University Hospitals Sussex
NHS Foundation Trust

# Care of Women / People in Labour

Maternity Protocol: MP035

Date Agreed: April 2022

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| **Guideline Reviewer:** | Hayley Stevenson & Sarah Robson |
| **Manager responsible:** | Amanda Clifton |
| **Version:** | 3.1 (placenta histology form updated) |
| **Approval Committee:** | Women's Safety and Quality Committee |
| **Date agreed:** | April 2022 (v3.1 – placenta histology form approved 17th April 2024) |
| **Amended Date:** | |
| **Review date:** | April 2025 |
| **Cross reference:** | **MP014** Perinatal Mental Health<br>**MP031** Preterm Labour<br>**MP039** Waterbirth<br>**MP037** Fetal Heart monitoring<br>**MP041** Delay in labour & use of Oxytocin<br>**MP042** Epidurals in Labour<br>**MP049** Assisted Vaginal Birth<br>**MP050** Caesarean Section<br>**MP052** Retained Placenta<br>**MP053** Obstetric Haemorrhage<br>**MP066** Neonatal Resuscitation<br>**MP040** Bladder Care |

# Contents

## Key Principles

*A protocol is a set of measurable, objective standards to determine a course of action. Professional judgment may be used in the application of a protocol.*

## Scope

This protocol applies to:

- Care of healthy pregnant women/people and their babies during labour and immediately after the birth, in all care settings.
- Focusing on pregnant women/ people who give birth between 37/42 weeks of pregnancy ('term').

## Responsibilities

Midwives & Obstetricians:

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this protocol

Management:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations
- To ensure the protocol is accessible to all relevant staff
- To ensure the protocol is available to service users on request

## Objective Standards

To ensure all stages of labour are managed correctly as per national guidance to achieve optimal outcomes for low risk pregnant women and people in labour. People have the right to be involved in discussions and make informed decisions about their care,(NICE 2017) and it is essential to include them in the decision making process.

# 2 Definition of the stages of labour

The onset of labour is a complex physiological process and therefore it cannot be easily defined by a single event. Although labour is a continuous process, it is convenient to divide it into stages. Definitions of the stages of labour need to be clear in order to ensure that pregnant women/people and the staff providing their care have an accurate and shared understanding of the concepts involved, enabling them to communicate effectively. For the purpose of this guideline, the following definitions of labour are recommended:

2.1 Definition 1st stage of labour

2.1.1 Latent stage of labour / Early labour

A period of time, not necessarily continuous, when there are painful contractions and there is some cervical change, including cervical effacement and dilatation up to 4 cm.

2.1.2 Established labour

Established first stage of labour when there are regular, painful contractions, with progressive cervical dilatation from 4 cm

2.2 Definition 2nd stage of labour

2.2.1 **Passive second stage**: Full dilation (10cm) of the cervix prior to or in the absence of involuntary expulsive contractions effort.

2.2.2 **Active second stage** – Expulsive contractions and/ or active effort with full dilation, or the baby is visible.

2.3 Definition 3rd stage labour

From the birth of the baby to the expulsion of the placenta and membranes.

# 3 Care of Women on Admission to Unit /Initial Assessment at Home

On attendance MP026 BSOTS protocol should be initiated and be documented on the BSOTS triage tab on BadgerNet

3.1 **If in the latent phase of labour:**

Please referral to MP030 Latent Phase of Labour

3.2 If labour is confirmed:

- Cardiotocography (CTG) monitoring is not required, unless risk factors are identified *MP037 Fetal Heart Monitoring* Offer vaginal examination (VE).
- Formulate a plan of care. For pregnant women/people at low risk of complications, amniotomy and oxytocin do not reduce the incidence of caesarean section, increase the incidence of spontaneous vaginal births or contribute to improved neonatal outcomes. They are therefore unnecessary for women at low risk of complications if labour is progressing normally. (NICE CG132 Caesarean Section).

3.3 Risk assessment

- An initial risk assessment should be carried out on all women/people in labour on each hospital admission or on attendance at home using the risk assessment page within the Labour Record.
- If the Risk Assessment is completed on admission or at home and the woman/person is subsequently discharged or if the midwife leaves the house not in labour a new Risk Assessment should be completed on the next admission.
- Midwives providing intrapartum care for pregnant women/people, while raising the profile of normal birth must be able to recognise deviations from normal progress at all three stages of labour, recognising events that may be detrimental to maternal and fetal wellbeing during labour. When new risks are identified during any stage of labour, the midwife is responsible for making a timely referral to the on-call obstetric Registrar or Consultant. This should be documented in the health record.
- Pregnant women/people should be made aware of the identified risk factors (at any time in the process) and referral, particularly women/people at home or in the birth centre who should be advised of the need to transfer into the maternity unit for obstetric review.

