Intrapartum Care – Physiological Labour and Birth

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• Directorate(s)	Women's Health
• Department(s)	Maternity and Newborn services
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• Used by which staff?	All clinicians in maternity including access holder lead maternity carers (LMCs)
• Excluded	
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1. Purpose of guideline

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

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

2. Definitions

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

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

3. Best practice recommendations for physiological labour and birth care

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

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

3.1 Latent first stage of labour of a physiological birth

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

3.2 Active first stage of labour of a physiological birth

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

3.3 Cervical dilatation threshold and normal labour progression

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

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

- Intravenous fluid infusion
- Insertion of intravenous cannula

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

Practices for which there is insufficient evidence to support use:

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

4. Practice actions

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

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

	Actions

Progress in labour	• Descent of presenting part:
	  ○ Abdominally palpate and document descent of presenting part before vaginal examinations (VE).
	• Cervical dilatation:
	  ○ Once membranes have ruptured, VE should be minimised to avoid infection.
	  ○ Where possible the same practitioner should perform the VE at each assessment for consistency.
	  ○ The practitioner who performs the VE is to document as many details as possible of the VE findings on the back page of the partogram in the area prescribed.
	  ○ Plot cervical dilatation and descent of presenting part on the partogram**. Do not commence partogram until labour is established** (see Section 7: First stage).
	  ○ Discuss reasons for considering vaginal examination four-hourly or as clinically indicated.

Analgesia/medications/ other management	• Document all medications including Entonox® administered on CR3895 National Women's Partogram. • Document any other complementary therapies and non-pharmacological measures and their effectiveness or side effects in the clinical notes (if any). • Food should not be restricted and fluids should be encouraged in normal labour.
Environmental safety	• The labour and birthing environment should be optimal for supporting oxytocin release. • Caregivers should remain mindful of the safety and preparedness of the birthing environment. • All maternal and neonatal emergency equipment should be checked to be present and in good working order. • The room should be adequately warmed in anticipation of birth and clinical supplies should remain adequately stocked.

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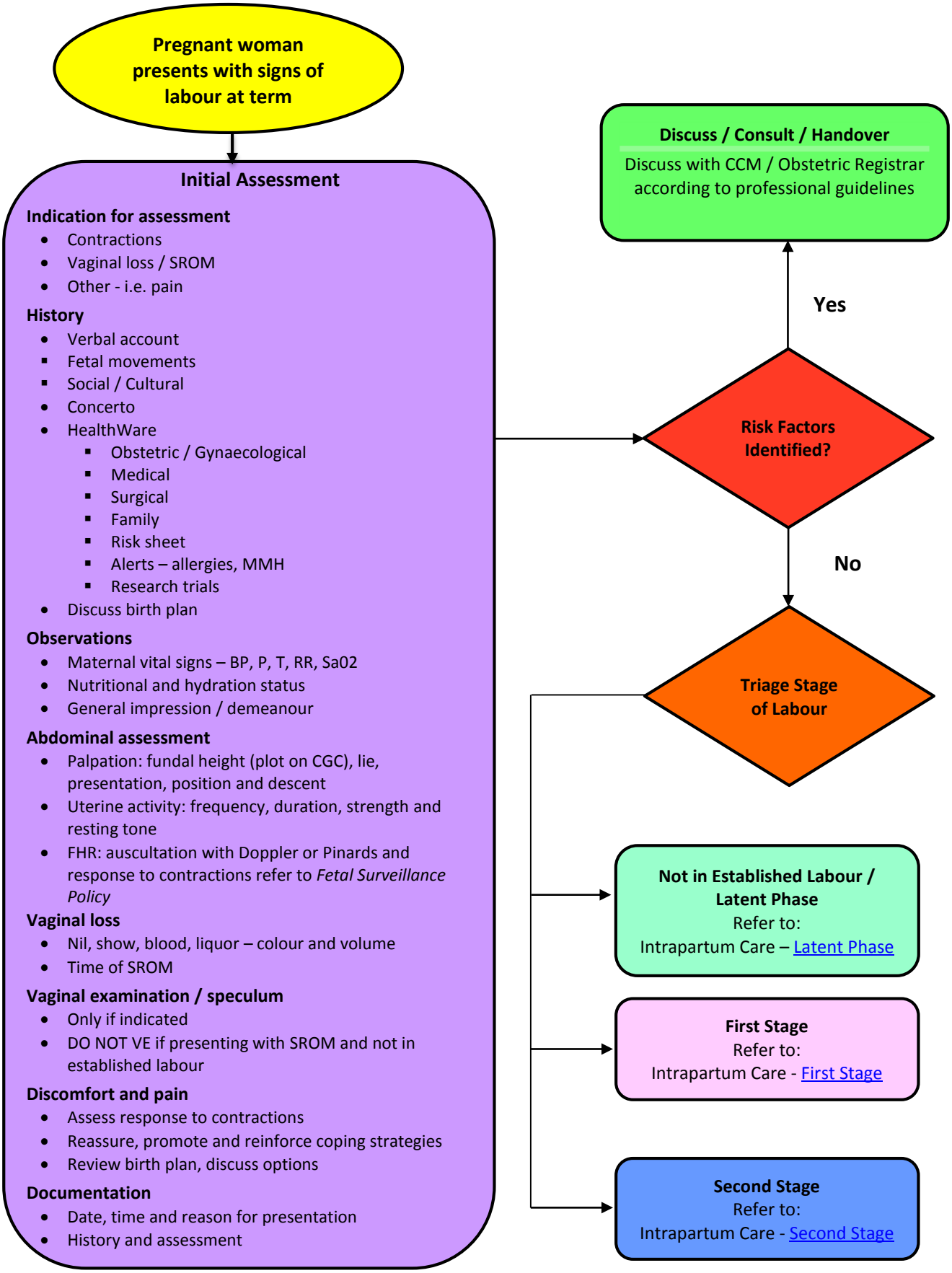
5. Initial assessment



