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TRUST CLINICAL GUIDELINE

Care in labour

Overview

This guideline aims to offer evidence-based guidance on care of women and birthing people during the first, second and third stage of labour. Care during the latent phase can be found in the 'Care in latent phase' guideline.

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Care in Labour

1.0 Introduction

The majority of women and birthing people with an uncomplicated pregnancy are fit and healthy and have the potential to have a physiological vaginal birth with healthy newborns as the expected outcome. Midwives are expert professionals skilled in supporting and maximising physiological birth and their skills should be promoted and valued. The role of the midwife is integral to provision of labour care in the UK.

Care in labour must be aimed at achieving the best possible physical, emotional and psychological outcomes for pregnant women and birthing people and babies with clinical intervention not being offered if labour is progressing normally and both woman/person and baby are well.

All staff and organisations should ensure that all birth settings have a culture of respect for each woman and birthing person as an individual undergoing a significant and emotionally intense life experience, so that the woman and birthing person is in control, is listened to, their choices are supported, and they are cared for with compassion (NICE, 2023).

When providing information on the benefits and risks of care options or suggested interventions:

- Encourage the woman and birthing person to ask questions
- If possible, give them time to think about the options and
- Help them make a supported decision (NICE, 2023).

One tool that may be used to support women and birthing people to make informed decisions is the BRAINS acronym:

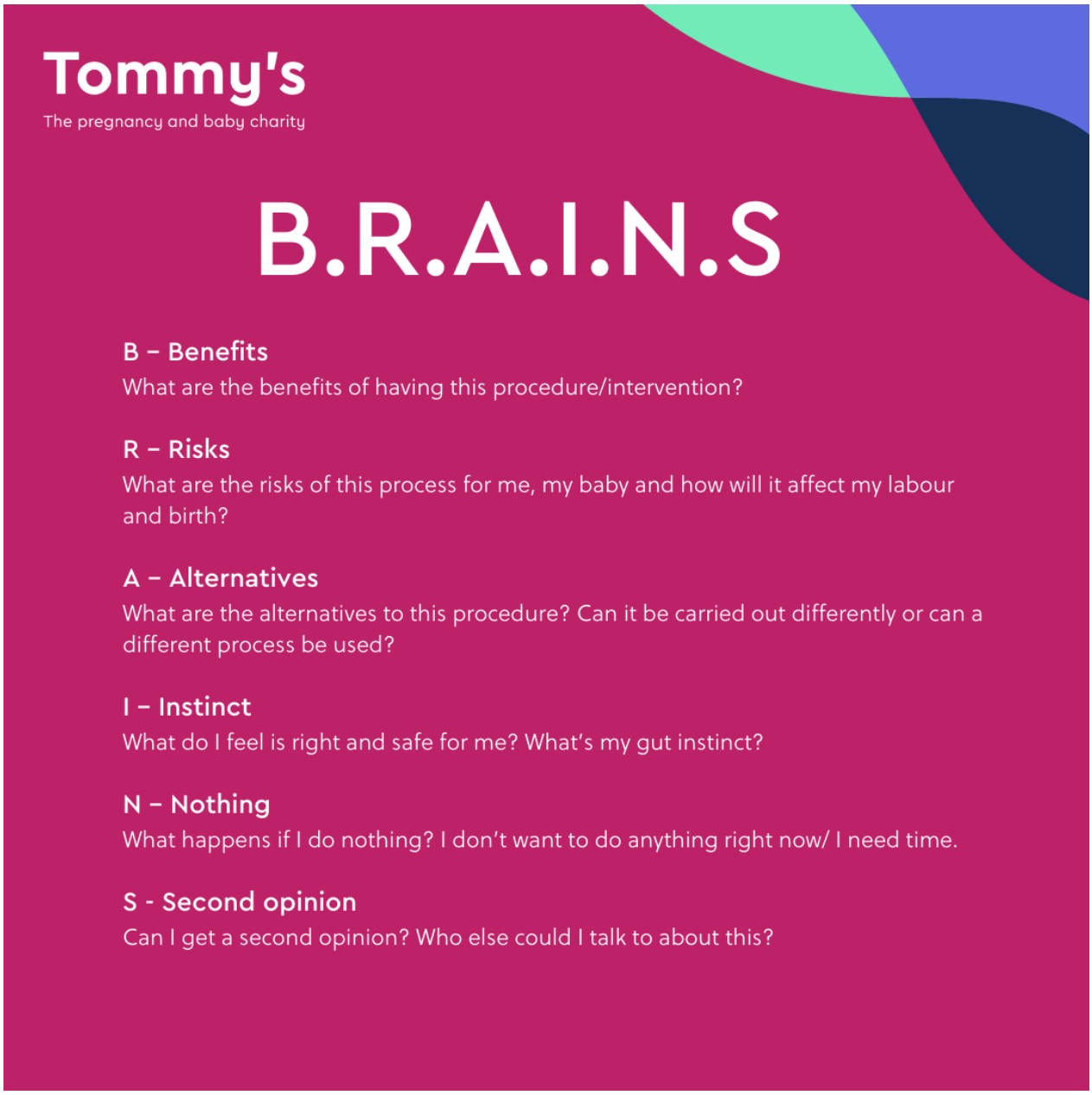

Figure 1: *BRAINS Acronym to support decision making* (Tommy's, 2024)

Informed consent must be obtained before carrying out the chosen care option or intervention (NICE, 2023).

All staff should demonstrate, through their own words and behaviour, appropriate ways of relating to and talking about women and birthing people and their birth companion(s), and of talking about birth and the choices to be made when giving birth (NICE, 2023).

2.0 Scope

This guideline applies to the following:

- Midwives
- Obstetricians

- Anaesthetists

3.0 Responsibilities

Midwives & obstetricians:

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

Management:

- To ensure the guideline is reviewed as required in line with Trust and National recommendations.
- To ensure the guideline is accessible to all relevant staff.

4.0 Definitions and abbreviations used within this guideline

BE Base excess	**NICU** Neonatal intensive care unit
CEFM Continuous Electronic Fetal Monitoring	**OASI** Obstetric anal sphincter injury
CTG Cardiotocograph	**PCA** Patient controlled analgesia
FGR Fetal Growth Restriction	**PET** Pre-eclampsia
IM Intramuscular Injection	**PPH** Postpartum haemorrhage
IOL Induction of labour	**TENS** Transcutaneous electrical nerve stimulation
IUGR Intrauterine growth restriction	**TTTS** Twin to twin transfusion syndrome
MLU Midwifery led unit	**UA** Uterine artery
MTOP Medical termination of pregnancy	**VE** Vaginal Examination
NICE National Institute of Health and Care Excellence	

Definitions:

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.

For the purposes of this guideline, the following definitions of labour are used:

- **Latent first stage of labour**
  A period of time, not necessarily continuous, when there are contractions **and** there is some cervical change, including cervical position, consistency, effacement and dilatation up to 4 cm.

- **Established first stage of labour**
  When there are regular contractions **and** there is progressive cervical dilatation from 4 cm.

- **Passive second stage of labour**
  When there is full dilatation of the cervix (determined by either vaginal examination or noting other external signs of full dilatation) before or in the absence of involuntary or active pushing.

- **Active second stage of labour**
  When there is involuntary or active pushing with full dilatation of the cervix **or** the baby is visible.

- **Third stage of labour**
  The time from the birth of the baby to the expulsion of the placenta and membranes (NICE, 2023).

5.0 Communication

When giving a woman or birthing person (and their birth companions) information about care during labour:

- Use clear, plain language and confirm with the woman or birthing person that they have understood the information.
- Tailor the content and delivery of information to the needs and preferences of the woman or birthing person.
- Ensure that the woman or birthing person is empowered to make a supported decision with their healthcare team, which may include:
  - Using reliable interpreting services when needed (see UHSTW046 UHSussex Interpretation & Translation Policy).
  - Using interpreters who are independent of the woman or birthing person.
  - Using culturally sensitive language.
  - Adapting communication, when necessary, for example, by using healthcare passports for people with learning disabilities or autism (NICE, 2023).

Treat all women and birthing people in labour with kindness, dignity and respect (NICE, 2023).

Ensure that the woman or birthing person is empowered, informed and central to making decisions about their care, and recognise that the way in which care is given is key to this. Support the woman or birthing person so they:

- Can continue to make decisions about their care.
- Feels confident that their care team is there to assist them.

- Understands that they can accept or decline care that is offered, can change their mind, and that decisions they make will not affect how care is provided to them (NICE, 2023).

To ensure this happens, establish a rapport with the woman or birthing person, ask them about their wants and expectations for labour, and be aware of the importance of both tone and demeanour and the actual words used. Use this information to support them and guide their care through their labour (NICE, 2023).

To establish communication with the woman or birthing person:

- Greet them and their birth companion(s) with a smile and a personal welcome, introduce yourself and explain your role in their care.
- Ask them what they want to be called.
- Maintain a calm, confident and professional approach.
- Respect the woman or birthing person's personal space, privacy and dignity, and ask others to do the same (for example, knock and wait before entering the woman or birthing person's room).
- Ask how the woman or birthing person is feeling and whether there is anything in particular they would like to discuss or if they have any concerns.
- Discuss the woman or birthing person's labour and birth preferences, and review and discuss any written birth plan.
- Ensure the woman or birthing person is aware of pain relief options, and provide both the opportunity to discuss these options, and give information if they request it to establish what their choices are.
- Encourage the woman or birthing person to adapt the environment to meet their individual needs.
- Explain all procedures and observations before they take place and ask for consent for them, focusing on the woman or birthing person rather than the technology or the documentation.
- Show the woman or birthing person and their birth companion(s) how to summon help and reassure them that they can do so whenever and as often as they need to.
- When leaving the room, let them know when you will return.
- Involve the woman or birthing person in any handover of care to another professional, either when additional expertise has been brought in or at the end of a shift – this should occur in the room, when appropriate, with the woman or birthing person at the centre of the handover discussion (NICE, 2023).

6.0 General Principles of Labour Care

Pregnant women and birthing people should have one to one care once in established labour. Do not leave a woman or birthing person in established labour on their own except for short periods or at the woman or birthing person's request (NICE, 2023).

Midwives should promote a homely environment in the labour room where the bed is not always the main focus and feel confident in offering equipment such as mats, birthing balls, hydrotherapy and non-invasive pain relief techniques such as massage and breathing techniques to promote active labour. Encourage the woman or birthing person to say if they need more analgesia at any point during labour.

