NHS Borders Midwifery Led Care Guidelines for the low risk labouring woman

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Contents

Introduction

Midwifery care perceives labour as a normal physiological process characterised by a spontaneous onset between 37 and 42 weeks, in a woman whose pregnancy has been uncomplicated. It also recognises that, for the woman, labour is not 'just normal' but actually extraordinary: as a 'good' or 'bad' experience it has great implications for her psychological well-being and her relationships with her family (Wiklund et al. 2008; Lemola et al. 2007; Waldenstrom et al 2004; Simkin 1991).

One of the key principles of midwifery-led care is the right of pregnant women to be provided with good information and to be involved in decisions about their own care and that of their babies (Rogers 2002). Failure to pay attention to the quality of that information, and an over-optimistic view of interventions, can have serious consequences in terms of iatrogenic harm, unnecessary costs and increased dissatisfaction (Coulter 1998).

These practice points have been drawn from the Royal College of Midwives (RCM) Evidenced Based Midwifery Led Care Guidelines, issued November 2012. Full discussion of the research behind the practice recommendations is contained within these guidelines and they can be accessed using this link, www.rcm.org.uk/guidelines.

Practice Points -Birth Environment

Ensure that pregnant women receive high quality care throughout their pregnancy, have a normal childbirth wherever possible, are involved in decisions about what is best for them and their babies, and have choices about how and where they give birth (DH 2004).

Respect for a woman's wishes and her involvement in decision making is essential to her care in pregnancy and labour (NICE 2007; DH 2004). The birth plan should be discussed in full with the midwife looking after the woman in labour.

Hospital is an alienating environment for most women, in which institutionalised routines and lack of privacy can contribute to feelings of loss of control and disempowerment (Lock and Gibb 2003; Steele 1995). The studies by Green et al. (1990) and Simkin (1992) found that control, or lack of it, was important to the women's experience of labour and their subsequent emotional well-being.

Trials have demonstrated the benefits to women of having a low-risk, midwife-led area as an alternative to the conventional labour ward (Birthplace in England Collaborative Group 2011; Hodnett et al. 2010; Hatem et al. 2008; Byrne et al. 2000; Hodnett 2000; Waldenstrom 1997; Hundley et al. 1994; McVicar et al. 1993).

The non-labour ward or radically modified environment is associated with lower rates of analgesia, augmentation and operative delivery, as well as greater satisfaction with care and positive effect on care givers (Birthplace in England Collaborative Group 2011; Hodnett et al. 2010; Hodnett et al. 2009).

Midwives should be aware of the influence the physical environment has on their practice (Hodnett et al 2009).

Practice Points - Latent Phase

Women and their chosen birth companions should be offered good education about the latent phase antenatally. Antenatal preparation can increase women's likelihood of arriving in hospital in established labour (Maimburg et al. 2010).

Women's need for reassurance that what they are experiencing is normal is cited as a main reason for contacting the hospital in early labour (Carlsson et al. 2011; Eri et al. 2010; Barnett et al. 2008; Cheyne et al. 2007). Midwives should acknowledge their important role in providing this reassurance.

Labour wards may not be the appropriate environment for women in the latent phase (Bailit et al. 2005; Klein et al. 2004; Holmes et al. 2001; McNiven 1998).

Women value home assessment in the latent phase and this can reduce the number of visits to hospital (Spiby et al. 2008; Jansssen et al. 2006).

Midwives should allow time to enable women to 'tell their story' before offering advice (Eri et al. 2010; Spiby et al.2006).

The duration of the latent phase is particularly difficult to measure, as women experience the onset of labour in a variety of different ways (Gross et al. 2006; Albers 2001; Enkin et al. 2000).
A long latent phase can often be a discouraging and exhausting experience, and women need good consistent psychological support (Simkin and Ancheta 2000).

NICE (2007) recommend the following definitions of stages of labour:
Latent phase:
• A period of time, not necessarily continuous, when there are painful contractions; and there is some cervical change, including cervical effacement and dilatation up to 4cm.
Active phase:
• There are regular painful contractions; and there is progressive cervical dilatation from 4cm.