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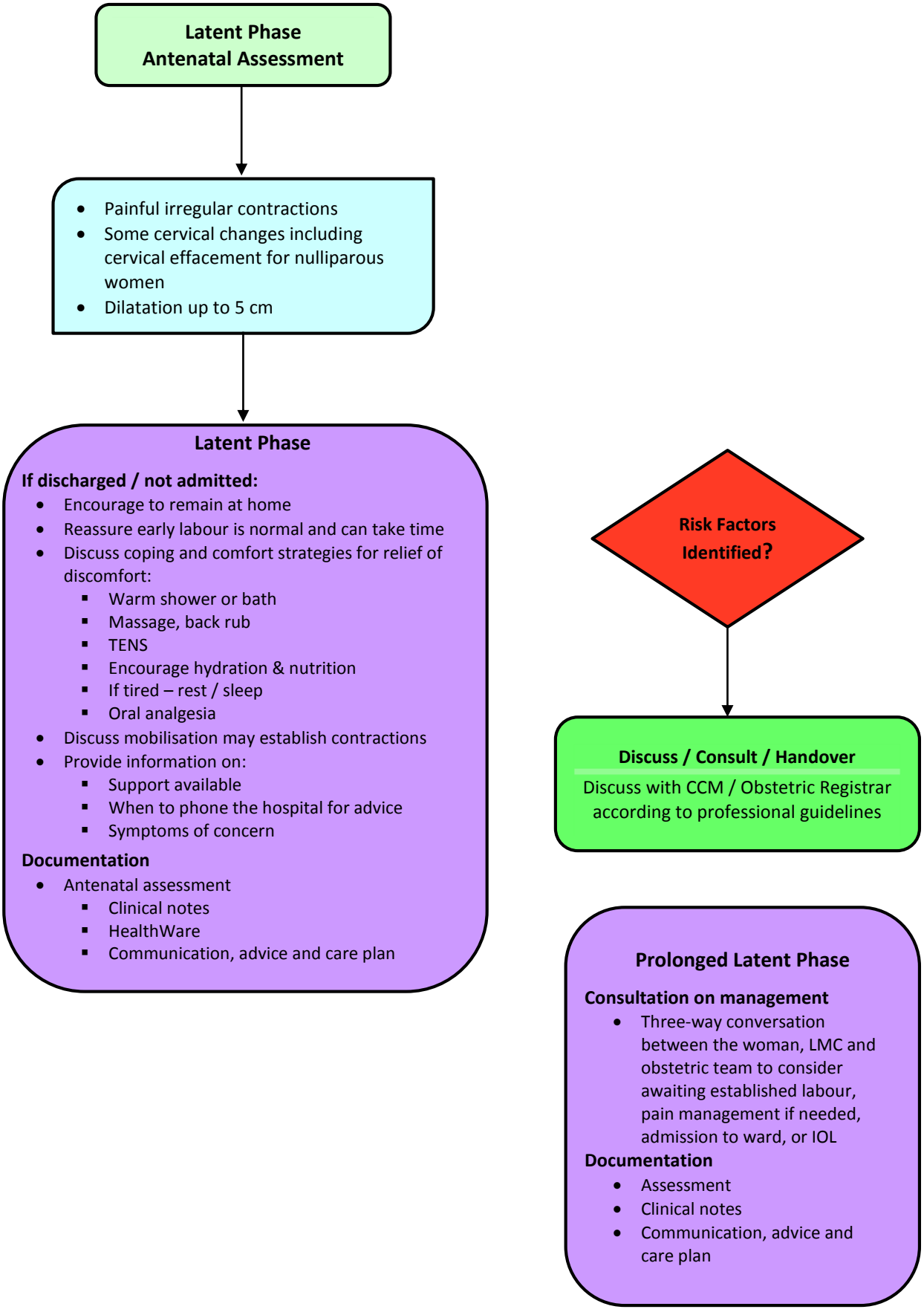
6. Latent phase