6.1 Factors requiring obstetric led care

Maternal Risk Factors	
Antenatal Risk Factors	**Developing risk factors**
Pre-eclampsia	Pulse over 120 beats a minute on 2 occasions 15 to 30 minutes apart.
Intrahepatic cholestasis of pregnancy	A single reading of either raised diastolic blood pressure of 110 mmHg or more or raised systolic blood pressure of 160 mmHg or more.
Pre-existing medical conditions impacting on pregnancy or labour.	Either raised diastolic blood pressure of 90 mmHg or more or raised systolic blood pressure of 140 mmHg or more on 2 consecutive readings taken 15 to 30 minutes apart.
Any other risk factors recorded in the woman or birthing person's notes that indicate the need for obstetric-led care.	Respiratory rate of less than 9 or more than 21 breaths per minute on 2 occasions 15 to 30 minutes apart.
	A reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (90 mmHg or more) or raised systolic blood pressure (140 mmHg or more).
	Temperature of 38°C or above on a single reading, or 37.5°C or above on 2 consecutive readings 1 hour apart.
	Fresh red bleeding or blood-stained liquor

	Rupture of membranes more than 24 hours **before the onset of established labour.**
	Pain reported by the woman or birthing person that differs from the pain normally associated with contractions.
	Confirmed delay in labour
	Request by the woman or birthing person for additional pain relief using regional analgesia.
	Obstetric emergency
Fetal Risk Factors	
Antenatal Risk Factors	**Developing risk factors**
Suspected or diagnosed small for gestational age or macrosomia.	Non-cephalic fetal presentation
Diagnosed fetal growth restriction.	High (4/5 to 5/5 palpable) or free-floating head in a nulliparous woman or birthing person.
Diagnosis of oligohydramnios, anhydramnios or moderate/severe polyhydramnios (deepest pool >12 cm) on ultrasound (Karkhanis & Patni, 2014)	Concerns about fetal monitoring
Reduced fetal movements in the last 24 hours reported by the woman or birthing person.	The presence of meconium
	Cord presentation

Table 1: Indications for obstetric led care, NICE 2023

6.1.1 Presence of meconium

If meconium is present, consider the character of the meconium and discuss the option of transfer to obstetric-led care with the woman or birthing person. Explain that meconium:

- May increase the risk to the baby.
- Means that continuous cardiotocography monitoring may be advised (see maternity guidance on fetal monitoring).
- May mean that healthcare professionals trained in advanced neonatal life support are needed as soon as the baby is born (NICE, 2023).

Be aware that meconium is more common after full term but should still trigger a full risk assessment and discussion with the woman or birthing person about the recommendation of transfer to obstetric-led care (NICE, 2023).

As per Table 1, blood-stained liquor is an indication for obstetric review and transfer to obstetric-led care.

6.2 Transfer of care

Transfer of care refers to the transfer between midwifery-led care and obstetric-led care. This includes the transfer of women and birthing people who are receiving midwifery-led care in an obstetric unit having the responsibility for their care transferred to being obstetric-led without being moved (NICE, 2023). If transferring from a homebirth or the MLU into the hospital environment - please see guidance in Homebirth & Freebirth guideline and SRH Birth Centre guideline

If any risk factors are identified at the initial assessment or at any time during labour, explain to the woman or birthing person that obstetric led care is recommended. Multiple risk factors may increase the urgency of the transfer, particularly if they have a cumulative effect. This list is not exhaustive, there may be other risk factors identified that indicate need for obstetric led care, including if the woman and birthing person requests transfer to obstetric led care (NICE, 2023).

Base any decisions about transfer of care on clinical findings and discuss the options with the woman or birthing person and their birth companion(s). If contemplating transfer of care:

- Talk with the woman or birthing person and their birth companion(s) about the reasons for this and what they can expect.
- Address any concerns they have and try to allay any anxiety.
- Ensure that their wishes are respected and their informed consent is obtained (NICE, 2023).

If any of the factors in Table 1 are observed but birth is imminent, assess whether birth in the current location is preferable to transferring the woman or birthing person to an obstetric unit and discuss this with the woman or birthing person and the coordinating midwife (NICE, 2023).

In all stages of labour, women and birthing people who have left the midwifery-led care pathway because of the development of complications can return to it if or when the complication is resolved (NICE 2023).

6.3 Eating and drinking

Inform the woman or birthing person that they can drink during labour when they are thirsty, but there is no benefit to drinking more than normal (NICE, 2023). Women and birthing people in labour should not be encouraged to drink beyond their own body's thirst impulse. All labouring women and birthing people should be made aware of the risks of excessive fluid intake and encouraged to engage with fluid balance monitoring by healthcare professionals. Fluid balance

should be kept for all women and birthing people in active labour (See Hyponatraemia in Labour guideline).

For women and birthing people at low risk of complications in labour, fasting may prolong labour (Ciardulli et al., 2017). See Table 2 below for guidance.

<table>
<tr><th colspan="2">Low-risk labour</th></tr>
<tr><td colspan="2">Light diet: E.g. biscuits, cereals, toast, jelly, ice lollies, jelly sweets, yoghurt, ice cream etc.</td></tr>
<tr><td colspan="2">Unrestricted fluid types</td></tr>
<tr><td colspan="2">Any woman or birthing person who does not have any relevant risk factors is considered “low risk”.
‘Epidural’ only is not a risk factor for eating and drinking during labour and is considered as a low-risk labour unless the woman or birthing person has another associated risk factor.</td></tr>
<tr><td colspan="2">Prophylactic Proton Pump Inhibitors (PPI): Low risk women and birthing people in active labour progressing normally do not require PPI prophylaxis.</td></tr>
<tr><th colspan="2">High-risk labour</th></tr>
<tr><td colspan="2">Approved fluids: Water, clear fluid (i.e. squash), black tea/coffee, non-fizzy isotonic sport drinks</td></tr>
<tr><td>Antenatal risk factors:</td><td>Intrapartum risk factors:</td></tr>
<tr><td>• Preterm <36/40
• FGR
• SGA with other high-risk features e.g. abnormal dopplers, reduced liquor volume or reduced growth velocity
• Breech presentation
• Multiple pregnancy
• Pre-eclampsia
• Previous C-section or uterine scar
• Previous PPH >1L or retained placenta
• Booking BMI>40
• Previous difficult intubation
• Pre-existing medical conditions e.g. Type 1 diabetes</td><td>• Oxytocin augmentation
• Delay in labour
• Opioid use
• CTG concerns
• Meconium-stained liquor
• Antepartum haemorrhage</td></tr>
<tr><td colspan="2">Prophylactic Proton Pump Inhibitors (PPI): Administer oral Omeprazole 20mg 12-hourly until birth. In cases of suspected liver or renal impairment, refer for obstetric review prior to administration.</td></tr>
</table>

Table 2: *Eating and drinking during labour*

6.4 Movement in labour

Freedom of movement during labour is beneficial to support the physiology of labour and birth (Kjeldsen et al., 2025) Women and birthing people who choose to be mobile during their labour and birth should be supported to do so. Telemetry should be considered if CEFM is recommended.

Midwives should discourage women and birthing people from lying in the supine position (NICE, 2023). Should pregnant women and birthing people feel the need to rest, they should be encouraged into a left lateral position thus enabling the sacrum to move giving optimum room for the baby to descend through the pelvis (Bick et al., 2017). Pregnant women and birthing people should be encouraged to move and adopt positions that they find comfortable (NICE, 2023).

Peanut balls can be used to support women and birthing people to adopt positions that open different parts of the pelvis depending on the stage of labour and descent of the baby. Peanut balls are a safe and low-cost intervention that shortens the length of labour and may reduce the chance of unplanned caesarean birth for women and birthing people with epidurals (Delgado et al., 2022). See Appendix 1 for different positions that may be used.

Biomechanics is the study of biology and the mechanisms of movement. Biomechanics and maternal positional changes in any stage of pregnancy and labour encourages optimal fetal positioning and its associated benefits. Different maternal positions may be used by a trained midwife or health professional, both preventatively and responsively to support labour physiology. On suspicion of a malposition, early support and advice regarding biomechanics may be of benefit. The use of these techniques should not delay or replace escalations of concerns. The aim of biomechanics in labour is to provide additional choice and holistic care to women and birthing people.

There is an increasing number of research studies to support the use of other biomechanic techniques to resolve malposition. By adopting these positions, the pelvic and uterine ligaments are stretched, and this may create space and encourage the baby to rotate into a more favourable position for labour. At an Irish maternity unit, introduction of the biomechanics toolkit increased the rate of spontaneous onset of labour and reduced the caesarean birth rate, without any reported adverse outcomes (Lennon, 2024). A biomechanical approach is being adopted by many NHS trusts across the UK.

Some benefits that have been identified in these studies include:

- Improved birth experience and maternal satisfaction (Farag et al., 2024; Iversen et al., 2017; Mahmoud Mahmoud Saadoon et al., 2023; Tandoğan & Oskay, 2024).
- Reduce pain and anxiety (Farag et al., 2024; Mahmoud Mahmoud Saadoon et al., 2023).
- Reduction in caesarean section rate (Barrera & Acosta, 2022; Funk, 2024; Lennon, 2024; Zwillinger & Burke, 2023).
- Shortened second stage of labour (Sears, 2023; Tandoğan & Oskay, 2024).
- Increased rate of spontaneous onset of labour (Lennon, 2024).

- Decrease in persistent OP position (Fumagalli et al., 2024).
- Increased feeling of being active participant in their labour and feelings of safety (Tandoğan & Oskay, 2024).

6.5 Birth environment

The birth environment plays an important part in the progression of labour. This birth environment is created not only by the physical space, but also by the care providers and the culture within which they practice. A birth environment that is calming and reduces stress supports physiologic birth. Low levels of stress hormones during labour and birth promote uterine blood flow and support neonatal well-being, whereas greater levels of stress hormones can lengthen labour and impede the neonatal transition. Privacy, freedom from distracting noises, and space that allows freedom of movement and position changes give comfort and reduce stress (Stark et al., 2016).