3.4 Initial labour risk assessment:

The initial assessment to identify risk factors or potential complications should be documented on SBAR form on badgernet following management of risk factors flow chart (Appendix A) and should take into account any issues or plans of care identified within the Antenatal Care Record.

This will include the following:

- Appropriate place of birth and the lead professional - midwife led or consultant led care.
- Clinical picture - gravida, parity, gestation by scan and LMP.

- Current and previous obstetric history- see Appendix B for conditions to be considered/ referred
- Medical history –see Appendix B for conditions to be considered/ referred
- Anaesthetic history- see Appendix B for conditions to be considered/ referred
- Risk factors for venous thromboembolism and complete VTE assessment form. • Social lifestyle history.
- Pressure area assessment
- Assessment of routine observations of the women/person and the fetus including: palpation and auscultation.
- Listen to the woman, consider her birth plan and wishes
- Observe maternal behaviour and ask mother about contractions, fetal movements and PV loss

3.5 Identified risk factors, care planning and referrals

3.5.1 Women in whom risks are identified during the clinical risk assessment should be advised of this and a referral made to obstetric care / for anaesthetic review (as appropriate) with clear documentation and an individualised plan of care in the maternity notes. Women at home with risk factors identified should be advised to transfer into the maternity unit for obstetric review and an interim individualised plan of care made. This should be clearly documented in the maternal notes

3.5.2 When referral to obstetric staff the midwife should clearly document in the maternal notes the name and grade of doctor consulted and the time the referral was made. For births at home requiring referrals the midwife should clearly document the name, designation and grade of the person she discusses care and agreed plans of care in maternal notes.

3.5.3 Referrals as a result of risk assessment and all referrals should be documented in the maternal notes, referrals can be made in the following ways

# 4 Pre-labour spontaneous rupture of membranes (SROM) at term >37 weeks

If spontaneous rupture of membranes >37 weeks is reported without contractions the pregnant woman/person should be assessed as soon as possible (home assessment or to attend the hospital). Where pregnant women/people have additional risks consider immediate assessment. See protocol *'MP032 Pre-Labour Rupture of Membranes'*

# 5 Care in Established Labour

**Support in labour**

5.1 Provide a woman or person in established labour with supportive one to one care. Do not leave women or people in established labour on her own except for short periods or at the women or persons request.

5.2 The initial assessment of a woman by a midwife should include:

| | |
|---|---|
| **Listening** | Listening to her story, considering her emotional and psychological needs and reviewing her clinical records including: scan reports to identify placental location/ medical history. |
| **Observations** | Physical observations – temperature, pulse, blood pressure, urinalysis |
| **Contractions** | Frequency, strength, and length of contractions (NICE 2014) |
| **Abdominal Palpation** | Fundal height, lie, presentation, position and engagement |
| **Vaginal loss** | E.g. show, liquor, blood |
| **Pain assessment** | Assessment of the woman's pain, including her wishes for coping with labour along with the range of options for pain relief. |
| **Fetal heart** | IA or CTG depending on risk assessment. Do not perform CTG for low-risk women in suspected labour as part of the initial assessment. (NICE) *See Maternity protocol* MP037: Fetal heart monitoring for further detail and guidance. |
| **Vaginal examination** | If the woman does not appear to be in established labour, after a period of assessment a vaginal assessment is not required. If the woman appears to be in established labour, a vaginal examination should be offered |
| **Fetal movements** | Ask the woman about the baby's movements in the last 24 hours. (NICE 2021) |

3.3.2 All care / procedures / discussions undertaken must be documented on badgernet by the person who undertook them.

3.3.3 Transfer the woman to obstetric-led care if there are any risk factors that indicate the need (See appendix B). If no risk factors, continue with midwifery-led care unless the woman requests transfer to obstetric-led care. If there are risk factors but birth is imminent, assess whether birth in the current location is preferable to transferring to labour ward, and discuss this with the LWC. (NICE 2021)

# 6 Observations during the established first stage of labour

It is the responsibility of the midwife to ensure that there is continuous evidence of care, support and assessment of the following on admission, throughout labour and the immediate postnatal period.