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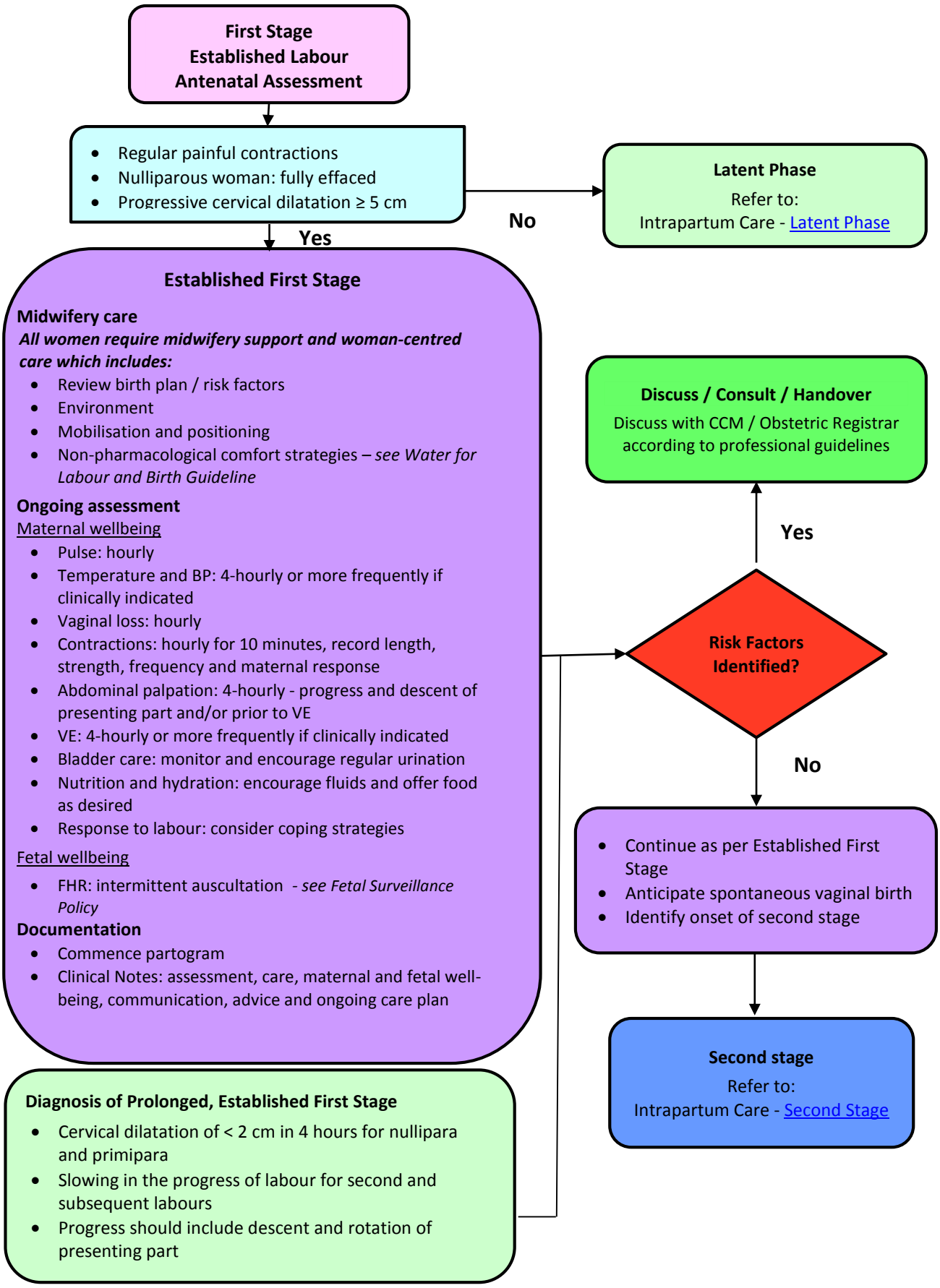
7. First stage