Midwives should encourage women and birthing people to adapt the birthing environment for their needs. Some strategies that may support physiology of labour include:

Strategy	Examples
Preparing birthing rooms	• Dim lighting • Moving the bed so it is not central to the room • Reducing medical equipment that is not in use • Having equipment that encourages movement and activity to be visible rather than tidied away (e.g. birthing balls, mats)
Encourage women and birthing people to adapt the space	• Music/ambient nature sounds • Bringing items from home (e.g. pillows) • Moving items to suit their needs
Protecting the space	• Provide a sense of privacy • Ensure all staff knock before entering the room • Reduce noise and unnecessary conversations in the room • Reduce the number of unnecessary people

Table 3: *Strategies to promote physiology of labour (Stark et al., 2016)*

7.0 Pain relief during labour

7.1 Attitudes to pain and pain relief in childbirth

Labouring women and birthing people should be offered support and encouragement to help them cope with the pain of contractions. Pregnant women and birthing people are to be informed of their choices regarding all analgesia available to them.

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 the woman or birthing person's choice (NICE, 2023).

Take into account that every woman and birthing person's experience of pain is unique and may be expressed in different ways, both verbally and non-verbally. This may vary because of:

- Their cultural background and beliefs.
- Their socioeconomic status.
- Any neurodiverse conditions they may have (NICE, 2023).

7.2 Non-pharmacological pain-relieving strategies

There are a number of different non-pharmacological pain-relieving strategies that women and birthing people may choose to use:

- Breathing and relaxation
- Massage
- TENS
- Water (e.g. shower, bath or pool)
- Hypnobirthing/hypnotherapy
- Acupuncture/acupressure (NICE, 2023)
- See Latent Phase guideline.

If a woman or birthing person chooses to use any of these methods, support their choice.

Advise women and birthing people who wish to use transcutaneous electrical nerve stimulation (TENS) that:

- If a woman or birthing person wants to use TENS to manage their comfort during labour, support their choice.
- There is very little evidence of its effectiveness in established labour, but no evidence of harm.
- Other forms of pain relief can be used alongside TENS if needed by the woman or birthing person (NICE, 2023).

The benefits of hydrotherapy for pain relief should be explained to all women and birthing people. Offer the woman or birthing person the opportunity to labour in water for pain relief (NICE, 2023).

7.3 Pharmacological and regional analgesia

There are a number of different pharmacological pain relief options available to women and birthing people:

Pain Relief Options	Details
Entonox (a 50:50 mixture of oxygen and nitrous oxide)	Available in all birth settings. It may reduce pain in labour but inform the woman or birthing person that it may make them feel nauseous and light-headed. This may be given under Midwife Exemption Policy. See Guideline for prescribing and administration of Entonox®.
Oral morphine	Oral morphine sulfate 10 milligrams repeated after 2-4 hours if needed, a maximum of 2 doses (20 milligram max) can be given. If the woman or birthing person has had dihydrocodeine before moving on to morphine sulfate PO - this needs to be taken account of and documented accordingly (30 milligrams of dihydrocodeine is equivalent to 3 milligrams morphine sulfate). Morphine sulfate PO must be prescribed during labour.
IM Morphine	10 milligrams Morphine sulfate 4-6 hourly. It should be given with an antiemetic e.g. prochlorperazine 12.5mg PO/IM (NICE, 2023). Inform the woman or birthing person that these will provide limited pain relief during labour and may have significant side effects for both them (for example, drowsiness, nausea and vomiting) and her/their baby (for example, short-term respiratory depression and drowsiness, which may last several days and may make it more difficult to breastfeed). Women and birthing people should not enter water (a birthing pool or bath) within 2 hours of opioid administration or if they feel drowsy. Wait a minimum of 1 hour post oral administration of morphine, ideally 2 before administering IM morphine and monitor for signs of toxicity. This may be given under Midwife Exemption Policy.
Remifentanyl Patient Controlled Analgesia	Remifentanyl PCA may be used in select cases. See maternity guidance on PCA.
Epidurals	Epidurals are available on obstetric-led units. If a woman or birthing person requests regional analgesia, talk with them about the benefits and risks and the effect it may have on her/their pain and her/their labour. See maternity guidance on epidurals in labour.

Table 4: *Pharmacological pain relief options in labour*

8.0 Initial Assessment

8.1 First contact with telephone triage

Women and birthing people should be advised to call Telephone Triage if they think they are in labour. Carry out an assessment of labour by telephone and determine whether a face-to-face assessment is needed (NICE, 2023).

Include the following in any early or telephone triage assessment of labour:

- Ask the woman or birthing person how they are, and about their wishes, expectations and any concerns they have.
- Ask the woman or birthing person about the baby's movements, including any changes in the last 24 hours.
- Ask them about the length, strength and frequency of their contractions.
- Ask them about any vaginal loss.
- Give information about what the woman or birthing person can expect in the latent first stage of labour and how to work with any pain they experience.
- Give information about what to expect when they access care.
- Agree a plan of care with the woman or birthing person, including guidance about who they should contact next and when.
- Provide guidance and support to the woman or birthing person's birth companion(s) (NICE, 2023).

Carry out a face-to-face early assessment of labour either:

- At home (regardless of planned place of birth) or
- In their planned place of birth (midwifery-led unit or obstetric unit), comprising one-to-one midwifery care for at least 1 hour (NICE, 2023).

Women and birthing people should be invited to attend the unit or have a home assessment if they call in suspected labour for a third time.

8.2 In-person initial assessment of women and birthing people in suspected labour

Carry out an initial assessment to determine if midwifery-led care in any setting is suitable for the woman or birthing person, irrespective of any previous plan including consultant-led care. When performing an initial assessment of a woman or birthing person in labour, listen to their story and support their preferences and their emotional and psychological needs (NICE, 2023).

This assessment should comprise the following:

Situation:

- Ask them about the length, strength and frequency of their contractions and when they started.

- Ask them about any pain they are experiencing and discuss her/their options for pain relief.
- Record if they have had any vaginal loss.
- Ask the woman or birthing person about the baby's movements in the last 24 hours.

Background:

- Review and discuss the antenatal notes (including all antenatal screening results).
- Review the personalised care plan including management of the third stage.
- Review if there are any antenatal or intrapartum risk factors for fetal hypoxia (see maternity fetal monitoring guidance). This should include reviewing fetal growth, and any uncompleted actions, such as growth scans requested but not yet carried out.
- Review if woman or birthing person has any risk factors for OASI (UHSx Perineal Trauma & Repair Guideline)
- Check if they need intrapartum antibiotics for group B streptococcus prophylaxis and, if so, that these are available in their chosen place of birth if needed (see maternity guidance on GBS).

Assessment:

- Record their pulse, blood pressure, temperature and respiratory rate, and carry out urinalysis.
- Palpate the woman or birthing person's abdomen to determine the fundal height (if not measured within 2 weeks), the baby's lie, presentation, position, engagement of the presenting part, and frequency and duration of contractions.
- Auscultate the fetal heart rate for a minimum of 1 minute immediately after a contraction; palpate the woman and birthing person's pulse to differentiate between the heartbeats of the woman or birthing person and the baby (NICE, 2023).

If a woman or birthing person seeks advice or attends a midwifery-led unit or obstetric unit with painful contractions, but is not in established labour:

- Recognise that a woman or birthing person may experience painful contractions without cervical change and offer them individualised support and analgesia if needed.
- Encourage them to remain at or return home, unless doing so leads to a significant risk that they could give birth without a midwife present or become distressed (NICE, 2023). (link to latent phase)

If a woman or birthing person is confirmed to be in established labour, commence labour care as appropriate for her stage of labour (NICE, 2023).

Once established labour has been confirmed, a formal intrapartum risk assessment must be documented on Badgernet Maternity.

8.3 Vaginal examinations

Vaginal examinations are a tool that can be used to assess if a women or birthing person is in established labour. Vaginal examinations are an intervention, and as such their use should be restricted to when there is a clinical need. Repeated vaginal examinations are known to increase the risk of infection (Gluck et al., 2020), therefore VEs should not be offered routinely more frequently than 4 hourly in established labour (NICE, 2023).

- If there is uncertainty about whether the woman or birthing person is in established labour, a vaginal examination may be helpful after a period of assessment but is not always necessary.
- If the woman or birthing person appears to be in established labour, offer a vaginal examination (NICE, 2023) to confirm.

When conducting a vaginal examination:

- Be sure that the examination is necessary and will add important information to the decision-making process.
- Recognise that a vaginal examination can be very distressing and uncomfortable for a woman or birthing person, especially if they are already in pain, highly anxious and in an unfamiliar environment. Consider offering a chaperone, particularly in cases of previous trauma.
- Explain the reason for the examination and what will be involved.
- Explain that repeated vaginal examinations (over 5) increase the risk of intrapartum infection (Gluck et al., 2020)
- Ensure the woman or birthing person's informed consent, privacy, dignity and comfort.
- Advise the woman or birthing person that they can decline the examination before it starts or ask to stop at any stage during the examination.
- Explain sensitively the findings of the examination and any impact on the birth plan to the woman or birthing person and their birth companion(s) (NICE, 2023).

8.4 Diagnosing labour in the absence of vaginal examinations

In some circumstances, a vaginal examination may not be appropriate or possible to perform. For example when:

- A woman or birthing person has declined a VE
- There is a change in maternal behaviour during the latent phase indicating progress, when it has been less than 4 hours since the last examination and there are no maternal or birthing parent, or fetal concerns.
- Considering whether a VE is indicated in an early labour assessment.
- There is a change in maternal behaviour indicating progress during an induction of labour.

- If a woman or birthing person declines vaginal examination this must not restrict their access to the care they require (including 1:1 labour care, admission to labour ward and pain relief).

Other external signs are often visible and can support midwives to diagnose the onset of established labour without vaginal examinations (Fumagalli et al., 2022). The Modified Burvill Score is a standardised assessment tool which can be used to capture these external signs. It is not intended to replace clinical assessment but is to enhance the assessment process of labouring women and birthing people, particularly when VEs have been declined or are not recommended.

It is suggested that where the Burvill score is 5 or more one to one care should be commenced. For women and birthing people on the antenatal ward (in early labour or undergoing an induction of labour), a score of 5 or more should be discussed with the labour ward coordinator. A high score may indicate prompt transfer to the labour ward without further VE to avoid delay in transfer, particularly in the presence of multiparity/previous precipitate birth.