6.1 Recommendations from NICE:

- A pictorial record of labour (partogram) should be used once labour is established.
- Observations by a midwife during the first stage of labour include (NICE[1]):

| | |
|---|---|
| Temperature<br>BP | 4 hourly (unless abnormal, or regional analgesia - BP). |
| Pulse | 1 hourly |
| Contractions | $^1/_2$ hourly documentation of frequency |
| Bladder | Frequency of voiding / bladder care |
| VE | • Offered 4 hourly,<br>• or where there is concern about progress<br>• or in response to the woman or person's wishes (after abdominal palpation and assessment of vaginal loss) |
| Liquor | Assessment if membranes are ruptured/ presence or absence of significant meconium. |
| Fetal heart | *See Maternity protocol MP037: Fetal heart monitoring* for further detail and guidance |
| Emotional and psychological needs | Ongoing consideration should be given to the woman or person's emotional and psychological needs |
| Pain relief | Women or person should be encouraged to communicate their need for analgesia at any point during labour. All women or people should be offered to use the birthing pool for labour and birth (if it is available and the inclusion criterion is met. |

6.2 Pain relief

Healthcare professionals should think about how their own values and beliefs inform their attitude to coping with pain in labour and ensure their care supports women and people's choice. (2007)

6.2.1 Pain-relieving strategies

- Labouring women/people should be offered support and encouragement to help them cope with the pain of contractions.
- Advice should be given on breathing and relaxation techniques.
- Low risk pregnant women/people should be offered the opportunity to labour and birth in water. The benefits of hydrotherapy for pain relief should be explained to all women/people.
- Transcutaneous electrical nerve stimulation (TENS) should not be offered to women/people in established labour.
- Midwives should feel confident to support women/people in hypnobirthing.
- Pregnant women/people are to be informed of their choices regarding all analgesia available to them.

6.2.2 Pharmacological analgesia

- **Oramorph**
- **Entonox:** Ensure that entonox is available in all birth settings, inform the women or person that it may make her nauseous and light headed.
- **Pethidine**: undertake a full maternal and fetal assessment including fetal heart (IA or CTG as per risk factors) and fetal movements prior to administration. This can be given under midwifery exemptions (NMC 2011) unless risk factors present then a obstetric review is required. The pool or water should not be used within 2 hours of opiod administration.

*6.2.3* Regional analgesia- for full guidance see protocol *'MP042 Epidurals in labour'*

- **Epidural**: For information about epidurals please see *MP042 Epidurals in Labour* All drugs used should be documented clearly in the prescription chart and on badgernet.
- Provide information about epidural analegsia including known risks and benefits, providing the epidural card from the epidural trolley.

6.2.4 Either H2- receptors antagonists or antacids should be considered for women who receive opioids or who have or develop risk factors that make a general anaesthetic more likely.

# 7 Identification of delay in the first stage of labour

7.1 Where delay in the established first stage is suspected the following should be considered:

- Parity
- Cervical dilation and rate of change
- Uterine contractions
- Station and position of presenting part
- The pregnant woman/person's emotional state.
- Consider emptying bladder.
- Referral to the appropriate healthcare professional

See protocol MP041 Delay in Labour and Use of Oxytocin *for full guidance*

# 8 Observations of women and babies during the second stage of labour

Second stage is confirmed either by full dilatation of the cervix on vaginal examination or by a visible presenting part at the perineum.

**Observations during the second stage**

All observations should be documented on the partogram.

Observations by a midwife of a woman or person in the second stage of labour include:

| | |
|---|---|
| BP | 1 hourly |
| Pulse | Every 15 mins |
| Temperature | 4 hourly |
| VE | • Consider and offer 1 hourly,<br>• or in response to the woman or person's wishes (after abdominal palpation and assessment of vaginal loss) |
| Contractions | $^1/_2$ hourly documentation of frequency and strength |
| Bladder | Frequency of voiding / bladder care |
| Liquor | Assessment if membranes are ruptured |
| Fetal heart | *See Maternity protocol MP037: Fetal heart monitoring* for further detail and guidance |

8.1 Ongoing consideration should be given to:
- the woman or person's position, hydration, coping strategies and pain relief throughout the second stage
- the woman or person's emotional and psychological needs

8.2 Assessment of progress should include maternal behaviour, effectiveness of pushing and fetal wellbeing, taking into account fetal position and station at the onset of the second stage

8.3 All observations and assessments should be documented, by the person carrying them out, in the maternal notes (either in the partogram or the free text pages where description is required)

