Insert Woman's Health & Care Identification sticker

Revised and updated September 2018

NORTHERN IRELAND NORMAL LABOUR AND BIRTH CARE PATHWAY*

Woman/Partner/Significant other Information

Following discussion with you/and your partner/significant other, a normal labour and birth care pathway will be designed that fits your needs and values. There will be ongoing discussion with you and your partner/significant other during your admission, labour and birth. If as an individual, your health requirements vary from those outlined in this pathway, members of the maternity care team will in discussion with you and other members of the team (if appropriate), adapt your care accordingly. You will be involved in all discussions and decision-making surrounding your care.

Staff Information

This Pathway aims to provide a structured, evidence based framework for normal labour and birth. It is not intended to be prescriptive but should act as a guide and encourages clinical judgment to be used and documented in partnership with the woman/and her partner/significant other. Each step of the pathway must be signed off as care is provided. Anyone completing any part of the document must ensure that it is secured within the **regional maternity hand held records** and sign the signature sheet. Remember to complete VTE assessment and review the woman's Group B Streptococcus status.

*Based on the SE Trust, Belfast Trust & Welsh Integrated Care Pathway for Normal Labour

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Topics for Discussion	Discussed Yes/No/NA
Labour and birth related topic(s) that the woman/partner/significant other may wish to discuss	
Birth preference(s) including water birth	
Mobilising and changing positions during childbirth	
The benefits of rest, massage, including reflexology	
Consider environment e.g. dimming of lights, music	
Refreshments - Light diet/isotonic fluids	
Pain relief – options e.g. labour in water, TENS, hypnobirthing, visualisation	
Importance of attempting to pass urine regularly	
Fetal heart rate monitoring	
Rupturing membranes	
Progress in labour and vaginal examination (with consent)	
Episiotomy and reasons why it might be done	
Third stage of labour - the choices	
Importance of skin-to-skin contact	
Who discovers the sex of the baby and cuts the cord	
Phytomenadione (Vitamin K)	
Timing of Cord Clamping	
If rhesus negative, need to take cord and maternal blood	
Transfer to consultant-led care if a problem arises	

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Initial Assessment

Date & Time of 1st assessment _____ Signature _____

Date & Time of 2nd assessment _____ Signature _____

Action	Within normal limits				Normal limits
	1st Assessment		2nd Assessment		
	YES	NO	YES	NO	
Abdominal Palpation					
Normal growth for gestation					
Lie					Longitudinal
Presentation					Cephalic
Head palpable **above** pelvic brim	/5ths		/5ths		Palpable
Fetal heart auscultation (listened to after a contraction for a period of at least one minute)					110 - 160 beats per minute
Rate of contractions					>1:5
Palpated strength of contraction					Moderate/strong
Length of contraction					>30 seconds
Maternal Observations					
Blood pressure					**Refer to OEWS**
Pulse					**Refer to OEWS**
Temperature					**Refer to OEWS**
Respirations					**Refer to OEWS**
O_2 Saturation					**Refer to OEWS**
Urinalysis					Blood can be present If glycosuria 2+ or more do a BM, if <8 mmol/L remain on Midwife-Led Unit. Negative to glucose Negative/Trace ketones Negative/Trace protein
Vaginal loss					**Refer to OEWS**
Medication including pain relief	Record in MHHR		Record in MHHR		

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Following verbal, informed consent from the woman, a vaginal examination (VE) is normally undertaken for confirmation of active labour within four hours of the onset of regular uterine contractions and the commencement of 1:1 midwifery care. Prior to VE, undertake abdominal palpation. If a VE is undertaken, then please complete the appropriate VE sticker and insert in the regional maternity hand held records and document maternal vital signs and fetal heart rate in the OEWS chart.

Date/Time of 1st Assessment Vaginal Examination: Date: Time:
Signature of midwife _____

Date/Time of 2nd Assessment Vaginal Examination: Date: _____ Time: _____
Signature of midwife _____

		1st Assessment	2nd Assessment
Cervix:	Position		
	Effacement		
	Application		
	Dilatation		
Presenting Part:	Cephalic/Breech		
	Relation to ischial spines		
	Position		
	Caput or moulding		
Membranes:	Present or Absent		
Liquor:	Colour		
Cord/Limbs:	Felt/Not felt		
	Fetal heart auscultated post procedure 110 - 160 bpm		