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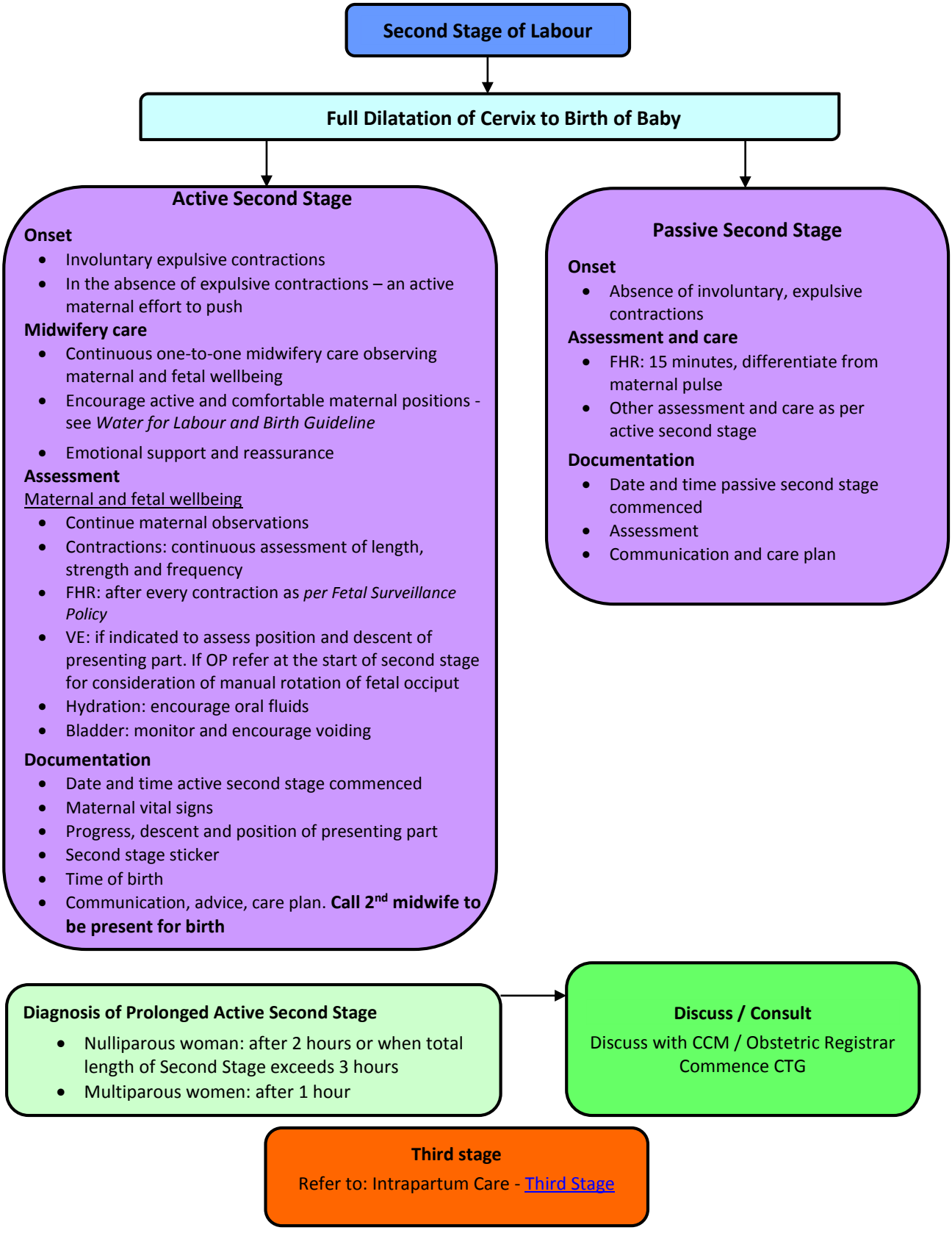
8. Second stage