Practice Points - Supporting women in labour

Studies have suggested four dimensions to the support that women want in labour: emotional support; informational support; physical support and advocacy (Hodnett et al. 2011; MIDIRS 2008; NICE 2007).

All women should receive one to one midwifery support in established labour (DH 2007; NICE 2007; RCOG 2007).

A woman in established labour should not be left on her own except for short periods or at the woman's request (NICE 2007).

Evidence indicates that continuous support during labour has a number of measurable positive impacts on key birth outcomes when compared to intermittent support (Hodnett 2011; Scott et al.1999; Zhang et al. 1996).

Continuous support is associated with less use of pharmacological analgesia, fewer operative births and fewer reports of dissatisfaction with birth (Hodnett 2011).

Support from the midwife may include helping the woman in her wish to avoid pharmacological pain relief or helping her choose among pharmacological and non-pharmacological methods of pain relief (Enkin et al. 2000).

The quality of the support may outweigh many other aspects of the birth experience when women describe their satisfaction with their birth, including the number of medical interventions, pain relief and the type of birth (Larkin and Begley 2009; Hauck et al. 2007; Commission for Healthcare Audit and Inspection 2007; Bowers 2002; Waldenstrom et al. 1996).

Poor support and communication during labour and birth is associated with a higher rate of postnatal mental health problems including postnatal depression and post traumatic stress disorder (Lemola et al. 2007; Creedy et al. 2000; Czarnocka and Slade 2000).

Midwives should support women in use of coping strategies (breathing, relaxation and positions) in labour as use is associated with benefits in terms of pain and women's emotional experiences of labour (Spiby et al. 2003; Spiby et al. 1999).

Midwives should keep up to date with non-pharmacological methods of pain relief. These include water, positions and movement, massage, coping strategies and alternative therapies (Simkin and Bolding 2004; Mander 1998).

Practice Points - Supporting and Involving women's birth companions

For many women, the companion that they bring with them in labour may be the only truly familiar person available to them (Odent 1999).

Women should be encouraged to have support by birth partners of their choice (MIDIRS 2008; NICE 2007).

The majority of women in the UK are accompanied in labour by their partners (Singh and Newburn 2000; Somers-Smith 1999); however, this should not be assumed.

Interventions to support partners should include ensuring that they are involved in discussions about birth options and involving them in practical support tasks, as well as discussing their expectations (Hildingsson et al. 2010; Backsttrom and Wahn 2009; Wockel et al 2007; Beardshaw 2001).

Separate educational sessions could help men feel more confident in their role and enable them to provide better support (Wockel et al. 2007).

It has been reported that partners want information on coping strategies for women in labour, alternative forms of pain relief and what to expect in labour and moving around in labour (Singh and Newburn 2000).

Partners need support for their role as coach, particularly when labouring women are experiencing pain (Chandler and Field 1997).

Birth companions need acknowledgement and facilitation of their role (Spiby et al. 1999).

Even if a woman in labour is accompanied by her partner, she may benefit from the continuous presence of a second support person of her choice (MIDIRS 2008).

Practice Points – Understanding pharmacological pain relief

Midwives need to be aware of the possibility of underestimating the intensity of pain experienced by women in labour and/or of overestimating the relief offered by analgesic drugs (Baker et al. 2001; Niven 1994; Rajan 1993).

Pharmacological methods of pain relief all have side effects (NMC 2010; NICE 2007; Enkin et al. 2000). If women have not had access to good information antenatally, the midwife must take responsbility for offering it in labour (NMC 2010).

Women should be informed that pethidine, diamorphine and other opioids will provide limited pain relief during labour and may have significant side effects for herself

(drowsiness, nausea and vomiting), and her baby (short term respiratory depression and drowsiness) (Ullman et al. 2010 ; NICE 2007).

Nitrous oxide (Entonox) seems to relieve some pain but can make women feel nauseous and light headed. There is no evidence of harm to the baby (Talebi et al. 2009; NICE 2007).