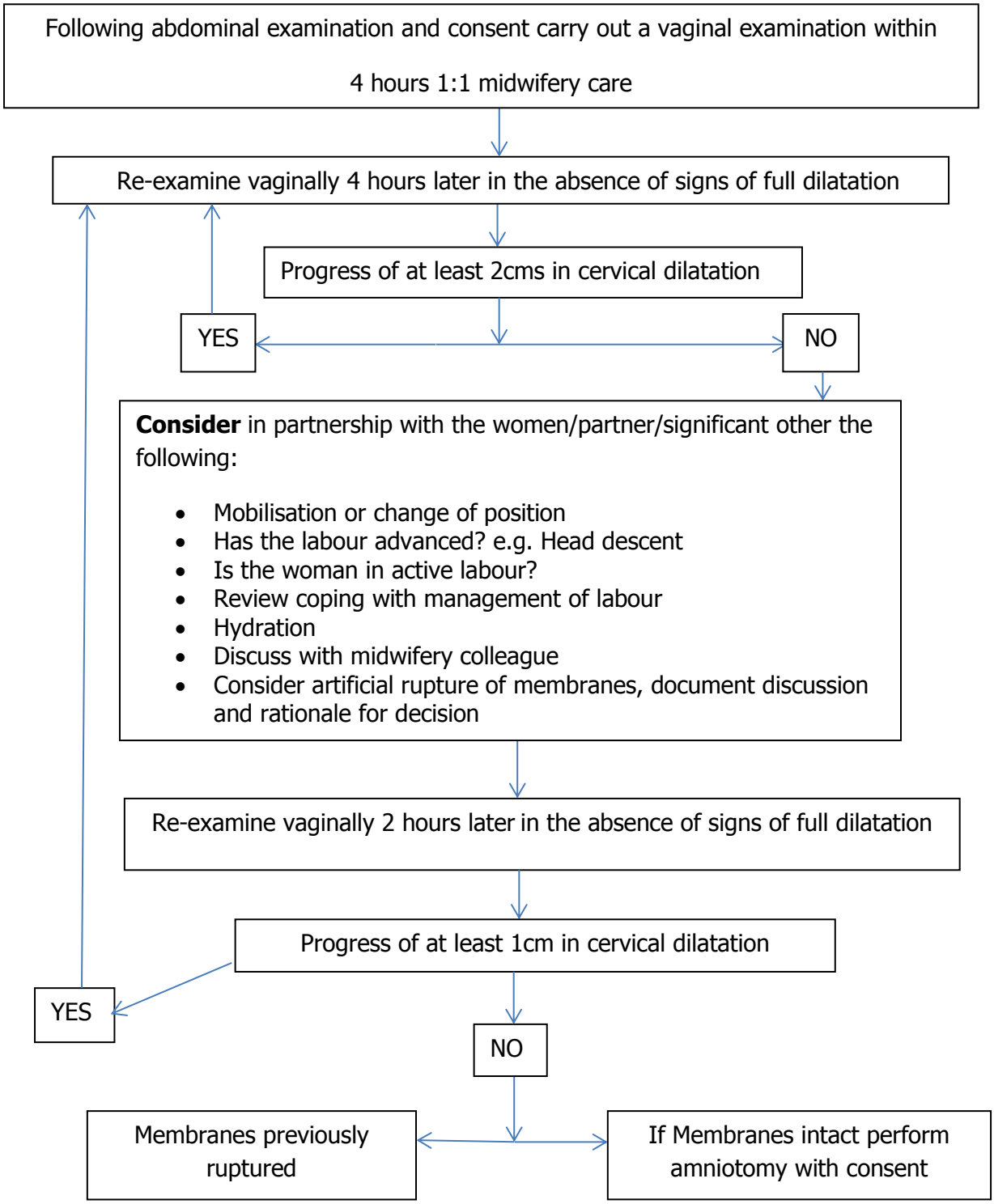
	1st Assessment		2nd Assessment	
	Yes	No	Yes	No
Diagnosis - In latent phase of labour				
Diagnosis – In active labour				
Continue pathway				

Commence partogram when the woman is deemed in <u>active labour</u> – Follow Northern Ireland Normal Labour and Birth Care Pathway and document in maternal hand held records

ACTIVE PHASE OF LABOUR - FIRST STAGE

All care provided will be in accordance with this midwifery guideline. If a deviation from normal progress in labour is suspected, seek advice from an appropriate colleague immediately.

Expected Progress in Labour - First Stage of Labour



Using appropriate communication tool, exit the Pathway and transfer to Consultant-Led Care

Remember One hour Transition phase for all women, as appropriate

EXPECTED PROGRESS IN SECOND STAGE

Fully Dilated

Nulliparous: Delay suspected if adequate progress after 1 hour of active second stage

Parous: Delay suspected if adequate if adequate progress after 30 minutes of active

Offer support and encouragement and consider:

- Are contractions adequate?
- Is the bladder empty?
- Change the position
- Seek opinion of colleague
- Consider analgesia/anaesthesia
- Amniotomy if membranes intact
- Document appropriately including rationale for decision-making

Nulliparous: No birth within next hour

(Total active 2nd stage - 2 hours)

Parous: No birth within 30 minutes

(Total active 2nd stage - 1 hour)

Diagnosis of delay in 2nd stage if birth not imminent

Transfer from MLU to Consultant-Led care and document appropriately

GUIDANCE:

- Full dilatation is confirmed by a visible vertex at the perineum. In some circumstances, it will be necessary to confirm full dilation by VE.
- As a guide, the midwife will support pushing only when a women feels expulsive contractions.
- Progress is made by advancement of the head, in presence of expulsive contractions with a stable women and baby.
- Undertake delayed cord clamping:
  Physiological management - await cessation of cord pulsation
  Active management - do not clamp the cord earlier than 1 minute from birth of the baby unless baby's heart rate <60bpm or concern for integrity of the cord, clamp cord before 5 minutes post birth to undertake controlled cord traction (NICE, 2014 https://www.nice.org.uk/guidance/cg190)

