but can also be accessed via the hospital intranet and thus any midwife or student midwife wishing to have their own copy can do so by printing off a copy.

The RCM Midwifery Practice Guideline: evidence based guidelines for midwifery-led care in labour are available on www.rcm.org.uk/data/education/data/practice_guidelines.htm

Issued – September 2005 **Review Date – August 2008**

Approved Signatures:

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