Epidural analgesia is a commonly-used method of pain relief in labour in the UK. For many women it is the most effective, though for some women total relief from pain is not achieved (MIDIRS 2008). There are, however, a number of possible unwanted consequences and side-effects (Anin-Somuah et al. 2011; O'Hana et al. 2008; Tracy et al. 2007; NICE 2007; Lieberman and O'Donoghue 2002; Leighton and Halpern 2002; Thorp and Breedlove 1996). Women should be counselled about these risks before labour begins. Epidural analgesia is associated with a longer second stage of labour, an increased incidence of fetal malposition, an increased use of oxytocin and instrumental delivery (Anin-Somuah et al. 2011; O'Hana et al. 2008; Tracy et al. 2007; Leiberman et al. 2005). Other associated risks are intrapartum fever and retention of urine (Anin-Somuah et al. 2011; Lieberman et al 2000).

Practice Points – Assessing progress in labour

Monitoring the progress of labour requires more than the assessment of cervical changes and fetal descent (Enkin et al. 2000). Midwives should give weight to their other skills, such as abdominal palpation and a knowledge of women's changing behaviour (Gross et al. 2003; Burvill 2002; Stuart 2000; Baker and Kenner 1993; McKay and Roberts 1990).

Midwives must give consideration to the emotional and psychosexual aspects of any procedure (Devane 1996). Many women find vaginal examinations painful and distressing (Lewin et al. 2005; Menage 1996).

Vaginal examinations are only one method of measuring progress in labour. These examinations should be carried out only after discussion with the woman, when the practitioner can justify that she believes the findings will add important information to the decision-making process (NICE 2007).

Vaginal examinations are an imprecise measure of the progress of labour when performed by different examiners (Buchmann and Libhaber 2007; Clement 1994; Robson 1991; Tufnell et al. 1989). Where possible, therefore, they should be carried out by the same midwife.

There is no research-based information on which to make recommendations for the timing and frequency of vaginal examinations.

When vaginal examinations are used, there are six ways to determine progress in labour (Simkin and Ancheta 2000):

- the cervix moves from a posterior to an anterior position;

- the cervix ripens or softens;

- the cervix effaces;

- the cervix dilates;

- the fetal head rotates, flexes and moulds;

- the fetus descends.

NICE (2007) recommends that progress in the first stage of labour should include:

- cervical dilatation of 2 cm in 4 hours;

- descent and rotation of the fetal head;

- changes in strength, duration and frequency of contractions.

Practice Points – Rupturing membranes

Amniotomy is not part of normal physiological labour (Andrees and Rankin 2007; RCM 1997). It should be reserved for women with abnormal labour progress (NICE 2007).

The intervention can cause an increase in pain which makes labour unmanageable (Fraser 1993; NCT 1989; Inch 1985). Any intervention that interferes with a woman's ability to cope in labour can have long-term implications for her own well-being and her relationship with her baby (Robson and Kumar 1980; Oakley 1979).

Amniotomy is not an effective method of shortening spontaneous labour and increases the risk of caesarian section and more fetal heart abnormalities (Smyth et al. 2007).

When there is concern that labour is slowing down, benign measures to intensify contractions such as positional changes and movement may prevent the need for more invasive interventions (Simkin 2010).

The decision to rupture membranes should only be taken in direct consultation with the woman, when the evidence is discussed and the effect of the intervention is not minimised. This discussion should form part of the birth plan, and not take place just before or during a vaginal examination.

Practice Points – Positions for labour and birth

There are significant advantages to assuming an upright position in labour and birth (Lawrence et al. 2009; MIDIRS 2008). However, lying down continues to be the most frequently used position (RCM 2010).

Women often "choose" to do what is expected of them, and the most common image of the labouring woman is "on the bed". Midwives therefore need to be proactive in demonstrating and encouraging different positions in labour (RCM 2010).
The environment is key to freedom of movement. There should be a variety of furniture and props available in the room that encourages women to try different positions (Albers 2007).

The use of electronic fetal monitoring, intravenous infusions and different methods of analgesia may affect a woman's mobility and use of postural change during labour (Spiby et al. 2003). Midwives should support women with suggestions on how to remain upright in these situations (RCM 2011).

Use of postural coping strategies during the first stage of labour is associated with providing some pain relief and helping a woman to cope with pain (Simkin and Bolding 2004; Spiby et al. 2003).