EXPECTED PROGRESS - THIRD STAGE OF LABOUR

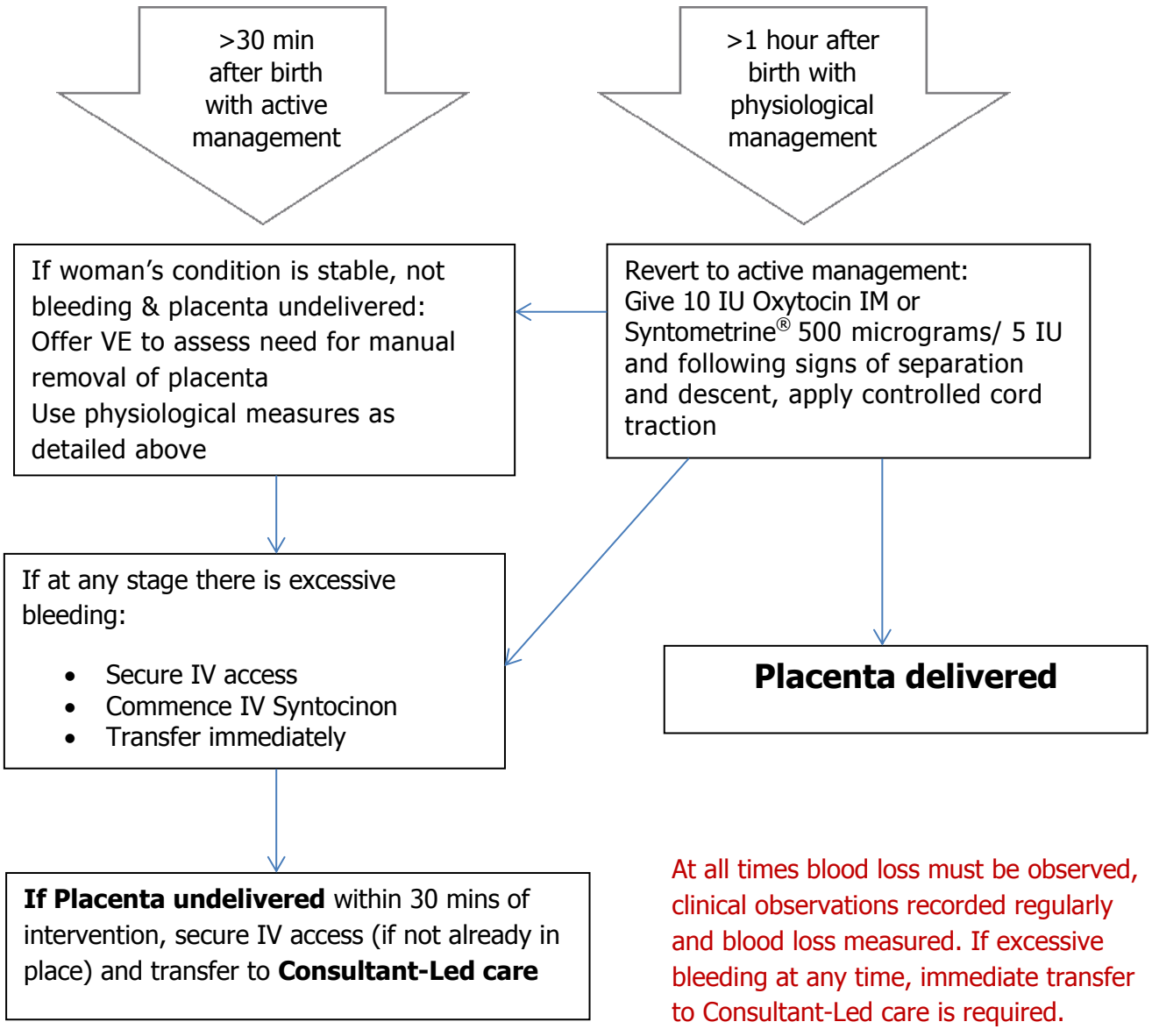
Third stage of labour may be managed actively or physiologically based on individual risk assessment and maternal choice.

Physiological measures to aid expulsion of placenta include:

- Ensuring the bladder is empty
- Encouraging the mother to breastfeed her baby to aid expulsion of placenta
- Encouraging maternal effort to expel the placenta
- Encouraging the mother to adopt an upright position

If there are no midwifery concerns and physiological management is planned it can proceed for up to one-hour duration without the need for active intervention. However, if physiological management is planned or commenced and intervention is needed, the third stage of labour must be managed actively.

Please follow this structured approach



At all times blood loss must be observed, clinical observations recorded regularly and blood loss measured. If excessive bleeding at any time, immediate transfer to Consultant-Led care is required.

You can view or print a copy of this pathway
by logging onto the
RQIA website www.rqia.org

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