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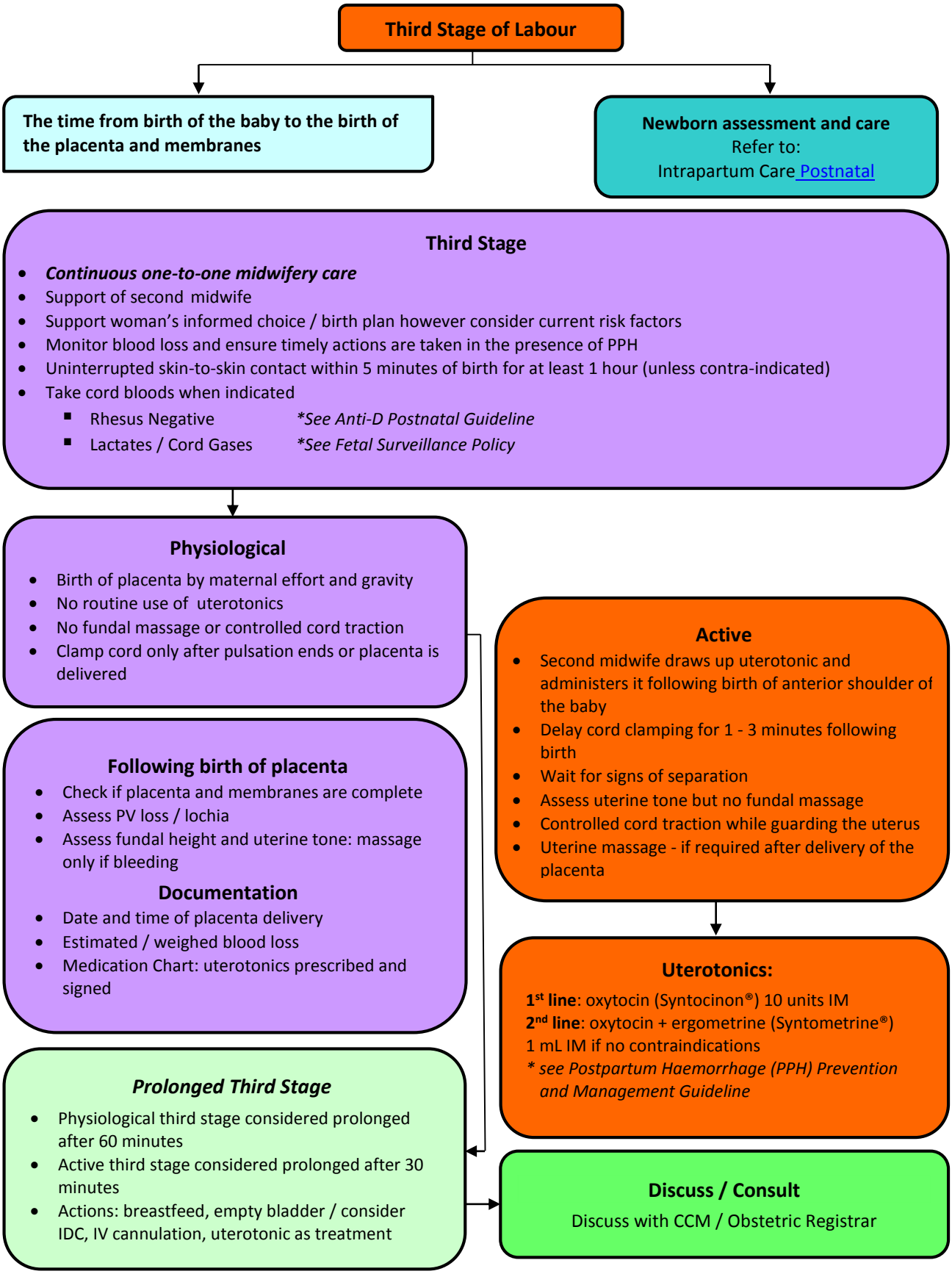
9. Third stage