Use of upright positions for the second stage of labour confers several benefits including a shorter second stage, fewer instrumental births and fewer episiotomies, although estimated blood loss is greater (De Jonge et al. 2004; Gupta et al. 2004).

Use of the lateral position for birth appears to protect the perineum (Shorten et al. 2002) whereas squatting using a birthing chair has been reported as a predisposing factor for third and fourth degree tears (Jander and Lyrenas 2001).

Women should be encouraged and helped to move and adopt whatever positions they find most comfortable throughout labour (NICE 2007).

Practice Points - Persistent lateral and posterior fetal positions at the onset of labour

Some women will begin their labour with their baby in an occipito-posterior or occipito-lateral position (Simkin 2010). Internal rotation to anterior positions can be expected in the majority of cases. Midwives should discuss this with women at late pregnancy and in early labour to ensure they understand what may happen and the activities that may help. Midwives should have a sound knowledge of the mechanism of labour when the baby is in this position and use positive actions to support women through this type of labour.

Women should be encouraged to adopt postures of comfort, to remain mobile if they wish, and should be supported in using coping methods to deal with their particular pattern of labour (Simkin 2010). Midwives should also be alert to the potential for

women to experience anxiety if interventions are followed and rotation does not occur (Walmsley 2000).

There is no current evidence of effectiveness of women adopting hands and knees positions with the aim of rotating a baby in a posterior position during late pregnancy or during labour (Hunter et al. 2007). The use of this strategy during labour is associated with a reduction in persistent back pain (Stremler et al 2005). Women should be encouraged to use this position for comfort in labour. Midwifery care should be supportive, encouraging and provide continuity where possible.

Practice Points - Nutrition in labour

While there are no risk factors suggesting the need for general anaesthesia, women should be free to eat and drink in labour or not, as they wish (Singata et al. 2010).

Eating and drinking allows a woman to feel normal and healthy. Denial of food can be seen as authoritarian, intimidating, and increase feelings of apprehension (Singata et al. 2010; Frye 1994; Simkin 1986).
There is insufficient evidence to support the practice of starving women in labour in order to lessen the risk of gastric acid aspiration (Singata et al. 2010; ACNM 2008; NICE 2007; Baker 1996; Johnson et al.1989).Fasting may result in dehydration and acidosis, which combined with fatigue can increase the likelilhood of augmentation, instrumental delivery and postpartum blood loss (Broach and Newton 1988; Foulkes and Dumoulin 1985).

Mild maternal ketosis is a physiological part of normal labour and might even be beneficial (Toohill et al. 2008; Sommer et al. 2000; Anderson 1998; Keppler 1988).

Narcotics appear to be the major factor in delaying stomach emptying. If these are used, then women should stop eating, and drinking be reduced to sips of water (NICE 2007; Holdsworth 1978; Nimmo et al. 1975).

The desire to eat would appear to be most common in early labour (Singata et al. 2010). As women do not usually wish to eat in active labour, it is inappropriate to be encouraging them to do so against their natural instincts (Odent 1994).

Non fizzy isotonic drinks can increase a woman's energy levels by providing a relatively small calorific intake. They maybe more beneficial than water (NICE 2007).

Practice Points - Second stage of labour

NICE (2007) suggest the following definitions of the second stage of labour

Passive second stage:

- the finding of full dilatation of the cervix prior to or in the absence of involuntary expulsive contractions

Onset of active second stage:

- the baby is visible

- expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation.

The mother can exhibit many signals indicating the transition into the active phase of the second stage of labour: change in facial expressions, words, and actions (Enkin et al. 2000; Bergstrom et al. 1992; McKay et al. 1990). However, if the progress of labour gives reason to believe that the cervix is not fully dilated, a vaginal examination should be carried out (Enkin et al. 2000).

Limited quality of evidence makes it difficult to assess the significance of a prolonged second stage (NICE 2007; Altman and Lydon-Rochelle 2006).

NICE (2007) recommend that a diagnosis of delay in the active second stage should be made for nulliparous women when it has lasted 2 hours, and for parous women when it has lasted 1 hour.

There is little ground for intervention while maternal and fetal conditions are satisfactory and there is clear progress with the descent of the presenting part (Janni et al. 2002; Menticoglou et al. 1995; Watson 1994; Paterson et al. 1992).