Score	0	1	2
Themes	**Signs may indicate Early Labour**	**Signs may indicate established labour**	**Signs may indicate advanced established labour**
Breathing	Exaggerated, pain like breathing.	Deeper breathing, controlled, pronounced, like a sigh.	Not shallow, cannot talk, focused on breathing slow with contractions; grunting sounds, cries out with expiration.
Conversation	Chatty, excitable, speaks quickly.	Speaks less.	Becomes quiet, conversation stops with each contraction, takes 20 seconds or more to resume talking; focus goes inward.
Mood	Excitement/anxiety, happy, slightly agitated.	Ceases to worry about external concerns.	Withdraws, focus is on self.
Energy	Wants to sort out practicalities	Becoming still. Inward focus on self.	Still. Withdrawn into self.
Movement & Posture	Grasps abdomen and bends forward with contractions.	Less mobile. Stops for contractions and holds onto something/one	Stays in one position with or without contraction. Sways hips during contraction
Contractions without palpation	20 - 40 seconds	50 seconds or more - at least 4 minutes apart.	50 seconds or more, 2-3 minutes apart.

Table 5: *Modified Burvill Score*

If the Modified Burvill Score is used, it should be recorded on BadgerNet Maternity using the appropriate form (see Appendix 2).

9.0 First stage of labour

9.1 Ongoing assessment during the first stage of labour

Record the following observations during the first stage of labour:

Observation	Frequency
Temperature	Every 4 hours (unless abnormal)
Respiratory rate	
Blood pressure	Every 4 hours (unless abnormal or if has regional analgesia)
Pulse	Every hour
Contraction frequency	Every 30 minutes
Bladder care	Bladder care should be reviewed at least every 4 hours and includes: • Frequency of passing urine and bladder sensation. Women or birthing person should be encouraged to void every 3-4 hours. • Offering to insert a catheter if there are any ongoing concerns over the woman or birthing person's ability to pass urine. • See Bladder care guideline
Vaginal examinations	Offer 4 hourly, or in response to the woman and birthing person's wishes if there is concern about progress (after abdominal palpation and assessment of vaginal loss).
Liquor	Liquor should be assessed hourly • Are membranes intact? • Appearance of liquor (including if there is meconium present)
Fetal heart rate	See Fetal monitoring INTRAPARTUM guideline. Fetal heart rate should be recorded every 15 minutes.
Emotional and psychological needs	Document the woman or birthing person's behaviour including their position, movements, emotional wellbeing and how they are managing with their contractions throughout labour.

Table 6: *Observations in the first stage of labour, (NICE, 2023)*

9.2 Holistic review during labour

Holistic review forms part of routine care provided by midwives during labour and should be documented hourly. The aim is to support effective and on-going holistic risk assessments during labour regardless of birth environment and risk status of the individual throughout labour. This assessment should be completed every hour by the midwife who is leading care, and includes review of the partogram, fluid balance chart as well as the general wellbeing of the woman or birthing person.

For women and birthing people who are on continuous monitoring, this review should be carried out with a second clinician every hour. For women and birthing people who are being intermittently monitored, this review should be completed with a second clinician every 4 hours at a minimum (NHS England, 2025; NICE, 2022). See maternity guidance on fetal monitoring.

If any new or developing intrapartum risk factors emerge, the Intrapartum Risk Assessment should be repeated.

9.3 Delay in the first stage

(See appendix 3)

If delay in the established first stage is suspected, take the following into account:

- Parity
- Cervical dilatation and rate of change
- Uterine contractions
- Station and position of presenting part.

Offer the woman or birthing person support, hydration, and appropriate and effective pain relief (NICE, 2023).

If delay in the established first stage is suspected, assess all aspects of progress in labour when diagnosing delay, including:

- Cervical dilatation of less than 2 cm in 4 hours for first labours.
- Cervical dilatation of less than 2 cm in 4 hours or a slowing in the progress of labour for second or subsequent labours.
- Descent and rotation of the baby's head.
- Changes in the strength, duration and frequency of uterine contractions (NICE, 2023).

If delay in the established first stage of labour is suspected, discuss the findings and the options available with the woman or birthing person, and support her decision (NICE, 2023). Offer individualised support, considering hydration and nutrition, emptying bladder, environmental factors, emotional support, mobilisation or change of position and effective pain relief where appropriate.

Advise all women and birthing people with suspected delay in the established first stage of labour to have a vaginal examination 2 hours later, and diagnose delay if progress is less than 1 cm.

If delay in the established first stage of labour is diagnosed, consider amniotomy for all women and birthing people with intact membranes, after explanation of the procedure and advise that it may increase the strength and pain of contractions. Do not advise transfer to obstetric-led care for amniotomy alone (NICE, 2023).

After amniotomy, advise the woman or birthing person to have a repeat vaginal examination 2 hours later. If there is no progress 2 hours after the amniotomy, transfer the woman or birthing person to obstetric-led care.

For all women and birthing people with confirmed delay in the established first stage of labour, an obstetrician should offer a full assessment. The obstetric review should include abdominal palpation and vaginal examination and consideration of oxytocin. See Induction of labour guidance for use of oxytocin for labour augmentation (NICE, 2023).

10.0 Second stage of labour

10.1 Ongoing assessment during the second stage of labour

Observation	Frequency
Temperature	Every 4 hours (unless abnormal).
Respiratory rate	
Blood pressure	Every 4 hours (unless abnormal or if has regional analgesia).
Pulse	Record rate every hour.
Contractions	Every 30 minutes assess the frequency, strength and duration of contractions.
Bladder care	Bladder care should be reviewed at least every 4 hours and includes: • Frequency of passing urine and bladder sensation. Women and birthing people should be encouraged to void every 3-4 hours. • Offering to insert an in/out catheter if there are any ongoing concerns over the woman or birthing person's ability to pass urine. • Indwelling catheters need to be removed prior to birth. • See Bladder care guideline
Vaginal examinations	Offer hourly in the **active** second stage, or in response to the woman or birthing person's wishes (after abdominal palpation and assessment of vaginal loss), particularly noting fetal position, descent and any caput or moulding.

Liquor	Liquor should be assessed hourly • Are membranes intact? • Appearance of liquor (including if there is meconium present).
Fetal heart rate	See Fetal monitoring INTRAPARTUM guideline. Fetal heart rate should be recorded every 5 minutes. Palpate the maternal pulse to differentiate between the two heartbeats.
Progress	Should be assessed hourly and include: • The woman or birthing person's behaviour. • The effectiveness of pushing and the baby's wellbeing, taking into account the baby's position and station at the onset of the second stage; these factors will assist in deciding the timing of further vaginal examinations and any need for transfer to obstetric-led care.
Emotional and psychological needs	Document the woman or birthing person's behaviour including their position, movements, emotional wellbeing and how they are managing with their contractions.

Table 7: Observations in the second stage of labour

Hourly holistic reviews should continue.

If outward signs indicate that a woman or birthing person appears to have progressed to the second stage of labour, second stage care should be commenced.

If after 1 hour there are no further signs of progress, then a vaginal examination should be offered. If this examination finds that the woman or birthing person is not in the second stage, the midwife should revert to first stage labour care.

10.2 Position and pushing in the second stage

10.2.1 Positions in the active second stage of labour

Women and birthing people will often spontaneously move into the right positions to birth their baby. Generally, upright positions and keeping mobile may be beneficial, as they can reduce fetal heart rate abnormalities, episiotomy rates and improve her birthing experience. However, women and birthing people should be encouraged to give birth in any positions they feel comfortable in (NICE, 2023).

Midwives should recognise static positions on the bed which put weight through the sacrum (including upright sitting positions on the bed, such as the throne position) do not allow the sacrum to move, close the pelvic outlet and are not supportive of physiology in the second stage of labour. Flexible sacrum positions can increase the rotation of the coccyx by 12 degrees more than non-flexible sacrum positions (Borges et al., 2021).

Lying supine can lead to a decrease in blood pressure and may reduce placental blood flow, so is not encouraged, particularly for women and birthing people with epidural analgesia. For these people, side lying positions have been shown to increase the chance of a spontaneous vaginal birth (Bick et al., 2017; NICE, 2023).

The peanut ball, or leg plates/bars on delivery beds can be used to support these positions (Appendix 4). The lithotomy position is associated with an increased risk of OASI injury (Elvander et al., 2015). Lithotomy should generally be avoided, unless assessing for assisted birth or episiotomy. Squatting or use of birthing stools may also increase the risk of OASI injury for multiparous women, so should be used with caution for this group of women and birthing people.

10.2.2 Pushing

Spontaneous pushing is when women and birthing people have an instinctive and irresistible urge to push and may push several times during one contraction.

Directed pushing is when women or birthing people are encouraged to take a deep breath in at the beginning of the contraction and push to the end of that breath, taking further breaths as necessary and repeating to the end of the contraction. Women can push with an open glottis (on exhalation) or closed glottis (Valsalva manoeuvre).

Pushing without an epidural	
Nulliparous women and birthing people	**Multiparous women and birthing people**
Spontaneous pushing may shorten the second stage of labour compared with directed pushing. If labour is progressing normally, directed pushing should not be encouraged.	
There was no difference in outcomes between pushing while exhaling and the Valsalva manoeuvre in nulliparous women.	If directed pushing is used, pushing while exhaling may shorten the active second stage of labour compared to the Valsalva manoeuvre.
Pushing with an epidural	
Nulliparous women and birthing people	**Multiparous women and birthing people**
Directed pushing rather than spontaneous pushing may reduce the likelihood of having an unplanned caesarean birth	Delaying directed pushing (allowing up to 1 hour for passive descent after full dilatation) may reduce the likelihood of needing birth with forceps or ventouse
Delaying directed pushing (allowing up to 2 hours for passive descent after full dilatation) may shorten the active second stage of labour.	Delaying directed pushing (allowing up to 1 hour for passive descent after full dilatation) may shorten the active second stage of labour.

Table 8: *Summary of evidence review for pushing techniques, (NICE, 2023)*

If full dilatation of the cervix has been confirmed in a woman or birthing person without an epidural in place, but they do not get an urge to push, offer to carry out further assessment after 1 hour (NICE, 2023).

If pushing is ineffective or if requested by the woman or birthing person, offer strategies to assist birth, such as support, change of position, emptying of the bladder and encouragement (NICE, 2023).

See Perineal Trauma & Repair guideline for guidance on reducing perineal trauma in the second stage of labour.

