LABOUR MANAGEMENT

### DEFINITION

<table>
<thead>
<tr>
<th>Latent phase</th>
<th>Period of time, not necessarily continuous, where there are painful contractions and some cervical change up to 4 cm dilatation – see Latent phase of labour guideline</th>
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<tbody>
<tr>
<td>First stage</td>
<td>Regular painful uterine contractions and progressive cervical dilatation from 4 cm (NICE 2007)</td>
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</table>
| Second stage
  - Passive  
    - Full dilatation of cervix before or in the absence of expulsive contractions  
  - Active  
    - Expulsive contractions with full dilatation of cervical os  
    - Presenting part of baby visible or active maternal effort in the absence of expulsive contractions |
| Third stage | Time of birth of baby to expulsion of placenta and membranes – see Third stage of labour guideline |

### INITIAL ASSESSMENT OF LABOUR

- Advise woman to telephone nearest labour ward for advice if she is concerned
- If homebirth planned, community midwife will attend
- If in-patient birth planned, advise woman to attend the unit for assessment if:
  - contraction pattern suggesting established labour
  - history suggestive of rupture of membranes
  - woman was advised during antenatal period to present early in labour

### ON ADMISSION

- If possible, review clinical records before admission
- Take history
- Assess emotional and physical needs
- See Clinical risk assessment guideline

#### Examination

- Abdominal palpation
- fundal height in centimetres
- lie
- presentation and position
- engagement
- Urinalysis
- Vaginal loss:
  - liquor colour (e.g. clear or meconium)
  - show
  - blood loss and amount

#### Vaginal assessment

- If in established labour, offer vaginal assessment
- explain reason and what is involved
- obtain verbal consent

#### Fetal wellbeing

- Auscultate fetal heart rate (FHR) for a minimum of one full minute immediately after a contraction
- Palpate maternal pulse rate to differentiate between maternal and FHR
- If there is a clinical indication, perform, electronic fetal monitoring (EFM)
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- Once labour diagnosed, complete intrapartum risk assessment and devise individualised management plan

Observations
- BP – 4-hrly
- Temperature – 4-hrly
- Maternal pulse – hourly
- 30-min measurement of contractions
- Frequency of bladder emptying
- Complete partogram when in established labour

Pain assessment
- Discuss pain relief options, including woman’s choice for coping

Communication and documentation
- Document findings of vaginal assessment
- Discuss findings, birth plan and analgesia with woman and her partner

FIRST STAGE OF LABOUR

**Carry out continual risk assessment to see if transfer to high-risk labour care necessary**

Observations and assessment during first stage
- As a minimum, perform and document the following on partogram at frequencies indicated, unless other clinical reasons to document more frequently:
  - temperature – 4-hrly
  - blood pressure – 4-hrly
  - maternal pulse – hourly
  - abdominal palpation followed by vaginal assessment – 4-hrly
  - frequency of contractions
  - frequency of bladder emptying (test and measure amount voided)
  - If not EFM, auscultate fetal heart rate for at least one full minute every 15 min following a contraction
  - If FHR abnormality suspected, palpate maternal pulse to differentiate – see Electronic fetal monitoring guideline
  - Complete partogram

Woman’s comfort
- Midwife must also consider:
  - regular assessment of woman’s emotional and physical state and pain relief
  - ongoing discussion regarding pain relief

Diet and fluids
- Throughout first stage of established labour offer a light, easily digestible diet and encourage fluid intake
- If clinical evidence of dehydration, give IV fluids, either 1 L sodium chloride 0.9% or compound sodium lactate (Hartmann’s) solution IV (according to local practice)
- High-risk women – clear fluid only

H2 receptor antagonists (antacids)
- Low risk women – not routinely offered
- High risk women – offer ranitidine150 mg oral 6-hrly (if oral inappropriate, 50 mg IM 6-hrly)

Position and mobility
- An upright position during labour facilitates efficient uterine contractions, shortens latent phase and reduces need for analgesia
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- Encourage mobilisation
- Allow woman to adopt a position she is comfortable with

**Delay in first stage of labour**
- See Delay in labour guideline

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**SECOND STAGE OF LABOUR**

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<tr>
<th>Risk to mother and fetus increases during second stage of labour</th>
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**Presumptive diagnosis of second stage**
- Overwhelming urge to push
- Presenting part becomes visible
- Patient wants to empty bowels and has heavy mucoid show

**Definitive diagnosis**
- Full dilatation of cervix on vaginal examination

**Maternal observations**
- Monitor and record on partogram:
  - temperature – 4-hrly (unless clinical indications for more frequently)
  - blood pressure – hourly (unless other indications e.g. medical reasons, epidural in situ)
  - pulse – hourly (rising pulse rate can signify maternal complication)
  - vaginal assessment hourly in active second stage (after abdominal assessment and assessment of vaginal loss)
  - frequency and length of contractions – 30 min intervals
  - Encourage woman to void bladder – test each void for ketones and protein
  - Document fluids given

**Fetal observations**

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- Unless continuous fetal monitoring, intermittent auscultation of FHR after each contraction for at least one full minute every 5 min
- if fetal bradycardia suspected, palpate maternal pulse rate
- record FHR on partogram (even if using continuous monitoring)
- Note colour of any liquor draining
- Palpate fetal position and abdominal descent of fetal pole
- Document all findings

**Care and positioning during second stage**
- Provide emotional and psychological support
- Respect woman’s choice of position but discourage from lying supine or semi-supine

**Delay in second stage/fetal distress**
- If delay in second stage suspected, see Delay in labour guideline

**Preparation for delivery**
- Prepare environment and equipment

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**THIRD STAGE LABOUR**

- See Third stage of labour guideline