8.4 These factors will assist in deciding the timing of further vaginal examination and the need for obstetric review.

# 9 Duration of the second stage and definition of delay

9.1 Guidance on duration of the second stage of labour

9.1.1 **Nulliparous women**:
- Birth would be expected to take place within 3 hours of the start of the active second stage in most women.
- Suspect delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 1 hour of active second stage. Offer vaginal examination and then offer amniotomy if the membranes are intact.
- Diagnose delay in active stage when it has lasted 2 hours and refer the woman or person healthcare professional trained to undertake an operative vaginal birth if birth is not imminent

9.1.2 Multiparous women:

- Birth would be expected to take place within 2 hours of the start of active second stage in most women.
- Suspect delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 30 minutes of active second stage. Offer vaginal examination and then offer amniotomy if the membranes are intact.
- diagnose delay in the active second stage when it has lasted 1 hour and refer the woman or person to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent. [2007]

9.1.3 If delay is suspected in a homebirth setting consider transfer into the Maternity Unit and discuss with LWC, Obstetric team and family

## 9.2 Defining lack of progress

Lack of continuing progress in second stage of labour with adequate contractions can be defined as follows:

| | **Primip (no epidural)** | **Primip (with epidural)** | **Multip (with or without epidural)** |
|---|---|---|---|
| **Passive** | 1 hour | 1-2 hours | 1 hour |
| **Active** | 2 hours | 2 hours | 1 hour |
| Refer to obstetrician for preparation for operative birth if delivery not imminent | | | |
| Delivery expected within 1 hour of obstetric review | | | |

9.3 Management of delay in progress in the second stage

- Pregnant women/people with intact membranes should be offered amniotomy.
- Consider emptying the bladder.
- Consider commencing EFM.

9.4 Referral to obstetric team:

In the absence of descent after one hour of ACTIVE pushing, a referral to the obstetric registrar should be considered for a review and plan.

Obstetric team referral is indicated if delivery not imminent:

- After 2 hours of active pushing for primiparous women/people.
- After 1 hour of active pushing for multiparous women/people.

See the following Maternity protocols for additional detail:

- MP041 Delay in Labour and Use of Oxytocin
- MP049 Operative Vaginal delivery

- MP050 Caesarean Section

9.5 The woman's position and pushing in the second stage

9.5.1 Discourage the woman from lying supine or semi-supine in the second stage of labour and encourage her to adopt any other position that she finds most comfortable. [2007]

9.5.2 If pushing is ineffective or if requested by the woman, offer strategies to assist birth, such as support, change of position, emptying of the bladder and encouragement. [2007]

9.6 Intrapartum interventions to reduce perineal trauma

9.6.1 Implement all 4 key principles of the O.A.S.I bundle:

- Discussion about OASI and reducing risk with women
- Manual perineal protection during birth- Hands on/poised, warm packs.
- Mediolateral episiotomy at 60 degrees from midline if indicated
- Systematic examination of vagina and ano-rectum after birth even if the perineum appears intact.

9.7 Either the 'hands on' (guarding the perineum and flexing the baby's head) or the 'hands poised' (with hands off the perineum and baby's head but in readiness)

9.8 Inform any woman with a history of severe perineal trauma that her risk of repeat severe perineal trauma is not increased in a subsequent birth, compared with women having their first baby. [2007]

9.9 Inform any woman with infibulated genital mutilation of the risks of difficulty with vaginal examination, catheterisation and application of fetal scalp electrodes. Inform her of the risks of delay in the second stage and spontaneous laceration together with the need for an anterior episiotomy and the possible need for defibulation in labour. [2007] MP027 female genital mutilation.

# 10 Definition and duration of the third stage of labour

Recognise that the time immediately after the birth is when the woman and her birth companion(s) are meeting and getting to know the baby. Ensure that any care or interventions are sensitive to this and minimise separation or disruption of the mother and baby. [2014]

Information should be discussed with all women/people to enable them to make an informed choice about their care for the third stage of labour. Information given and plans for third stage including delayed cord clamping should be documented in the maternal notes.

### 10.1 Delayed cord clamping

Delayed cord clamping in a well full term baby following birth for approximately 3minutes (WHO, 2012) has been shown to be beneficial in improving the neonatal iron stores and preventing neonatal anaemia. There is some evidence that delayed cord clamping may increase the chance of jaundice in the postnatal period.

- After birth the baby should be given to the mother to hold, ideally skin to skin on her chest (it is advised to keep baby at maternal chest level during delayed cord clamping). The cord should be observed to ensure it is long enough to allow the baby to be held by the mother and is still intact. PV loss should be observed as usual, whilst maintaining the mother's privacy and dignity.