There is no evidence to suggest that women need to be taught when and how to push (NICE 2007; Bloom et al. 2005; Sleep 1990). The practice of sustained breath holding in directed pushing may be harmful (Prins et al. 2011; Cooke 2010; Yildirim and Beji 2008; Thomson 1993). Women should be given confidence in following their own urge to push.

A “no noise”’ rule is unacceptable: “a woman’s sounds in labour should be expected, supported and explained” (McKay and Roberts 1990).

Use of upright positions for the second stage of labour confers several benefits including a shorter second stage, fewer instrumental births, fewer episiotomies, although estimated blood loss is greater (De Jonge et al. 2004; Gupta et al. 2004).

Women should be encouraged to combine spontaneous pushing with upright postures and helped to adopt whatever positions they find most comfortable throughout labour (NICE 2007).

Practice Points - Third stage of labour

Midwives should be competent in both active management and physiological management.
Active management involves giving a prophylactic uterotonic, cord clamping and controlled cord traction (Begley et al. 2011).

Physiological management involves no administration of a prophylactic uterotonic, no clamping and cutting the cord until the placenta is delivered and promoting the use of gravity to assist delivery of the placenta in a timely manner with maternal effort (Begley et al. 2011).

Skin to skin contact and early breast feeding may facilitate the delivery of the placenta (Begley et al. 2011; Marin et al. 2010; Fahy et al. 2009; Mercer et al. 2007).

Reducing the duration of the third stage through proactively encouraging women to adopt an upright position shortly after birth may assist in reducing blood loss without the necessity of resorting to uterotonics and cord traction (Cohain 2010; Hastie and Fahy 2009).

Delayed cord clamping is currently the recommended practice known to benefit the neonate in improving iron status up to six months but with a possible risk of jaundice that requires phototherapy (Resuscitation Council 2010; McDonald and Middleton 2009; WHO 2007; Mercer et al. 2007).
'Benefits and harms' of both physiological and active management of third stage of labour have been identified (Begley et al. 2011) and midwives need to be aware of these when discussing management choice with women and applying clinical decision making.

When physiological management is offered to women as a reasonable option, many will choose it (Rogers and Wood 1999). Physiological management can be seen as the logical ending to a normal physiological labour (Soltani 2008; RCM 1997).

Women at low risk of postpartum haemorrhage who request physiological management of the third stage should be supported in their choice (NICE 2007).

If physiological management is attempted but intervention is subsequently required, then management must proceed actively. If the placenta is retained after one hour, active management should be considered (NICE 2007; Prendeville et al 1988).

Practice Points - Care of the perineum

Antenatal perineal massage carried out by the mother or her partner in the third trimester is an effective approach to reduce perineal trauma among women who have not had a previous vaginal birth (Beckmann and Garrett 2006).

Women should be offered the application of warm compresses in the second stage of labour as this may reduce perineal trauma and the intervention is acceptable to both women and midwives (Aasheim et al. 2011).
Studies are inconclusive on using guidance or flexion of the presenting part with the aim of reducing perineal trauma (Aasheim et al. 2011; Pirhonen et al 1998; Myrfield 1997). NICE (2007) recommend that either the 'hands on' or the 'hands poised' technique can be used to facilitate spontaneous birth.

There is no evidence of short-term or long-term maternal benefit to support the use of routine episiotomy (Carroli and Mignini 2009). Episiotomy has been associated with increased risk of severe perineal trauma (Dudding et al. 2008; Eason et al. 2000; Renfrew et al. 1998; Albers et al 1999).

Practice Points - Suturing the perineum

Midwives should be aware that suturing is a major and sometimes traumatic event for women (Green et al. 1998). The most common complaint being about the delay in waiting to be sutured that causes anxiety as well as physical discomfort.
Before assessing for genital trauma, healthcare professionals should:

• explain to the woman what they plan to do and why

• offer inhalational analgesia

• ensure good lighting

• position the woman so that she is comfortable and so that the genital structures can be seen clearly. (NICE 2007)

The timing of the systematic assessment should not interfere with mother–infant bonding unless the woman has bleeding that requires urgent attention (NICE 2007).