10.3 Duration of second stage and definitions of delay

	WITHOUT EPIDURAL		WITH EPIDURAL	
	Nulliparous	**Multiparous**	**Nulliparous**	**Multiparous**
Passive	1 hour, unless urge to push	1 hour, unless urge to push	Up to 2 hours	1 hour
Active	• Birth should be expected within 3 hours of the start of active second stage in most women and birthing people. • After 1 hour of active pushing, reassess and offer vaginal examination and consider amniotomy if the membranes are intact. • If birth not imminent after 2 hours of pushing, refer woman or birthing person for a senior review and a decision on place and mode of birth.	• Birth would be expected to take place within 2 hours of the start of the active second stage in most women and birthing people. • After 30 minutes of active pushing, reassess if there are no signs of progress, offer vaginal examination and consider amniotomy if the membranes are intact. • If birth is not imminent after 1 hour of pushing, refer the woman or birthing person for senior review and decision on place and mode of birth.	• Birth would be expected to take place within 3 hours of the start of the active second stage in most women and birthing people but be aware that these women and birthing people may have had a passive stage of up to 2 hours after full dilatation before commencing active pushing. • After 1 hour of active pushing reassess and offer vaginal examination and consider amniotomy if the membranes are intact. • If birth not imminent after 2 hours of pushing, refer the woman or birthing person for a senior review and a decision on place and mode of birth.	• Birth would be expected to take place within 2 hours of the start of the active second stage in most women and birthing people but be aware that these women and birthing people may have had a passive stage of up to 1 hour after full dilatation before commencing active pushing. • After 30 minutes of active pushing, reassess if there are no signs of progress, offer vaginal examination and consider amniotomy if the membranes are intact. • If birth is not imminent after 1 hour of pushing, refer the woman or birthing person for senior review and decision on place and mode of birth.

Table 9: Duration of active second stage of labour (NICE, 2023)

If there is delay in the second stage of labour, or if the woman or birthing person is excessively distressed, provide support and sensitive encouragement and ask them if they need analgesia or anaesthesia. Offer the woman or birthing person individualised support, considering:

- Hydration and nutrition
- Emptying bladder
- Environmental factors
- Emotional support
- The position of baby
- Mobilisation or change of position or rest
- Effective pain relief where appropriate
- Artificial rupture of membranes (NICE, 2023)

If there is delay in the second stage of labour and the decision is made to transfer the woman or birthing person to obstetric-led care follow the general principles in section 6.2. Take into account that the presence of other risk factors (in addition to delay) may increase the urgency of the transfer (NICE, 2023).

An obstetrician should carry out an in-person assessment of a woman or birthing person with confirmed delay in the second stage after transfer to obstetric-led care before contemplating the use of oxytocin. This should include:

- Assessment and confirmation of fetal wellbeing (including presentation, position and heart rate).
- Differentiation between the fetal and maternal or birthing parent heart rates.
- Confirmation that there are no signs of obstructed labour.
- Confirmation that contractions are infrequent or ineffective (NICE, 2023).

After initial obstetric assessment of a woman or birthing person with delay in the second stage, maintain ongoing obstetric review every 15 to 30 minutes (NICE, 2023).

Please see Induction of Labour guideline for obstetric review and use of oxytocin in labour.

10.4 Expediting birth

If the birth needs to be expedited for maternal or fetal reasons, assess both the risk to the baby and the safety of the woman or birthing person. The assessment should include:

- The degree of urgency.
- Clinical findings on abdominal and vaginal examination.
- The mode of birth (and whether to use forceps or ventouse if indicated).
- Anticipated degree of difficulty, including the likelihood of success if birth with forceps or ventouse is attempted.

- Location
- Any time that may be needed for transfer to obstetric-led care.
- The need for additional analgesia or anaesthesia.
- The woman or birthing person's preferences (NICE, 2023).

Talk with the woman or birthing person and their birth companion(s) about why the birth needs to be expedited and what the options are. Record the time at which the decision to expedite the birth is made. (NICE, 2023). See maternity guidance on assisted vaginal birth.

11.0 Third stage of labour

The time immediately after the birth is when the woman or birthing person and their birth companion(s) are meeting and getting to know their baby. Ensure that any care or interventions are sensitive to this and minimise separation or disruption of the mother or birthing parent and baby (NICE, 2023). Wherever possible, the baby should be brought up to the woman or birthing person's chest for immediate skin to skin contact, and this should be uninterrupted until after the first feed and for a minimum of one hour after birth.

Discuss with the woman or birthing person antenatally, during their initial assessment and in labour:

- The different options for managing the third stage of labour, and what to expect with each option.
- The benefits and risks associated with active and physiological management of the third stage (see Table 9, Table 10 NICE, 2023).

Advise women and birthing people that active management of the third stage of labour is associated with a lower risk of a postpartum haemorrhage or blood transfusion (NICE, 2023).

If a woman or birthing person requests physiological management of the third stage:

- Discuss their level of risk so they can make an informed decision and
- Support them in their choice (NICE, 2023).

If a woman or birthing person has risk factors for postpartum haemorrhage (see Table 12 in Appendix 5), highlight these in their notes, and agree with them a care plan covering the third stage of labour (NICE, 2023).

For those pregnant women and birthing people who choose to keep their placenta, give them the information sheet 'Releasing placentas to parents – Information sheet for parents' and ask them to sign the release form and scan into BadgerNet Maternity (Appendix 6).

11.1 Observations in the third stage

Record the following observations for a woman or birthing person in the third stage of labour:

- Their general physical condition, as shown by their colour, respiration and their own report of how they feel.

- Vaginal blood loss (NICE, 2023).

If there is postpartum haemorrhage, a retained placenta, or maternal or birthing parent collapse, or any other concerns about the woman or birthing person's wellbeing:

- Carry out frequent observations to assess whether resuscitation is needed
- Transfer her to obstetric-led care; follow the general principles for transfer of care described in section 6.2, taking into account that multiple risk factors may increase the urgency of the transfer, particularly if they have a cumulative effect (NICE, 2023).

11.2 Active management

Active management of the third stage of labour involves a package of care comprising the following components:

- Routine use of uterotonic drugs.
- Cord clamping and cutting of the cord.
- Controlled cord traction after signs of separation of the placenta (NICE, 2023).

For a woman or birthing person who is having a vaginal birth and has chosen to have an active third stage, discuss the choice of uterotonic for active management.

- Oxytocin (5 units slow IV injection or 10 units IM) is associated with fewer side effects such as nausea and vomiting.
- Syntometrine (5 units oxytocin plus 500 micrograms ergometrine) may be more effective than oxytocin at reducing the risk of postpartum haemorrhage, therefore is advised if there are additional risk factors for PPH. However, syntometrine is contraindicated in women and birthing people with severe hypertension, pre-eclampsia, eclampsia, or severe cardiac, hepatic or renal disease, and is associated with more side effects. Antiemetics (for example, cyclizine) should be offered to women and birthing people having syntometrine (NICE, 2023).
- Carbetocin is recommended for women and birthing people who are having a caesarean birth. (see Carbetocin to prevent PPH at CS)

Uterotonics should be administered immediately after the birth of the baby and before the cord is clamped and cut (NICE, 2023).

After administering the uterotonic, clamp and cut the cord, but:

- 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 heart rate below 60 beats a minute that is not getting faster.
- Clamp the cord before 5 minutes in order to perform controlled cord traction as part of active management.
- If the woman or birthing person requests that the cord is clamped and cut later than 5 minutes, support her choice (NICE, 2023).

After cutting the cord, perform controlled cord traction as part of active management only after administration of oxytocin and signs of separation of the placenta.

With active management, delivery of the placenta should be achieved within 30 minutes. If placenta has not been delivered within 30 minutes this should be escalated (NICE, 2023). (See Retained placenta).

11.3 Physiological management

Physiological management of the third stage of labour involves promoting the physiology of birth, to support the woman or birthing person to independently birth her/their placenta. There is no routine use of uterotonic drugs, and the cord is left intact at least until the pulsation has stopped (NICE, 2023).

Midwives should be skilled in both active and physiological approaches.

A physiological third stage of labour can be offered to low risk women and birthing people who have had a physiological 1st and 2nd stage and the following are present:

- >37 weeks.
- Singleton cephalic birth.
- At low risk of postpartum haemorrhage (PPH).

There should have been no procedures known to interfere with the natural release of oxytocin e.g. IV oxytocin, prostaglandins, epidural, opioid analgesia.

Following the birth of the baby, the mother or birthing parent and baby should be encouraged to bond in a warm, calm environment, breast feed if appropriate and allow natural separation of placenta and membranes to occur. They should be encouraged to adopt an upright position. Once the midwife has observed signs of placental separation, the woman or birthing person can be asked to bear down to aid delivery of the placenta.

The cord should be left alone until physiological separation occurs unless there is an indication to intervene. If the mother or birthing parent 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.

The following factors may assist separation or expulsion:

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

Delivery of the placenta is anticipated within one hour by maternal or birthing parent effort only. Physiological management should never include controlled cord traction.

Change from physiological management to active management in the case of:

- Haemorrhage.
- Placenta not delivered within 1 hour.
- The woman or birthing person's desire to artificially shorten the third stage.
- Neonatal resuscitation required (NICE, 2023).

11.4 Prolonged third stage of labour

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 (NICE, 2023). (See Retained placenta).

11.5 Lotus birth

Some women and birthing people may request lotus births, where the cord and placenta remain attached to the baby for several days until the cord separates naturally. Women and birthing people who have made informed decisions should be supported to achieve their wishes. Women and birthing people should be asked to provide any materials required to achieve a lotus birth.

11.6 Placenta histology

Placentas should be sent for histology in the following cases (Royal College of Pathologists, 2022):

- Miscarriage (14+1-23+6 weeks).
- FGR <3rd 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<7.05 / BE≥-12/scalp lactate >4.8mmol.
- Caesarean paripartum hysterectomy for morbidly adherent placenta.
- Stillbirth or early neonatal death (if placenta still available).
- MTOP (if requested by screening).

See Appendix 7.

RSCH/PRH: Placentas should be requested using the form in Appendix 8.

SRH/WH: Placenta histology should be requested on ICE.

12.0 Immediate postnatal care

12.1 Initial assessment of the woman or birthing person

Carry out the following observations of the woman or birthing person after birth:

- Record their temperature, pulse, blood pressure and respiratory rate.
- Check uterine contraction and lochia.
- Offer inspection of the perineum for trauma (refer to Perineal Trauma & Repair).
- Examine the placenta and membranes: assess their condition, structure, cord vessels and completeness; transfer the woman or birthing person (with their baby) to obstetric-led care if the placenta is incomplete.
- Make an early assessment of the woman or birthing person's emotional and psychological condition in response to labour and birth.
- Check for successful voiding of the bladder (NICE, 2023). See Bladder Care guideline.