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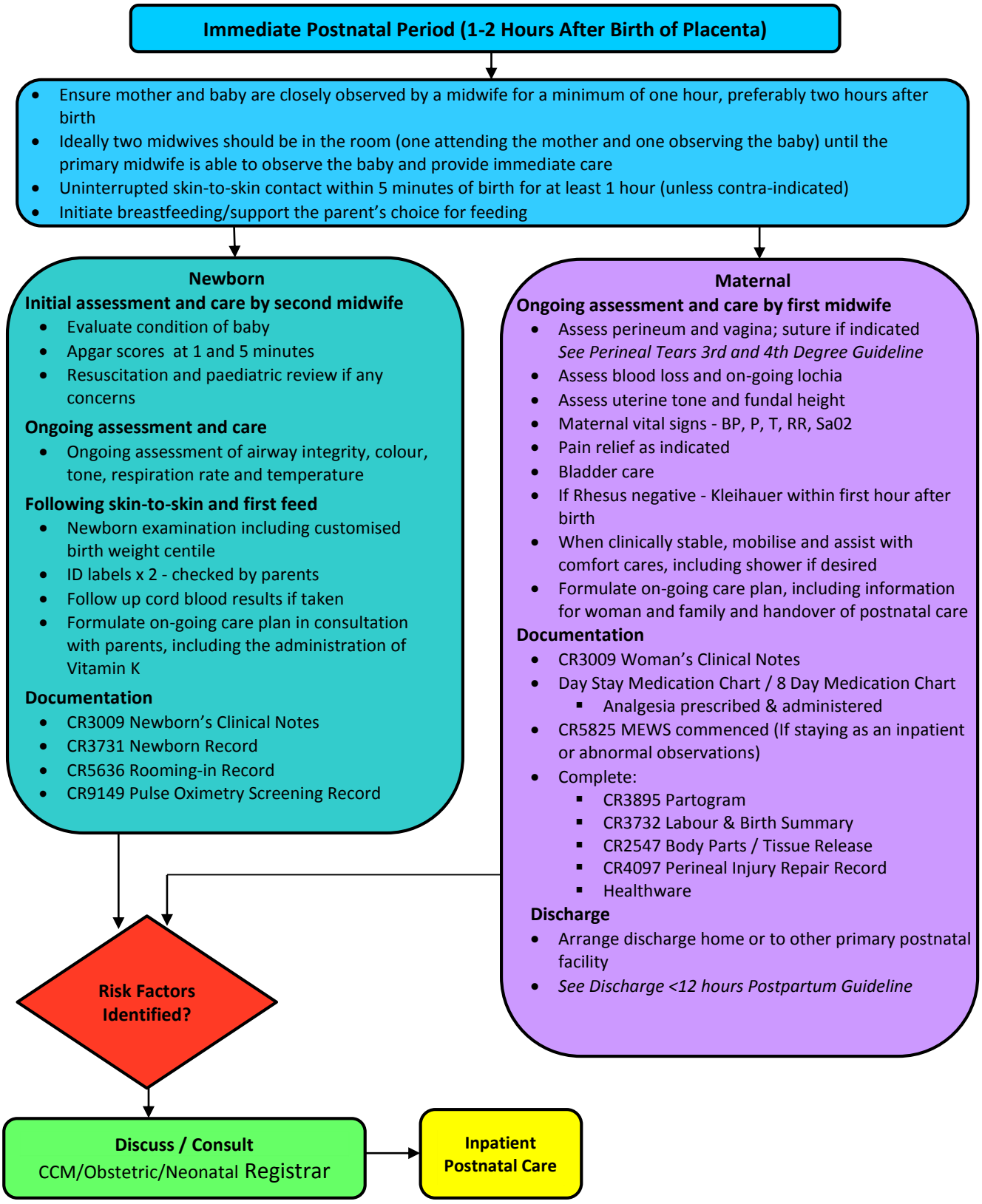
10. Immediate postnatal period



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12. Associated documents

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

Clinical forms

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

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

13. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

14. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or Document Control without delay.