

Intrapartum Care – Physiological Labour and Birth

Unique Identifier	NMP200/SSM/043
Document Type	Clinical Guideline
Risk of non-compliance	may result in significant harm to the patient/DHB
Function	Clinical Practice, Patient Care
User Group(s)	Auckland DHB only
Organisation(s)	Auckland District Health Board
Directorate(s)	Women's Health
Department(s)	Maternity and Newborn services
Used for which patients?	All maternity patients
Used by which staff?	All clinicians in maternity including access holder lead maternity carers (LMCs)
Excluded	
Keywords	
Author	Charge Midwife - Delivery Unit
Authorisation	
Owner	Midwifery Director – Women's Health
Delegate / Issuer	General Manager - Women's Health
Edited by	Document Control
First issued	Yet to be determined
This version issued	03 June 2020 - updated
Review frequency	3 yearly

Contents

1.	Purpose of guideline	
2.	Definitions	
3.	Best practice recommendations for physiological labour and birth care	
3	Latent first stage of labour of a physiological birth	3
3	3.2 Active first stage of labour of a physiological birth	
3	3.3 Cervical dilatation threshold and normal labour progression	
4.	Practice actions	
5.	Initial assessment	7
6.	Latent phase	
7.	First stage	9
8.	Second stage	
9.	Third stage	
10.	Immediate postnatal period	
11.	Supporting evidence	13
	Associated documents	
13.	Disclaimer	15
	Corrections and amendments	



1. Purpose of guideline

The purpose of this guideline is to promote consistent evidence-based labour and birth care with women whose pregnancies are considered low risk by:

- Acknowledging:
 - O That outcomes for low-risk women depend on where they birth and who provides their care (Birthplace in England Collaborative Group, 2011; Bailey, 2017; Grigg et al, 2017)
 - The importance of promoting and facilitating labour and birth as normal physiological events.
- Providing evidence-based labour and birth care guidelines that support staff and Lead Maternity Care (LMC) access holders to:
 - Promote and facilitate physiological birth
 - Only interfere with the physiological process if clinically or medically indicated and for a valid reason
 - Appropriately recognise deviation from the normal physiological process of labour and birth and refer as required (MOH, 2012).

2. Definitions

Physiological labour and birth includes the following (NZCOM, 2006; ACNM, 2013):

- Singleton pregnancy
- Vertex presentation
- Between 37 and 42 completed weeks gestation
- Spontaneous in onset and progression
- Preceded by a healthy pregnancy that is considered low risk in relation to both maternal and fetal condition
- Intact membranes or spontaneous rupture of membranes
- Supported by non-pharmacological measures to increase comfort, e.g. whānau/family support, water immersion, massage, meditation, karakia or prayer, music, heat, TENS, mobilisation, positioning, adequate hydration, continuity of competent practitioner
- If required, supported by low level forms of pharmacological measures to decrease labour pain, including paracetamol and nitrous oxide (Entonox®)
- Free of surgical or medical intervention, e.g. artificial rupture of membranes and oxytocin augmentation
- Free from complication throughout labour and birth
- Spontaneous vaginal birth of the infant and placenta
- Early skin-to-skin contact between the mother and infant
- Mother and infant who are in good condition following birth.



3. Best practice recommendations for physiological labour and birth care

The following have been shown to be effective and useful in supporting physiological labour and birth and should be encouraged (WHO Technical Working Group, 1997):

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

3.1 Latent first stage of labour of a physiological birth

 Characterised by painful uterine contractions and variable changes of the cervix, including some degree of effacement and slower progression of dilatation up to 5 cm for first and subsequent labours (WHO, 2018).

3.2 Active first stage of labour of a physiological birth

Characterised by regular painful uterine contractions, a substantial degree of cervical
effacement and more rapid cervical dilatation from 5 cm until full dilatation for first and
subsequent labours (WHO, 2018).