If transferring the woman or birthing person to obstetric-led care, follow the general principles for transfer of care described in section 6.2 and take into account that multiple risk factors may increase the urgency of the transfer, particularly if they have a cumulative effect (NICE, 2023).

12.2 Care of the newborn immediately after birth

After the baby has born, their condition should be assessed to determine if any resuscitation is required using the APGAR score. If the baby is born in poor condition (for example, with abnormal breathing, heart rate or tone):

- follow recommendations on neonatal resuscitation and
- take paired cord-blood samples for blood gas analysis, after double-clamping the cord using 2 clamps (NICE, 2023).

Encourage women and birthing people to have skin-to-skin contact with their babies as soon as possible after the birth. In order to keep the baby warm, dry and cover them with a warm, dry blanket or towel while maintaining skin-to-skin contact.

If the woman or birthing person is not well enough, encourage their birth companion to have skin-to-skin contact instead. Prioritise optimal baby airway positioning, ensuring the head is supported so the airway does not become obstructed during skin-to-skin contact and explain to the woman or birthing person and their birth companion(s) how to maintain the baby's airway (NICE, 2023).

This is particularly important during suturing especially if the woman or birthing person is using Entonox. If the woman or birthing person is unable to ensure safe skin to skin, they should either be supported by another person (e.g. birthing partner or staff member), or if that is not possible skin to skin should be paused until it is safe to be continued. The birth partner may wish to do skin to skin in this case.

Avoid separating the woman or birthing person 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. Encourage initiation of breastfeeding as soon as possible after the birth, ideally within 1 hour (NICE, 2023). See maternity infant feeding and skin-to-skin guidance.

If a woman or birthing person needs to return to theatre in the immediate postnatal period (for example for perineal repair or manual removal of placenta) and the woman or birthing person is well, every effort should be made for the baby to remain with the mother or birthing parent so that skin to skin may be continued.

12.3 Initial examination of the newborn

Ensure that any examination or treatment of the baby is undertaken with the consent of the parents and either in their presence or, if this is not possible, with their knowledge (NICE, 2023).

Undertake an initial examination to detect any major physical abnormality and to identify any problems that need referral. Record head circumference and birth weight soon after the first hour following birth. Check the baby's body temperature is in the normal range (NICE, 2023).

13.0 Monitoring

Issue being monitored	**Monitoring method**	**Responsibility**	**Frequency**	**Reviewed by and actions arising followed up by**
Clinical incidents relating to management of labour Service User experience	Datix/Incident review process, Service user feedback via MNVP, complaints and Friends and Family Test.	Patient Safety/ Governance/ Clinical Effectiveness Team	On-going	Maternity Quality and Safety

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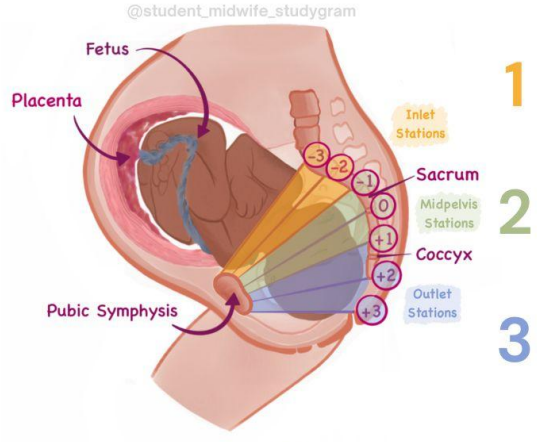
Appendix 1: Peanut ball positions handout

PEANUT BALL POSITIONS



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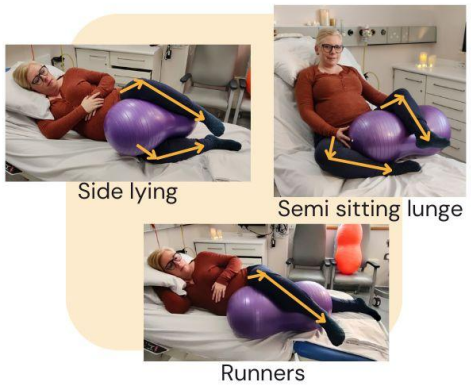
- Change positions regularly, at least every hour
- Cover peanut ball with patient gown and incos
- Clean with green Clinell wipes NOT ChlorClean
- One person might need different size balls for different positions