- If active management of the 3rd stage has been chosen by the mother:

    - Do not clamp the cord earlier than 1 minute from the birth of the baby unless there is concern about the integrity of the cord or the baby has a heartbeat below 60 beats/min which is not improving.
    - Clamp the cord before 5 minutes in order to perform controlled cord traction after signs of separation have been seen as part of active management. If the woman requests that the cord is clamped and cut later than 5 minutes, support her in her choice.
    - Delayed cord clamping can take place for waterbirths.
    - If cord blood is required (e.g. for rhesus negative women) this should be done *after* the delayed cord clamping has been completed
    - Record the timing of cord clamping for both active and physiological management of the 3rd stage in the maternal notes.
    - For delayed cord clamping during a caesarean section please see *MP050 Caesarean Section protocol*
    - For delayed cord clamping with preterm births please see the *MP031 Preterm protocol*
    - For delayed cord clamping with unwell babies requiring resuscitation please see the *MP066 Neonatal Resuscitation protocol*

### 10.2 Definition of the third stage

The third stage of labour is the time from the birth of the baby to the expulsion of the placenta and membranes.

10.2.1 **Physiological management** of the third stage involves a package of care that includes:

- No routine use of uterotonic drugs
- No clamping of the cord until pulsation has stopped
- Delivery of the placenta by maternal effort. [2014]

10.2.2 Advise a change from physiological management to active management if either of the following occur:

- Haemorrhage. Maternity protocol MP053 Obstetric Haemorrhage
- The placenta is not delivered within 1 hour of the birth of the baby. [2014]
- The woman wants to shorten the duration of the 3rd stage. (NICE)

10.2.3 The cord should be left alone until physiological separation occurs unless there is an indication to intervene. If the woman or person requests the cord to be clamped and cut, there should be a natural cessation of cord pulsation before clamping and cutting to gain equilibrium between baby and placenta.

10.2.4 Once signs of separation observed the following may assist separation/ expulsion:

- Putting the baby to the breast.
- The mother adopting an upright position.
- Maternal expulsive efforts.
- Quiet, warm room.
- Emptying of bladder.

10.3 **Active management** of the third stage involves a package of care which includes:

- clamping and cutting of the cord (this can be delayed in most cases – see below)
- Routine use of uterotonic drugs - 10 iu oxytocin is recommended as is associated with fewer side effects than oxytocin and ergometrine (NICE).
- Controlled cord traction, after signs of separation of the placenta.

10.4 Lotus Birth

Some women may request lotus births. This means the cord remains attached to the placenta until the cord separates naturally, usually after several days. Women who have made informed decisions should be supported to achieve their wishes. Women would be asked to provide any materials required to achieve a lotus birth.

10.5 Prolonged third stage

Diagnose a prolonged third stage of labour if it is not completed within 30 minutes of the birth with active management or within 60 minutes of the birth with physiological management. Please see *MP052 Retained placenta*

10.6 **Birth at Home**: the midwife should remain vigilant to maternal wellbeing throughout the third stage and consider the time required should transfer be necessary for a prolonged third stage. Using the above timings as guidance, the midwives should consider, and discuss with the mother the plans for the third stage, including timings, and possible need to for transfer in. once the above timings have been reached, the midwife should phone the labour ward and speak to the LW coordinator for support and agree a plan. If women decline to transfer in on midwifery advice, the midwife should discuss the rationale for transfer, risks and benefits clearly with the woman, documenting this in the notes and inform the labour ward Co-ordinator. A woman should be supported in her informed choices.

10.7 **Observations in the third stage of labour** (NICE 2014) by the Midwife

- General physical condition, as shown by her:
  - Colour
  - respiration
  - her own report of how she feels
- Vaginal blood loss
- Any observations relating the above should be documented on badgernet.
- In addition, in the presence of haemorrhage, retained placenta or maternal collapse, frequent observations (pulse, blood pressure, respirations) to assess the need for resuscitation are required

# 11 Referral to Obstetric Care

11.1 In recognising the parameters of what are considered to be evidence based care and raising the profile of normal birth, a midwife must be able to identify the following:

- Recognise deviations from normal progress as identified in all 3 stages of labour.
- Recognise events that may be detrimental to maternal and fetal health during labour

11.2 **Referral to an obstetrician**

The following situations indicate a referral to an Obstetrician (list no exhaustive):

- Delay in any stage of labour.
- Consideration should be given for referral in the presence of a non-reassuring CTG trace (see *MP037 fetal heart monitoring*)
- All Abnormal CTGs

- Abnormal bleeding at any stage in labour
- Concerns over maternal or fetal condition at any stage in labour
- Identified risk factors.