3.3 Cervical dilatation threshold and normal labour progression

- For pregnant women with spontaneous labour onset, the cervical dilatation rate threshold of 1 cm per hour during active first stage is inaccurate to identify women at risk of adverse birth outcomes and is therefore not recommended for this purpose.
- A minimum cervical dilatation rate of 1 cm per hour throughout active first stage is unrealistically fast for some women and is therefore not recommended for identification of normal labour progression.
- A slower than 1 cm per hour cervical dilatation rate alone should not be a routine indication for obstetric intervention.
- Labour may not naturally accelerate until a cervical dilatation threshold of **5 cm** is reached. Therefore, **the use of medical interventions to accelerate labour and birth (such as oxytocin augmentation or caesarean section) before this threshold is not recommended, provided fetal and maternal conditions are reassuring (WHO, 2018).**

There is evidence that the following practices should <u>only</u> be used where there is a clinical indication:

- Intravenous fluid infusion
- Insertion of intravenous cannula



- Use of supine position or stirrups during labour or birth
- Sustained, directed bearing down efforts (Valsalva manoeuvre) during second stage of labour
- Massaging and stretching the perineum during second stage
- Admission and/or continuous electronic fetal monitoring
- Bladder catheterisation
- Episiotomy
- Augmentation of labour
- Nasal or oral suctioning of the infant at birth

Practices for which there is insufficient evidence to support use:

- Routine amniotomy
- Manoeuvres related to protecting the perineum
- Active manipulation of the fetus at the moment of birth
- Restriction on food and fluid during labour unless medically indicated

4. Practice actions

	Actions	
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 a management plan 	
	for labour and birth on the CR3895 National Women's Partogram and update the plan throughout labour.	
	 Ongoing informed choice and consent throughout labour is required (see Informed Consent policy). 	
Admission	Document admission details in the clinical notes. Include:	
	Source and reason for admission.	
	 Relevant previous obstetric, gynaecology, medical, family or social history. Confirm that the woman is low risk. 	
	 History of contractions, show, rupture of membranes, any other vaginal loss and fetal movements. 	
	Abdominal palpation findings.	
	Date, time, signature, designation and printed name of clinician.	
	 Commence CR3732 Labour and Birth Summary and CR3731 NWH Newborn Record. 	
	Thereafter, continue to document progress and ongoing care.	
Observations	Record and document observations contemporaneously on CR3895 National Women's Partogram once labour is established. This should be dated, legibly documented with names printed and signed by caregivers and include the woman's name and NHI number, EDD, gravida and parity.	
	Fetal	
	Intermittent auscultation of the fetal heart rate is an appropriate	
	method of intrapartum fetal monitoring in women experiencing	



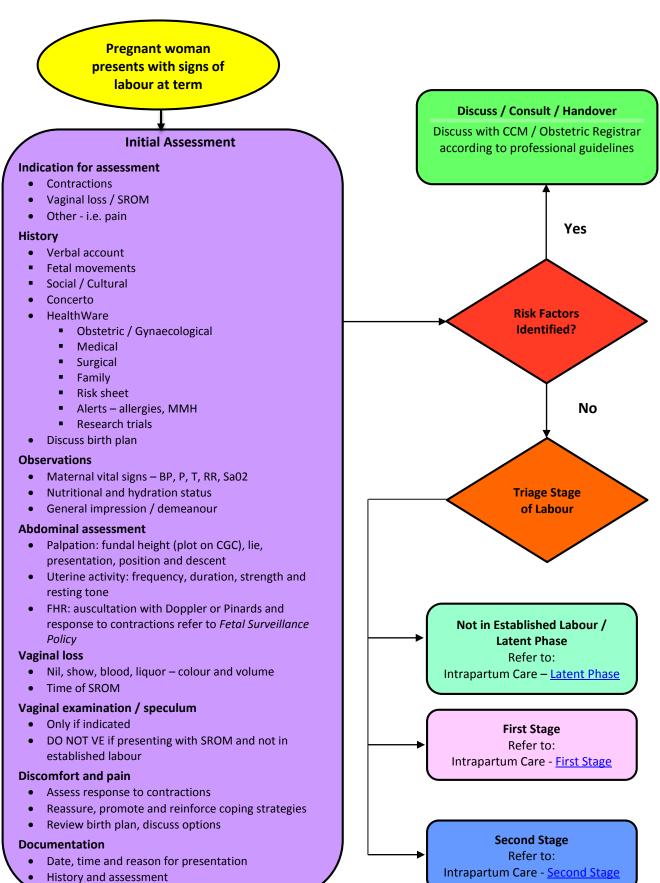
	Actions
	physiological labour and birth. Please see recommendation 4, 5 and 6 of the RANZCOG 2014 Clinical Guideline. These guidelines state: Auscultation in labour should be undertaken and documented every 15-30 minutes in the active phase of the first stage of labour and after each contraction or at least every five minutes in the active second stage of labour. Each auscultation episode should commence toward the end of a contraction and be continued for at least 30-60 seconds after the contraction has finished. Continuous CTG monitoring is recommended when risk factors for fetal compromise have been detected antenatally, are detected at the onset of labour, or develop during labour. The method of intermittent auscultation should be documented (refer to Fetal Surveillance policy). Maternal If outside normal parameters, refer as appropriate. Temperature: On admission and then four-hourly Two-hourly if membranes ruptured Hourly if temperature greater than 37.4°C Pulse: On admission and then hourly Blood pressure: On admission and then four-hourly (between contractions) Urine output: Document micturition on CR3895 National Women's Partogram (see Bladder Care Postpartum and Urinary Retention Management guideline).
Liquor	 Artificial rupture of membranes is not routine practice and should only be considered after a diagnosis of delay in first stage or second stage of labour once labour is established. Document date and time of rupture of membranes, method of rupture and colour of liquor, noting amount and odour (only if offensive). Clearly document rationale for ARM. Continue to document evidence of amount, colour and consistency of liquor, and indication for artificial rupture of membranes if required.
Contractions	 Assess and record strength, length and frequency of contractions on a regular basis throughout the labour. Follow guide as described on partogram to record contractions.