1

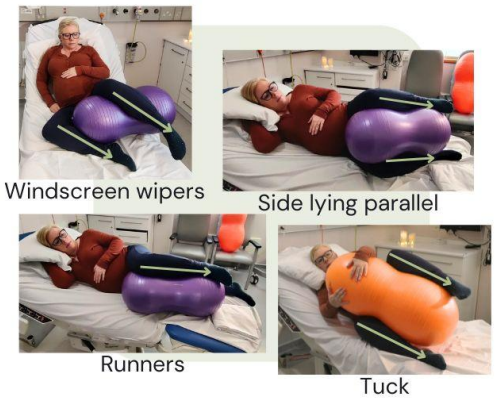
POSITIONS TO OPEN THE INLET



open knees to open inlet

2

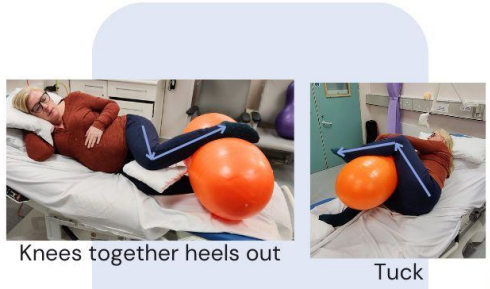
POSITIONS TO OPEN THE MID-PELVIS



keep knees and ankles parallel to open the mid-pelvis

3

POSITIONS TO OPEN THE OUTLET

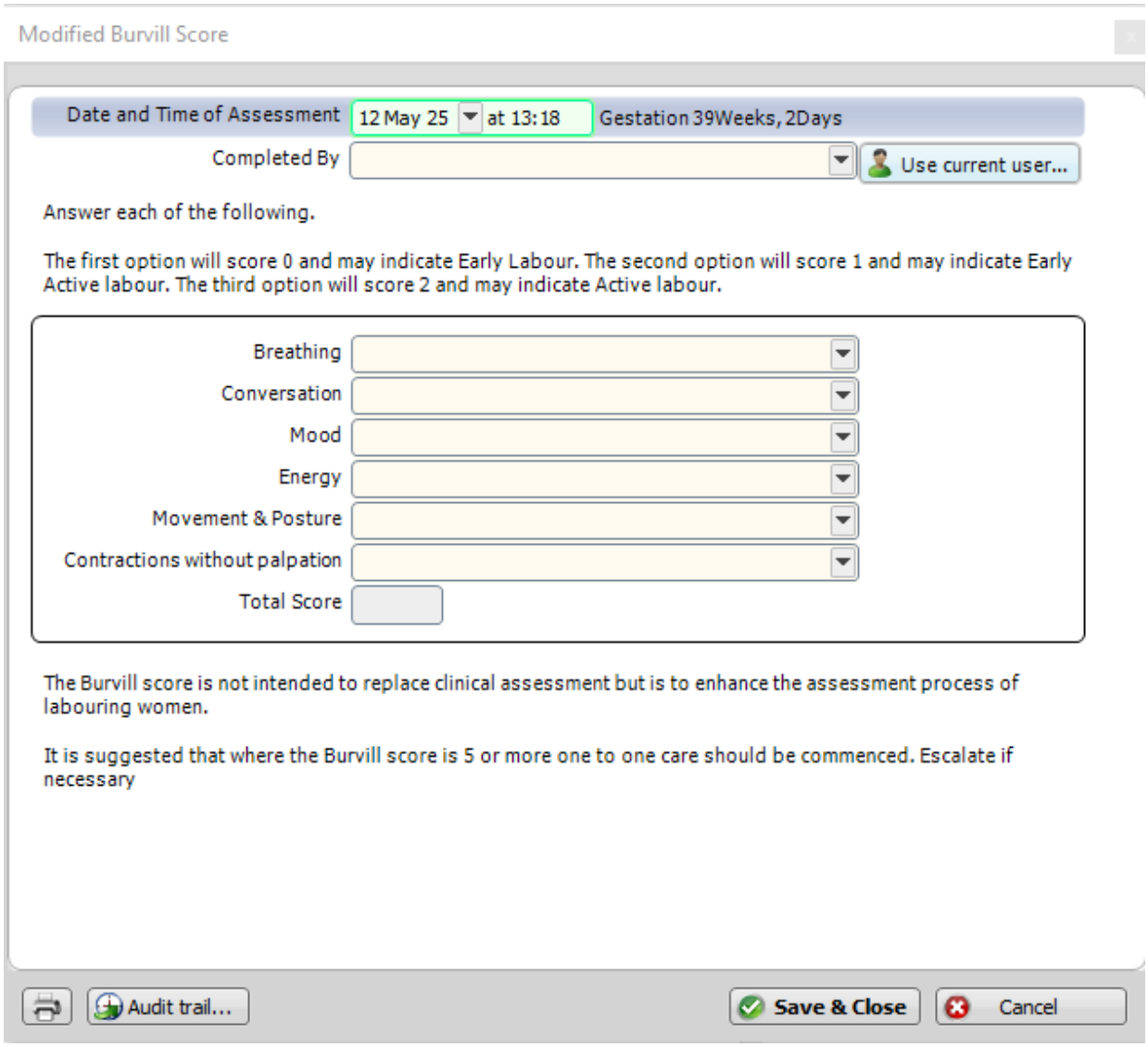


knees together heels out to open the outlet

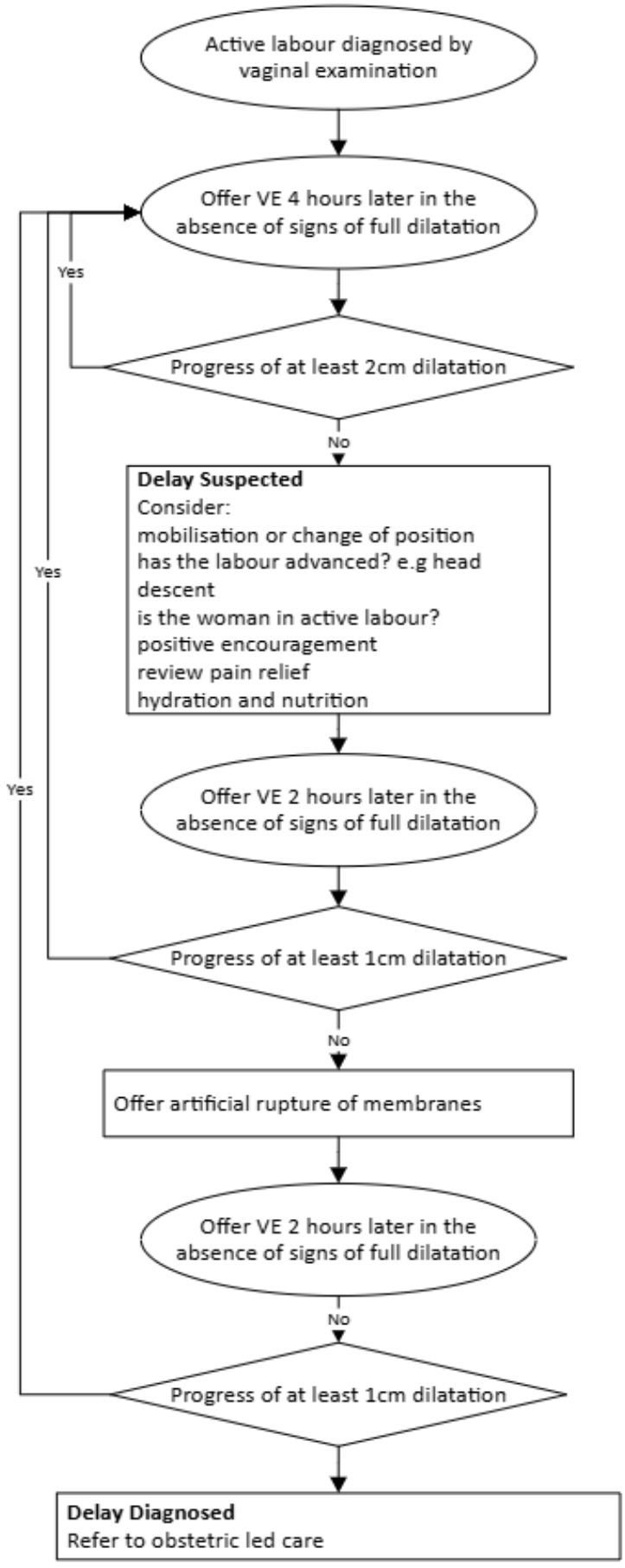
Peanut Ball Handout v1.0

Appendix 2: Modified Burvill Score Documentation

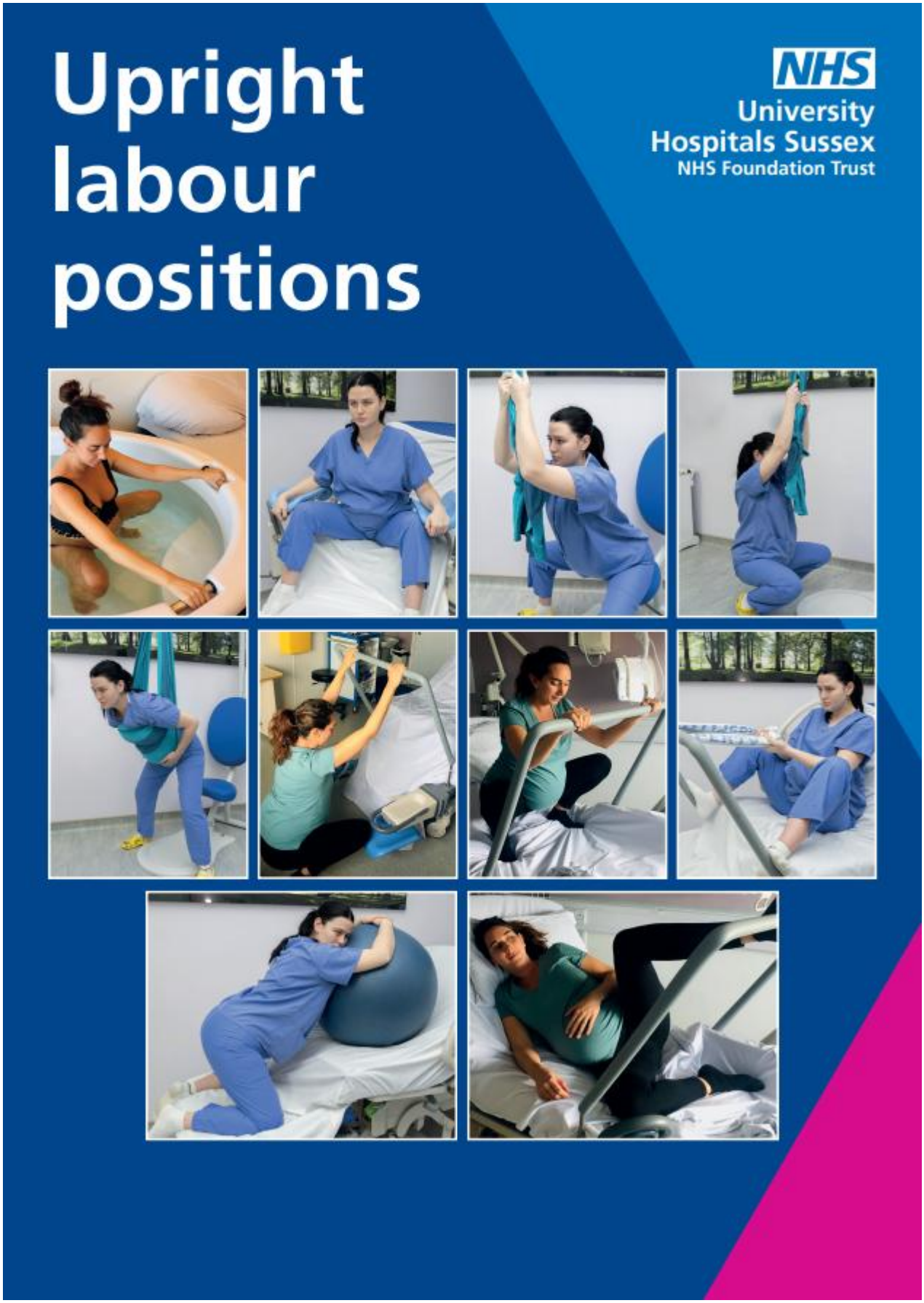
Modified Burvill Score form on Badgernet Maternity:



Appendix 3: Flowchart for management of suspected and diagnosed delay in the first stage of labour



Appendix 4: Upright labour positions poster



Appendix 5: NICE PPH evidence review summaries

Outcome	Active management of the third stage of labour	Physiological management of the third stage of labour	Risk difference
Haemorrhage of more than 500 mL	About 68 women per 1,000 would be expected to have a haemorrhage of more than 500 mL (so 932 per 1,000 would not)	About 188 women per 1,000 would be expected to have a haemorrhage of more than 500 mL (so 812 per 1,000 would not)	About 120 per 1,000 fewer women would be expected to have a haemorrhage of more than 500 mL with active management, so for 880 there would be no difference
Haemorrhage of more than 1 litre	About 13 women per 1,000 would be expected to have a haemorrhage of more than 1 litre (so 987 per 1,000 would not)	About 29 women per 1,000 would be expected to have a haemorrhage of more than 1 litre (so 971 per 1,000 would not)	About 16 per 1,000 fewer women would be expected to have a haemorrhage of more than 1 litre with active management, so for 984 there would be no difference
Need for blood transfusion	About 13 women per 1,000 would be expected to need a blood transfusion (so 987 per 1,000 would not)	About 35 women per 1,000 would be expected to need a blood transfusion (so 965 per 1,000 would not)	About 23 per 1,000 fewer women would be expected to need a blood transfusion with active management, so for 977 there would be no difference
Postpartum anaemia (haemoglobin less than 9 g/dL)	About 30 women per 1,000 would be expected to have anaemia (so 970 per 1,000 would not)	About 60 women per 1,000 would be expected to have anaemia (so 940 per 1,000 would not)	About 30 per 1,000 fewer women would be expected to have anaemia with active management, so for 970 there would be no difference
Need for further uterotonics	About 47 women per 1,000 would be expected to need further uterotonics (so 953 per 1,000 would not)	About 247 women per 1,000 would be expected to need further uterotonics (so 753 per 1,000 would not)	About 200 per 1,000 fewer women would be expected to need further uterotonics with active management, so for 800 there would be no difference

Side effects (nausea and vomiting, headache, hypertension, readmission for bleeding)	About 186 women per 1,000 would be expected to have these side effects (so 814 per 1,000 would not)	About 90 women per 1,000 would be expected to have these side effects (so 910 per 1,000 would not)	About 96 per 1,000 more women would be expected to have these side effects with active management, so for 904 there would be no difference

Table 10: Outcomes that were more or less likely for women having active management of the third stage compared with physiological management (NICE, 2023)

Outcome
Retained placenta beyond 1 hour or need for manual removal
Antibiotics for bleeding (discharge to 6 weeks)
Satisfied with third-stage management
Felt in control during labour