11.3 **Process for referral**

The midwife should inform the LWC of the need for referral, contact the obstetrician, document in the maternal notes when and who they have informed/ called and the time that the obstetrician attends.

# 12 Placenta

Consider if you placenta needs to be sent to histopathology on the list below:

- Stillbirth
- Miscarriage (14+1-23+6 weeks)
- FGR <3$^{rd}$ centile or drop in growth velocity >50 percentiles
- Fetal hydrops
- UA Dopplers (absent/reversed end diastolic flow)
- Monochorionic twins with TTTS
- Preterm birth <32 weeks
- <32-week-onset severe PET
- Severe sepsis with maternal ITU admission and/or fetal sepsis requiring ventilation or level 3 NICU (placenta swabs taken at birth)
- Massive placental abruption with retroplacental clot
- Severe fetal distress pH<705 / BE≥-12/scalp lactate >4.8mmol
- Caesarean paripartum hysterectomy for morbidity adherent placenta

See appendix B for Placental Histology Form.

# 13 Care of the newborn baby

Initial assessment of the newborn baby and mother–baby bonding

13.1 Record the Apgar score routinely at 1 and 5 minutes for all births.

13.2 Record the time from birth to the onset of regular respirations.

13.3 If the baby is born in poor condition (on the basis of abnormal breathing, heart rate or tone): follow on neonatal resuscitation and take paired cord-blood samples for blood gas analysis, after clamping the cord using 2 clamps. Continue to evaluate and record the baby's condition until it is improved and stable.

13.4 Do not take paired cord blood samples (for blood gas analysis) routinely.

13.5 Ensure that a second clamp to allow double-clamping of the cord is available in all birth settings.

13.6 Encourage women to have skin-to-skin contact with their babies as soon as possible after the birth.

13.7 In order to keep the baby warm, dry and cover him or her with a warm, dry blanket or towel while maintaining skin-to-skin contact with the woman.

13.8 Avoid separation of a woman and her baby within the first hour of the birth for routine postnatal procedures, for example, weighing, measuring and bathing, unless these measures are requested by the woman, or are necessary for the immediate care of the baby.

13.9 Encourage initiation of breastfeeding as soon as possible after the birth, ideally within 1 hour.

13.10 Record, body temperature and birth weight

13.11 If resuscitation is needed see maternity protocol MP066 Neonatal resuscitation.

# 14 Care of the woman after birth

Initial assessment

14.1 Carry out the following observations of the woman after birth:

14.2 Record her temperature, pulse and blood pressure. Transfer the woman (with her baby) to obstetric-led care if any of the relevant indications listed in recommendation are met.

14.3 Uterine contraction and lochia

14.4 Examine the placenta and membranes: assess their condition, structure, cord vessels and completeness. Transfer the woman (with her baby) to obstetric-led care if the placenta is incomplete.