	Actions	
Progress in labour	Descent of presenting part:	
	 Abdominally palpate and document descent part before vaginal examinations (VE). 	t of presenting
	Cervical dilatation:	
	 Once membranes have ruptured, VE should avoid infection. 	be minimised to
	 Where possible the same practitioner shoul at each assessment for consistency. 	d perform the VE
	 The practitioner who performs the VE is to of many details as possible of the VE findings of of the partogram in the area prescribed. 	
	 Plot cervical dilatation and descent of prese partogram. Do not commence partogram u established (see <u>Section 7: First stage</u>). 	ntil labour is
	 Discuss reasons for considering vaginal exar hourly or as clinically indicated. 	nination four-
Analgesia/medications/ other management	Document all medications including Entonox® a CR3895 National Women's Partogram.	dministered on
	Document any other complementary therapies and non- pharmacological measures and their effectiveness or side effects in the clinical notes (if any).	
	Food should not be restricted and fluids should normal labour.	be encouraged in
Environmental safety	 The labour and birthing environment should be optimal for supporting oxytocin release. 	
	Caregivers should remain mindful of the safety and	
	preparedness of the birthing environment.	
	All maternal and neonatal emergency equipment should be	
	checked to be present and in good working order.	
	The room should be adequately warmed in anti and clinical supplies should remain adequately	•

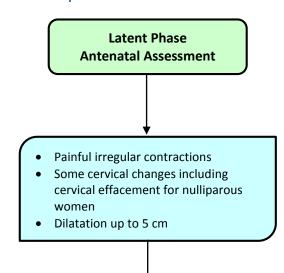


Initial assessment





6. Latent phase



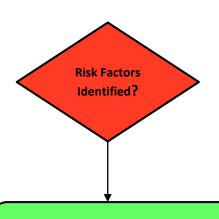
Latent Phase

If discharged / not admitted:

- Encourage to remain at home
- Reassure early labour is normal and can take time
- Discuss coping and comfort strategies for relief of discomfort:
 - Warm shower or bath
 - Massage, back rub
 - TENS
 - Encourage hydration & nutrition
 - If tired rest / sleep
 - Oral analgesia
- Discuss mobilisation may establish contractions
- Provide information on:
 - Support available
 - When to phone the hospital for advice
 - Symptoms of concern

Documentation

- Antenatal assessment
 - Clinical notes
 - HealthWare
 - Communication, advice and care plan