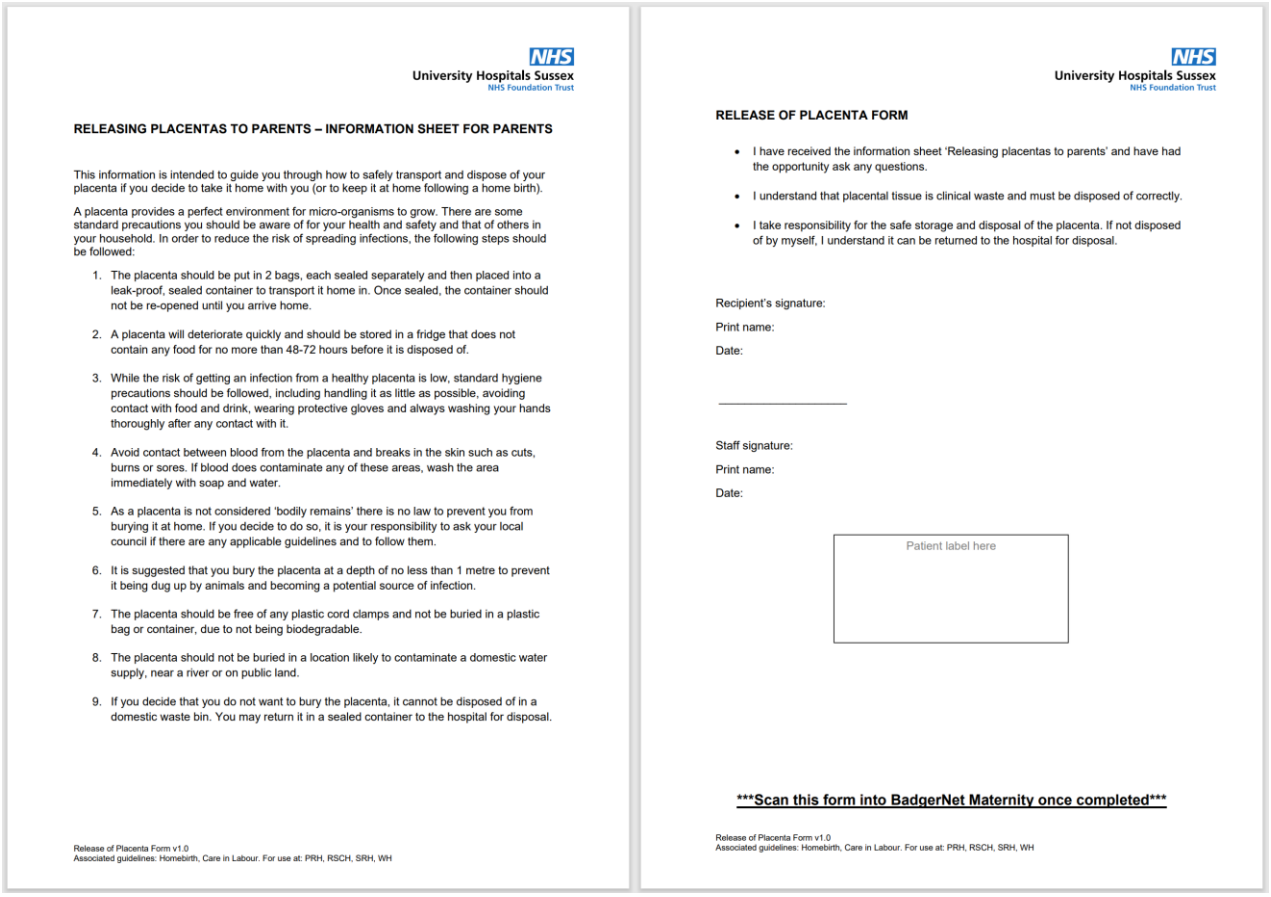
Table 11: Outcomes that were similar for both active and physiological management of the third stage (NICE, 2023)

Antenatal risk factors for PPH	Intrapartum risk factors for PPH
Previous PPH over 1 litre, or requiring blood transfusion	Induction or augmentation of labour with oxytocin or prostaglandins
Placenta accreta spectrum	Prolonged first or second stage of labour
Pre-eclampsia	Sepsis
Maternal haemoglobin level below 85 g/litre at onset of labour	Oxytocin use during labour
Booking BMI over 35 kg/m^2	Precipitate labour
Grand multiparity (parity 4 or more)	Birth with forceps or ventouse
Antepartum haemorrhage or placental abruption	Caesarean birth
Overdistention of the uterus (for example, multiple pregnancy, polyhydramnios)	Shoulder dystocia
Existing uterine abnormalities (for example, fibroids)	Delay in delivery of the placenta
Low-lying placenta	

Table 12: Antenatal and intrapartum risk factors for PPH (NICE, 2023)

Appendix 6: Releasing placentas to parents – Information sheet and release form

Please access this form via link: [Releasing placentas to parents form]



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RELEASING PLACENTAS TO PARENTS – INFORMATION SHEET FOR PARENTS

This information is intended to guide you through how to safely transport and dispose of your placenta if you decide to take it home with you (or to keep it at home following a home birth).

A placenta provides a perfect environment for micro-organisms to grow. There are some standard precautions you should be aware of for your health and safety and that of others in your household. In order to reduce the risk of spreading infections, the following steps should be followed:

1. The placenta should be put in 2 bags, each sealed separately and then placed into a leak-proof, sealed container to transport it home in. Once sealed, the container should not be re-opened until you arrive home.
2. A placenta will deteriorate quickly and should be stored in a fridge that does not contain any food for no more than 48-72 hours before it is disposed of.
3. While the risk of getting an infection from a healthy placenta is low, standard hygiene precautions should be followed, including handling it as little as possible, avoiding contact with food and drink, wearing protective gloves and always washing your hands thoroughly after any contact with it.
4. Avoid contact between blood from the placenta and breaks in the skin such as cuts, burns or sores. If blood does contaminate any of these areas, wash the area immediately with soap and water.
5. As a placenta is not considered 'bodily remains' there is no law to prevent you from burying it at home. If you decide to do so, it is your responsibility to ask your local council if there are any applicable guidelines and to follow them.
6. It is suggested that you bury the placenta at a depth of no less than 1 metre to prevent it being dug up by animals and becoming a potential source of infection.
7. The placenta should be free of any plastic cord clamps and not be buried in a plastic bag or container, due to not being biodegradable.
8. The placenta should not be buried in a location likely to contaminate a domestic water supply, near a river or on public land.
9. If you decide that you do not want to bury the placenta, it cannot be disposed of in a domestic waste bin. You may return it in a sealed container to the hospital for disposal.

Release of Placenta Form v1.0
Associated guidelines: Homebirth, Care in Labour. For use at: PRH, RSCH, SRH, WH

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RELEASE OF PLACENTA FORM

- I have received the information sheet 'Releasing placentas to parents' and have had the opportunity ask any questions.
- I understand that placental tissue is clinical waste and must be disposed of correctly.
- I take responsibility for the safe storage and disposal of the placenta. If not disposed of by myself, I understand it can be returned to the hospital for disposal.

Recipient's signature:

Print name:

Date:

Staff signature:

Print name:

Date:

Patient label here

*****Scan this form into BadgerNet Maternity once completed*****

Release of Placenta Form v1.0
Associated guidelines: Homebirth, Care in Labour. For use at: PRH, RSCH, SRH, WH

Appendix 7: Placenta Histology Poster

Stop! Does this placenta need to be sent for histology?

- **Miscarriage (14+1-23+6 weeks).**
- **FGR <3rd 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<7.05 / BE≥-12/scalp lactate >4.8mmol.**
- **Caesarean paripartum hysterectomy for morbidly adherent placenta.**

If yes to any of the above:

1. In a well-ventilated area, select a large specimen container (bucket) and ensure the lid fits tightly.
2. Put the placenta in the bucket.
3. Pour formalin (10% formal saline) over it, covering it to **about five times** the volume of the placenta.
4. Put the lid on.
5. Label the bucket **only** (not lid) with:
    a. The patient's name and date of birth and hospital number.
    b. The nature of **specimen** – placenta.
    c. The ward – labour ward.
    d. Date of specimen.
    e. Securely attach the specimen label from ICE
6. Call porter to collect specimen.

- **Stillbirth or early neonatal death (if placenta still available)**
- **MTOP (if requested by screening)**

In cases of Stillbirth or early neonatal death or MTOP:

1. Keep the placenta in a pot but do not add formalin until you have confirmed that the placenta is to be sent for histology.
2. Remember that a live born baby at any gestation, who then dies, may require a Coroner's PM, so do not add formalin to the placenta, even if the parents do not request a PM, until this has been discussed with the Coroner.
3. **The placenta must be refrigerated in these cases.**

Appendix 8: Placenta Histology Request form (PRH & RSCH)

This form can be accessed here: Maternity forms & proformas (Trust-wide)

Patient name:
NHS number:
Address:

Affix label here

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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)

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) Parity: (total number of live births post 24 weeks)	Sex:

	Please tick		Please tick
Stillbirth or early neonatal death (if placenta still available)		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) v2.1 June 2025

Guideline Version Control Log

Version	Date	Author	Comment
1.0	June 2025	Sophie McCambridge, Consultant Midwife Zamira Brice, Audit & Guidelines Midwife	New merged guideline replacing: • MP035 Care of women / people in labour (PRH&RSCH) • CG1196 Care in labour (SRH/WH)

Due Regard Assessment Tool

To be completed and attached to any guideline when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	Age	*No*	
	· Disability	*No*	
	· Gender (Sex)	*No*	
	· Gender Identity	*No*	
	· Marriage and civil partnership	*No*	
	· Pregnancy and maternity	*No*	
	· Race (ethnicity, nationality, colour)	*No*	
	· Religion or Belief	*No*	
	· Sexual orientation, including lesbian, gay and bisexual people	*No*	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	*No*	
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	*NA*	
4.	**Is the impact of the document likely to be negative?**	*No*	
5.	**If so, can the impact be avoided?**	*NA*	
6.	**What alternative is there to achieving the intent of the document without the impact?**	*NA*	
7.	**Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the guideline should continue in its current form?**	*NA*	
8.	**Has the document been assessed to ensure service users, staff and other stakeholders are treated in line with Human Rights FREDA principles (fairness, respect, equality, dignity and autonomy)?**	*Yes*	

If you have identified a potential discriminatory impact of this guideline, please refer it to [Insert Name], together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact uhsussex.equality@nhs.net 01273 664685).

Dissemination, Implementation and Access Plan

To be completed and attached to any guideline when submitted to Corporate Governance for consideration and TMB approval.

	Dissemination Plan	**Comments**
1.	Identify:	
	Which members of staff or staff groups will be affected by this guideline?	Midwives and obstetricians
	How will you confirm that they have received the guideline and understood its implications?	Dissemination through the usual communication channels and highlighted at Safety Huddles.
	How have you linked the dissemination of the guideline with induction training, continuous professional development, and clinical supervision as appropriate?	All new members of staff are shown where to access Clinical documents that are relevant to their area of practice.
2.	How and where will staff access the document (at operational level)?	Accessed by staff via Sharepoint.

		Yes/No	**Comments**
3.	Have you made any plans to remove old versions of the guideline or related documents from circulation?	Yes	Previous versions will be archived as part of the uploading onto sharepoint process.
4.	Have you ensured staff are aware the document is logged on the organisation's register?	Yes	Dissemination plan includes notifying staff via email, departmental noticeboards, and safety huddles.

Additional guidance and information

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