14.5 Early assessment of the woman's emotional and psychological condition in response to labour and birth.

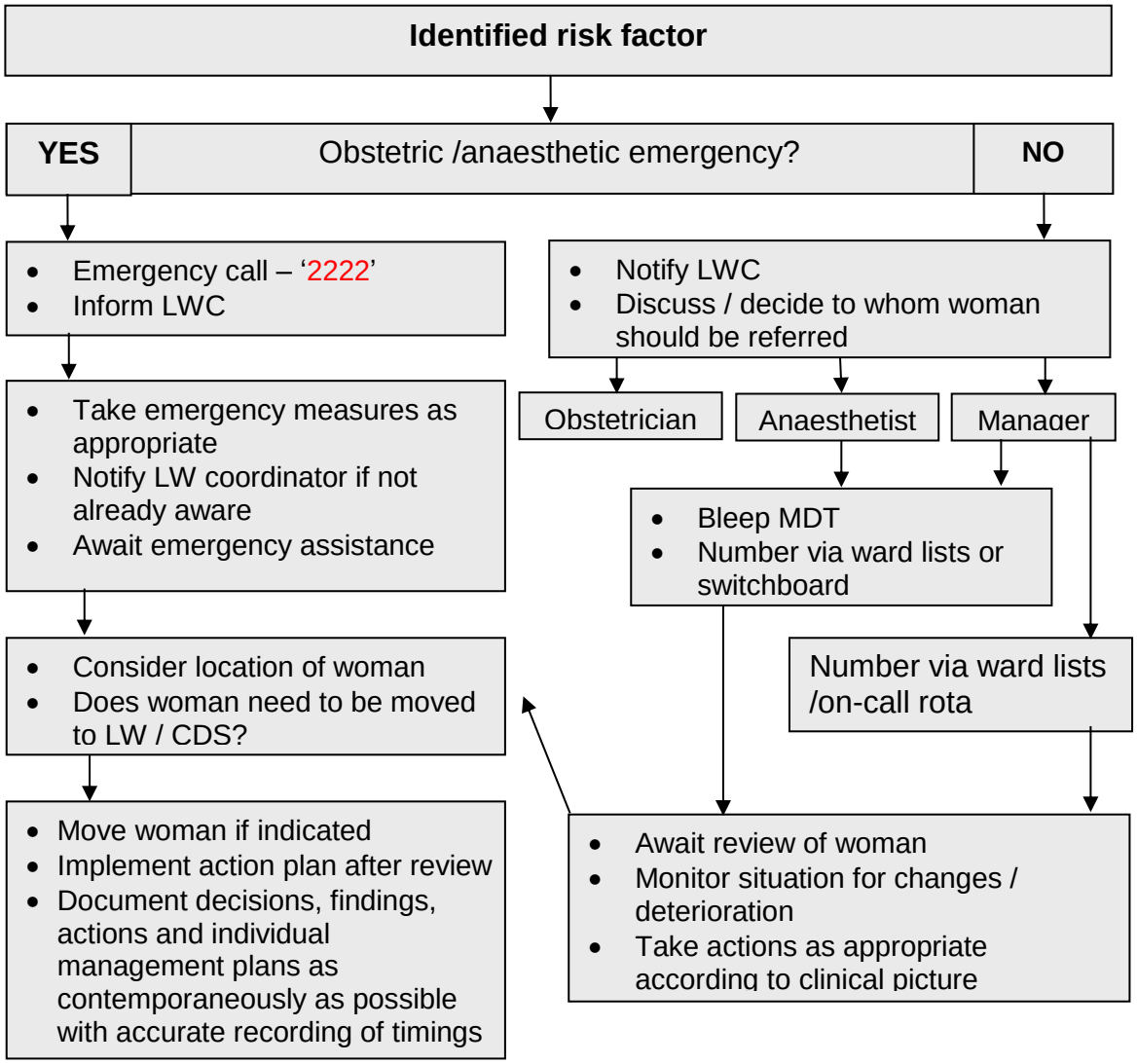
14.6 MP040 Bladder Care Pathway MP040

# 15 References

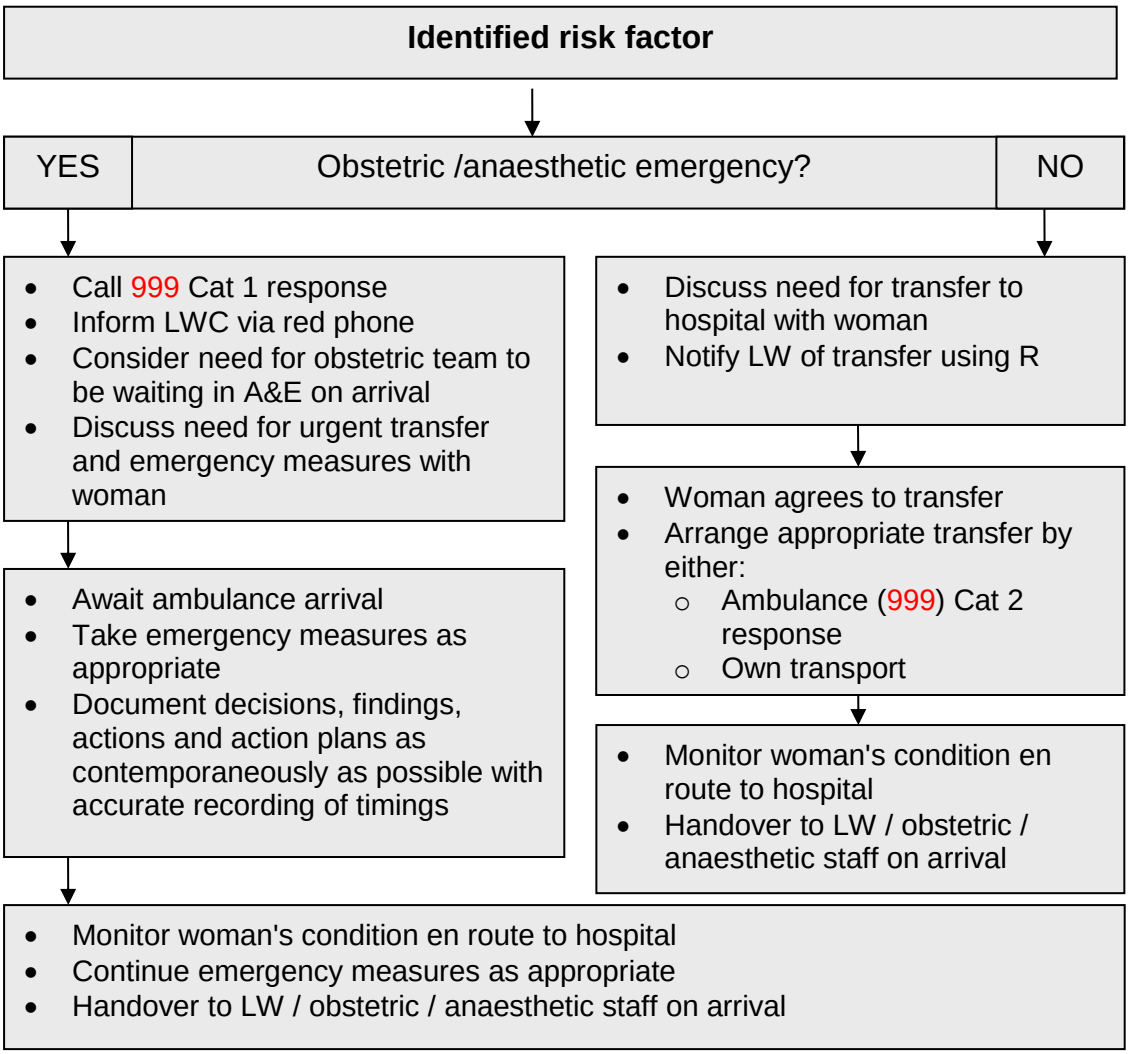
1) National Institute for Health and Clinical Excellence. (2017). *Intrapartum care: Care of healthy women and their babies during childbirth.* London: NICE. www.nice.org.uk

## Appendix A –

**Within the hospital**:



**At home / GP surgery / clinic / community setting:**



# Appendix B – Placental Histology Form

| Patient name:<br>NHS number:<br>Address:<br><br>*Affix label here* | NHS<br>University Hospitals Sussex<br>NHS Foundation Trust<br><br>**Lab number: (lab use only)** |
|---|---|

Send placenta and this request form to: ***Department of Cellular Pathology, Pathology, South Block, Royal Sussex County Hospital, Eastern Road, Brighton, BN2 5BE***

| **GESTATION:** (essential, if not supplied the placenta will be returned)<br>Birth weight centile: ☐ GAP ☐ Intergrowth ☐ Other |
|---|
| **INDICATION(S) for examination** (essential, if not supplied the placenta will be returned) |

**CLINICAL DETAILS:**

| | |
|---|---|
| Consultant obstetrician: | Livebirth (Y/N): |