Discuss / Consult / Handover

Discuss with CCM / Obstetric Registrar according to professional guidelines

Prolonged Latent Phase

Consultation on management

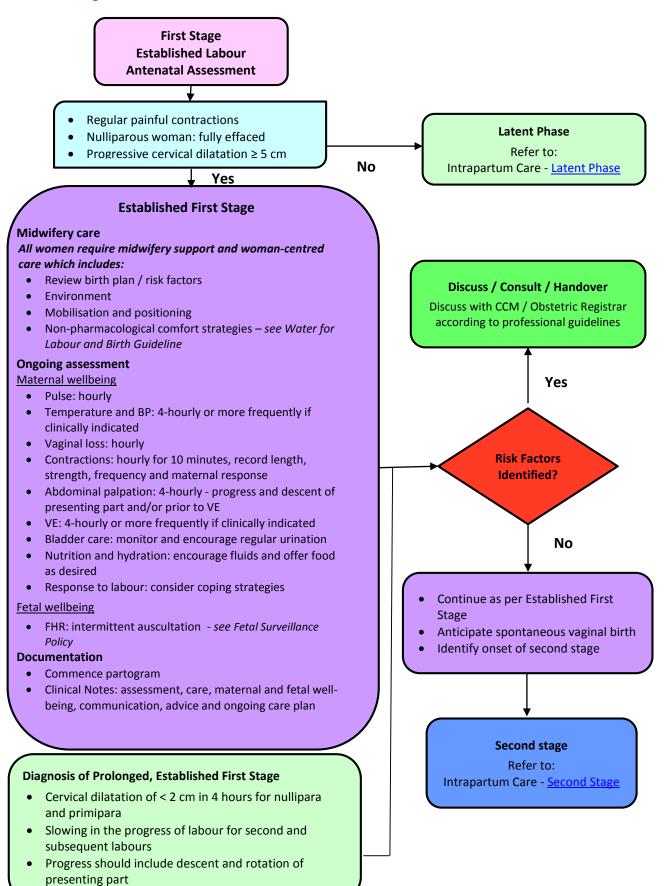
 Three-way conversation between the woman, LMC and obstetric team to consider awaiting established labour, pain management if needed, admission to ward, or IOL

Documentation

- Assessment
- Clinical notes
- Communication, advice and care plan

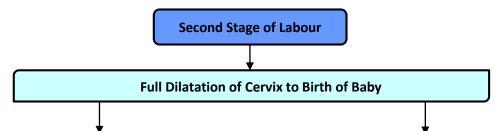


7. First stage





8. Second stage



Active Second Stage

Onset

- Involuntary expulsive contractions
- In the absence of expulsive contractions an active maternal effort to push

Midwifery care

- Continuous one-to-one midwifery care observing maternal and fetal wellbeing
- Encourage active and comfortable maternal positions see Water for Labour and Birth Guideline
- Emotional support and reassurance

Assessment

Maternal and fetal wellbeing

- Continue maternal observations
- Contractions: continuous assessment of length, strength and frequency
- FHR: after every contraction as per Fetal Surveillance Policy
- VE: if indicated to assess position and descent of presenting part. If OP refer at the start of second stage for consideration of manual rotation of fetal occiput
- Hydration: encourage oral fluids
- Bladder: monitor and encourage voiding

Documentation

- Date and time active second stage commenced
- Maternal vital signs
- Progress, descent and position of presenting part
- Second stage sticker
- Time of birth
- Communication, advice, care plan. Call 2nd midwife to be present for birth

Passive Second Stage

Onset

Absence of involuntary, expulsive contractions

Assessment and care

- FHR: 15 minutes, differentiate from maternal pulse
- Other assessment and care as per active second stage

Documentation

- Date and time passive second stage commenced
- Assessment
- Communication and care plan

Diagnosis of Prolonged Active Second Stage

- Nulliparous woman: after 2 hours or when total length of Second Stage exceeds 3 hours
- Multiparous women: after 1 hour

Discuss / Consult

Discuss with CCM / Obstetric Registrar Commence CTG

Third stage

Refer to: Intrapartum Care - Third Stage



9. Third stage

Third Stage of Labour

The time from birth of the baby to the birth of the placenta and membranes

Newborn assessment and care Refer to: Intrapartum Care Postnatal

Third Stage

- Continuous one-to-one midwifery care
- Support of second midwife
- Support woman's informed choice / birth plan however consider current risk factors
- Monitor blood loss and ensure timely actions are taken in the presence of PPH
- Uninterrupted skin-to-skin contact within 5 minutes of birth for at least 1 hour (unless contra-indicated)
- Take cord bloods when indicated
 - Rhesus Negative *See Anti-D Postnatal Guideline
 - Lactates / Cord Gases *See Fetal Surveillance Policy

Physiological

- Birth of placenta by maternal effort and gravity
- No routine use of uterotonics
- No fundal massage or controlled cord traction
- Clamp cord only after pulsation ends or placenta is delivered

Following birth of placenta

- Check if placenta and membranes are complete
- Assess PV loss / lochia
- Assess fundal height and uterine tone: massage only if bleeding

Documentation

- Date and time of placenta delivery
- Estimated / weighed blood loss
- Medication Chart: uterotonics prescribed and signed

Prolonged Third Stage

- Physiological third stage considered prolonged after 60 minutes
- Active third stage considered prolonged after 30 minutes
- Actions: breastfeed, empty bladder / consider IDC, IV cannulation, uterotonic as treatment