The assessment and its results should be fully documented, possibly pictorially (NICE 2007).

The amount of pain experienced during perineal suturing is considerable amongst women who have not received regional analgesia (Sanders et al. 2002).

Absorbable synthetic suture material is associated with less perineal pain and less wound breakdown compared to non absorbable material. However, more women with standard synthetic sutures required removal of suture material (Kettle et al. 2010).

The continuous suturing technique when compared to interrupted sutures is associated with less short term pain (Kettle et al. 2007).

There is limited evidence comparing non-suturing to suturing of perineal tears sustained during childbirth regarding perineal pain and wound healing (Elharmeel et al. 2011;

Lundquist et al. 2000; Fleming et al. 2003). Practitioners must be cautious about leaving trauma unsutured unless it is the explicit wish of the woman.

NSAID rectal suppositories are associated with less pain up to 24 hours after birth, and less additional analgesia (Hedayati et al. 2003).

Women have reported a preference for using a specially designed cooling gel pad for pain relief, when compared with ice packs or no treatment. (East et al 2007; Steen and Marchant 2007).

Midwives should discuss with women the importance of good personal hygiene necessary to avoid genital tract infection (CMACE 2011).

Practice Points - Immediate care of the newborn

Kindness and respect of the newborn baby should involve gentle handling and avoidance of excessive noise (Carbajal 2003, Tyson 1992).

Babies can lose heat quite dramatically after birth (Resuscitation Council 2011, Enkin et al. 2000). They should be placed in contact with the mother's skin and dried with pre-warmed towels (Moore et al. 2009, Christensson et al. 1992).

Routine suctioning of the newborn's oral and nasal passages is not recommended as the baby is capable of clearing fairly large amounts of lung fluid (Resuscitation Council UK 2011).

Early mother-baby contact should be encouraged (Moore et al. 2009; Enkin et al. 2000). Such close contact is known to have positive effects on the initiation and duration of breastfeeding (Bramson et al. 2010; Moore et al. 2009; Colson et al. 2008; Anderson et al. 2004; Perez-Escamilla et al. 1994).

Routine labour ward practice should not be allowed to interfere with the interaction between the mother and her baby and the initiation of breastfeeding (NICE 2007).

A holistic and detailed physical examination should be undertaken within 72 hours after the initial examination immediately after birth (RCM 2009). The national standards and competencies for physical examination of the newborn screening address four areas of the examination: eyes, testes, hips and heart (UK NSC 2008).

Any assessment or examination at birth or later should be seen as an opportunity for parental education and health promotion (DH 2009; RCM 2009; NICE 2006; NHS Quality Improvement Scotland 2004).

Administration of Vitamin K requires informed consent, as well as explanation and education regarding Vitamin K deficiency bleeding and its signs and symptoms (NICE 2006; MIDIRS 2008).

Practice Points - Early breastfeeding

Practices that support the initiation of breastfeeding include antenatal group discussion, the availability of peer support, and maternity routines that keep mothers and babies together (Bramson et al. 2010; Dyson et al. 2006; Fairbank et al. 2000).

There is no critical period during which the first breastfeed should occur as long as mothers and babies have unrestricted contact in a relaxed atmosphere; the pace and timing of the first feed should be left to them (Colson et al. 2008, Britton et al. 2007; Colson 2007; Moore et al. 2007; Dyson et al. 2006).

Skin-to-skin contact positively impacts on the first breastfeed and on maternal and newborn physiological and behavioural outcomes and there is no evidence of harm (Bramson et al. 2010; Moore et al. 2007). The mother should be ensured opportunities for early skin-to-skin contact.
Routines in practice should not interfere with the opportunity for a mother and baby to be together (DH 2009; Britton et al. 2007; NICE 2006; Olsen 2000).

Mothers should have access to support for their baby's first breastfeed (Dyson et al. 2006; Renfrew et al. 2000).

Mothers should be helped to achieve a comfortable position for themselves and with attaching the baby so that feeding does not hurt (RCM 2002).
Pharmacological analgesia in labour, including those used in epidural administration should be considered carefully in the light of potential effects on the baby and on feeding (Jordan et al 2005; Radzyminki 2005; Renfrew et al 2000).

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