| Date of birth: | Birth weight/s: |
| Gravidity: (total number of pregnancies)<br>Parity: (total number of live births post 24 weeks) | Sex: |

| | Please tick | | Please tick |
|---|---|---|---|
| Stillbirth | | Preterm birth <32 weeks | |
| Miscarriage (14+1-23+6 weeks) | | <32-week-onset severe PET | |
| FGR <3rd centile or drop in growth velocity >50 percentiles | | Severe sepsis with maternal ITU admission and/or fetal sepsis requiring ventilation or level 3 NICU (placenta swabs taken at birth) | |
| Fetal hydrops | | Massive placental abruption with retroplacental clot | |
| UA Dopplers (absent/reversed end diastolic flow) | | Severe fetal distress pH<705 / BE≥-12/scalp lactate >4.8mmol | |
| Monochorionic twins with TTTS | | Caesarean paripartum hysterectomy for morbidity adherent placenta | |

Twin 1: Sex ..... Number of cord clamps .....

Twin 2: Sex ..... Number of cord clamps .....

| Any other information: eg maternal smoking, BMI, medications, viral infections during pregnancy, mode of birth, Rhesus status, significant maternal co-morbidities |
|---|

**Person completing the request form:**

Name: (print) ..... Hospital/Ward: .....

Full contact number: ..... Date: .....

Placenta Histology Form (PRH&RSCH) v2.0 April 24