Active

- Second midwife draws up uterotonic and administers it following birth of anterior shoulder of the baby
- Delay cord clamping for 1 3 minutes following birth
- Wait for signs of separation
- Assess uterine tone but no fundal massage
- Controlled cord traction while guarding the uterus
- Uterine massage if required after delivery of the placenta

Uterotonics:

1st line: oxytocin (Syntocinon®) 10 units IM

2nd **line**: oxytocin + ergometrine (Syntometrine®)

1 mL IM if no contraindications

* see Postpartum Haemorrhage (PPH) Prevention and Management Guideline

Discuss / Consult

Discuss with CCM / Obstetric Registrar



10. Immediate postnatal period

Immediate Postnatal Period (1-2 Hours After Birth of Placenta)

- Ensure mother and baby are closely observed by a midwife for a minimum of one hour, preferably two hours after birth
- Ideally two midwives should be in the room (one attending the mother and one observing the baby) until the primary midwife is able to observe the baby and provide immediate care
- Uninterrupted skin-to-skin contact within 5 minutes of birth for at least 1 hour (unless contra-indicated)
- Initiate breastfeeding/support the parent's choice for feeding

Newborn

Initial assessment and care by second midwife

- Evaluate condition of baby
- Apgar scores at 1 and 5 minutes
- Resuscitation and paediatric review if any concerns

Ongoing assessment and care

 Ongoing assessment of airway integrity, colour, tone, respiration rate and temperature

Following skin-to-skin and first feed

- Newborn examination including customised birth weight centile
- ID labels x 2 checked by parents
- Follow up cord blood results if taken
- Formulate on-going care plan in consultation with parents, including the administration of Vitamin K

Documentation

- CR3009 Newborn's Clinical Notes
- CR3731 Newborn Record
- CR5636 Rooming-in Record
- CR9149 Pulse Oximetry Screening Record

Maternal

Ongoing assessment and care by first midwife

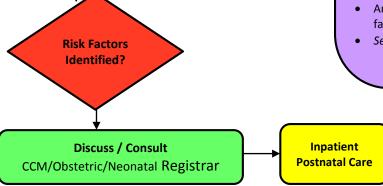
- Assess perineum and vagina; suture if indicated See Perineal Tears 3rd and 4th Degree Guideline
- Assess blood loss and on-going lochia
- Assess uterine tone and fundal height
- Maternal vital signs BP, P, T, RR, Sa02
- Pain relief as indicated
- Bladder care
- If Rhesus negative Kleihauer within first hour after birth
- When clinically stable, mobilise and assist with comfort cares, including shower if desired
- Formulate on-going care plan, including information for woman and family and handover of postnatal care

Documentation

- CR3009 Woman's Clinical Notes
- Day Stay Medication Chart / 8 Day Medication Chart
 - Analgesia prescribed & administered
- CR5825 MEWS commenced (If staying as an inpatient or abnormal observations)
- Complete:
 - CR3895 Partogram
 - CR3732 Labour & Birth Summary
 - CR2547 Body Parts / Tissue Release
 - CR4097 Perineal Injury Repair Record
 - Healthware

Discharge

- Arrange discharge home or to other primary postnatal facility
- See Discharge <12 hours Postpartum Guideline





11. Supporting evidence

- American College of Nurse-Midwives (ACNM), Midwives Alliance of North America (MANA),
 National Association of Certified Professional Midwives (NACPM). (2013). Supporting healthy
 and normal physiologic childbirth: A consensus statement by ACNM, MANA, and NACPM.
 Journal of Perinatal Education, 22(1), 14-18. Retrieved from:

 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647729/.
- Bailey, D. J. (2017). Birth outcomes for women using free-standing birth centers in South Auckland, New Zealand. *Birth*, *44*(3), 246-251.
- Birthplace in England Collaborative Group. (2011). Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ*, 343.
- Carroli, G., & Belizan, J. (1999). Episiotomy for vaginal birth. *Cochrane database of systematic reviews*, (3). Retreived from: https://www.ncbi.nlm.nih.gov/pubmed/10796120.
- McDonald, S.J. (2004). Prophylactic ergometrine-oxytocin versus oxytocin for the third stage of labour, *Cochrane database of systematic reviews*. Retrieved from: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000201.pub2/full.
- Fitzpatrick, M., Harkin, R., McQuillan, K., O'Brien, C., O'Connell, P.R., & O'Herlihy, C. (2002). A randomised clinical trial comparing the effects of delayed versus immediate pushing with epidural analgesia on mode of delivery and faecal continence. *BJOG: An International Journal of Obstetrics & Gynaecology*, 109(12), 1359-1365. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/12504971.
- Goddard, R. (2001). Electronic fetal monitoring: Is not necessary for low risk labours. BMJ, 322(7300), 1436-1437. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1120506/.
- Grigg, C. P., Tracy, S. K., Tracy, M., Daellenbach, R., Kensington, M., Monk, A., & Schmied, V. (2017). Evaluating Maternity Units: a prospective cohort study of freestanding midwife-led primary maternity units in New Zealand clinical outcomes. *BMJ open*, 7(8).
- Keane, H.E., & Thornton, J.G. (1998). A trial of cetrimide/chlorhexidine or tap water for perineal cleaning. *British Journal of Midwifery*, 6(1), 34-37.
- Leung, S.W., Ng, P.S., Wong, W.Y., & Cheung, T.H. (2006). A randomised trial of carbetocin versus syntometrine in the management of the third stage of labour. *BJOG: An International Journal of Obstetrics & Gynaecology*, 113(12), 1459-1464. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1804104/
- Ministry of Health (MOH). (2012). Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Referral Guidelines). Retrieved from: https://www.health.govt.nz/system/files/documents/publications/referral-glines-jan12.pdf.
- National Institute for Health and Care Excellence (NICE). (2017) Intrapartum Care for healthy women and babies (Clinical Guideline 190). Retrieved from: https://www.nice.org.uk/guidance/cg190/chapter/Recommendations.
- New Zealand College of Midwives (NZCOM). (2006). Consensus Statement: Normal Birth.
 Retrieved from: https://www.midwife.org.nz/midwives/professional-standards/consensus-statements/.
- New Zealand Resuscitation Council. (2016). *Section 13 Neonatal Resuscitation*. Retrieved from: https://www.nzrc.org.nz/guidelines/.



- Prendiville, W.J., Elbourne, D., & McDonald, S.J. (2000). Active versus expectant management in the third stage of labour. *Cochrane database of systematic reviews*, (3). Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10908457.
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). (2014). Intrapartum Fetal Surveillance Clinical Guideline (third edition). Retrieved from: https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Summary-of-Recommendations-and-Good-Practice-Notes-Aug-2014-(1).pdf?ext=.pdf.
- Royal College of Obstetricians and Gynaecologists. (2001). The Use of Electronic Fetal
 Monitoring: The use and interpretation of cardiotocography in intrapartum fetal surveillance.
 London: Royal College of Obstetricians and Gynaecologists.
- Singata, M., Tranmer, J., & Gyte, G.M. (2010). Restricting oral fluid and food intake during labour. *Cochrane database of systematic reviews*, (8).
- World Health Organization (WHO). (1996). Care in Normal Birth: A Practical Guide. Report of a Technical Working Group. Publication no. WHO/FRH/MSM/96.24. Geneva: World Health Organisation.
- World Health Organization (WHO) Technical Working Group. (1997). Care in normal birth: a practical guide. *Birth*, *24*(2), 121-123.
- World Health Organization (WHO). (2018). WHO recommendations: Intrapartum care for a positive childbirth experience. Retrieved from: https://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/.

12. Associated documents

- Anti-D Administration
- Bladder Care Postpartum and Management of Urinary Retention
- Cord Blood Haematology
- Count Policy for Surgical Procedures
- Discharge < 12 Hours Postpartum
- Fetal Surveillance Policy
- Group & Screen Requirements in Maternity
- Group B Streptococcus (GBS) Prevention of Early-Onset Neonatal Infection
- Identification of Patients (including Newborns)
- Informed Consent
- Starship Child Heatlh Clinical Guideline: Immunisation Hepatitis B Vaccination
- Starship Child Health Clinical Guideline: Vitamin K deficiency bleeding and prophylaxis in the newborn
- Perineal Tears Third and Fourth Degree (OASIS)
- Postpartum Haemorrhage (PPH) Prevention and Management
- Retained Placenta Management

Clinical forms

- CR0452 Fluid Balance Record
- CR2547 Body Parts/Tissue Release



- CR3009 Clinical Notes Form
- CR3731 NWH Newborn Record
- CR3732 Labour and Birth Summary
- CR3895 National Women's Partogram
- CR4039 Epidural/Spinal Insertion Record
- CR4097 Perineal Injury Repair Record
- CR5636 Rooming In Record
- CR5782 Adult Observations Chart

13. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB 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.

14. Corrections and 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 <u>Document Control</u> without delay.