

Guideline for the Management of Intrapartum Care

Document Type:	Clinical Guidelines
Ref:	MM202
Author:	Bryany Tweedale, Dawn Apsee, Fran Hodge
Executive Sponsor:	Choose an item.
Approved By:	Choose an item.
Approval / Effective Date:	March 2025
Review Date:	March 2028
Version:	2

Target Audience:

People who need to know about this document in detail	All Midwifery and obstetric staff working within CTM UHB
People who need to have a broad understanding of this document	As above
People who need to know that this document exists	As above

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: December 2024 Outcome: No negative impact
Welsh Language Standard	Choose an item.
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.



Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Guidelines Definition

Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Minor Amendments

If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

Type of change	Why change made	Page number	Date of change	Version 1 to 1.1	Name of responsible person
New Guideline for CTMUHB	Amalgamation of POW into CTMUHB	All	20/3/2020	1	Mohamed Elnasharty
Update / revise as out of date	Updating required in line with NICE guidance		December 2024	2	Dawn Apsee, Bryany Tweedale and Fran Hodge

Contents

Guidelines Definition	2
Minor Amendments	2
1. Introduction	1
General principles	1
Communication.....	2
2. Women following a midwifery-led care pathway	2
3. Women with medical or obstetric conditions following a consultant-led pathway	2
4. Admission of Women in Labour	3
5. Fetal Heart Rate Monitoring in Labour	4
6. Spontaneous Rupture of Membranes	4
7. Pre-Labour Rupture of Membranes	4
8. Controlling gastric acidity	4
9. Eating and drinking	4
10. Vaginal Examination	4
11. Intrapartum Care of the Bladder during labour and birth	5
12. Presence of meconium	6
13. Water immersion during labour and birth	6
14. Pain relief during labour	6
Non-pharmacological pain-relieving strategies	7
Inhalational analgesia.....	7
Pharmacological analgesia.....	8
Regional analgesia	8
Care and observations for women with regional analgesia	8
15. First stage of Labour.....	9
Definitions of the latent and established first stages of labour.....	9
Ongoing assessment of women in the first stage of labour	9
Duration of the first stage	11
Delay in the first stage	11
16. Second stage of labour	13
Assessment of women during the second stage of labour	14
The woman's position and pushing in the second stage.....	14
Duration of the active second stage and definition of delay	15
Delay in the second stage	17
17. Expediting birth	17
Birth with forceps or ventouse in delayed second stage	18
18. Intrapartum interventions to reduce perineal trauma	18
19. Third stage of labour	19
Definition of the third stage.....	19
Observations in the third stage	20
Management of the third stage	20

20.	Retained placenta	22
21.	Postpartum Haemorrhage	22
22.	Care of the newborn baby	22
	Initial assessment of the newborn baby and mother–baby bonding	22
23.	Neonatal Resuscitation.....	24
24.	Care of the woman after birth.....	24
	Initial assessment	24
25.	Perineal Care.....	244
26.	References	244
27.	Appendix 1	25

1. Introduction

This guideline has been developed to support clinicians in the provision of optimal care to women and their babies in the management of intrapartum care and will replace any previous health board versions.

The guideline supports clinicians in supporting women to make an informed choice about their place of birth, fetal heart rate monitoring during labour and management of the third stage of labour.

General principles

All women should be given information about their birth options during the antenatal period by their community midwife, with the opportunity to complete a birth plan at 36 weeks of pregnancy

Within CTMUHB, there is the availability of all four places of birth; including:

- Home
- Tirion Freestanding Midwife-led Unit (FMU)
- Tair Afon Alongside Midwife-led Unit (AMU)(Prince Charles Hospital)/ Daffodil Suite Alongside Midwife-led room (Princess of Wales Hospital)
- Labour Ward (Princess of Wales Hospital)
- Labour Ward (Prince Charles Hospital)

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

- Encourage the woman to ask questions
- Ensure time is given for her to think about the options
- Help her make a supported decision

Obtain consent before carrying out the chosen care option or intervention.

All staff should ensure that all birth settings have a culture of respect for each woman as individual undergoing a significant and emotionally intense life experience, so that the woman is in control, is listened to, her choices are supported and she is cared for with respect, kindness and compassion.

All women should receive continuous one-to-one care during established labour.

Women in established labour should not be left on their own except for short periods of time, or at their request. Knock and wait before entering a woman's room; respecting it as her personal space, and ask others to do the same.

Communication

When giving a woman and her birth companion/s information about care during labour:

- Use clear, plain language and confirm with the woman that they have understood the information
- Tailor the content and delivery of information to the needs and preferences of the woman
- If the woman has a written birth plan; read and discuss it with her.
- Ensure that the woman is empowered to make a supported decision with her healthcare team, which may include:
 - Reliable interpreting services where needed
 - Using interpreting services that are independent of the woman (not a family member or friend)
 - Using culturally sensitive language and adapting communication when necessary

2. Women following a midwifery-led care pathway

- Appendix 2, Pathway C of the All Wales Midwife Led Guideline identifies those women who would be appropriate to follow a midwife-led care pathway for labour.
- All women suitable for Pathway C should be offered intrapartum care in accordance with the All Wales Midwife Led Guideline (AWMLG) and the All Wales Clinical Pathway for Normal Labour (AWCPNL).

wisdom.nhs.wales/health-board-guidelines/guidelines-by-health-board/cwm-taf-morgannwg/cwm-taf-morgannwg-maternity/all-wales-midwifery-led-care-guideline-2022pdf/

3. Women with medical or obstetric conditions following a consultant-led pathway

- Appendix 2, Pathway A of the All Wales Midwife Led Guideline should be utilised to support recommendations where women have existing medical complexity or obstetric conditions where there is an increased risk for the mother and/or baby during or shortly after labour where care in an obstetric unit would be expected to reduce the risk, and therefore birth in an obstetric unit is clinically recommended.

wisdom.nhs.wales/health-board-guidelines/guidelines-by-health-board/cwm-taf-morgannwg/cwm-taf-morgannwg-maternity/all-wales-midwifery-led-care-guideline-2022pdf/

- Appendix 2, Pathway B of the All Wales Midwife Led Guideline should be utilised to guide individualised care for women with

medical conditions indicating assessment is recommended when planning place of birth. These women may be suitable to give birth in a midwifery-led setting following individual assessment wisdom.nhs.wales/health-board-guidelines/guidelines-by-health-board/cwm-taf-morgannwg/cwm-taf-morgannwg-maternity/all-wales-midwifery-led-care-guideline-2022pdf/

- Where women are following a midwifery-led pathway of care and choosing to birth on an obstetric unit without clinical indication, an additional discussion should take place to ensure women are supported to make a fully informed choice. This should be documented in the maternity records.

4. Admission of Women in Labour

The majority of women will refer themselves. It is expected practice for all women to be seen by a midwife within 15 minutes of presentation in accordance with Maternity Priority Guidance and model of care wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/maternity-priority-unit-guidelines/

Women following pathway C of the All Wales Midwife Led Guideline should have an initial assessment of labour aligning with the All Wales Clinical Pathway for Normal Labour ([All Wales Clinical Pathway parts 2 and 3 January 2024.pdf](https://wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/all-wales-clinical-pathway-for-normal-labour-january-2024.pdf))

Women following pathway A or B, who are recommended to give birth on an obstetric unit should have an initial assessment of labour aligning with the BSOTS card 'Suspected labour' wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/maternity-priority-unit-guidelines/

All women admitted to labour ward who are following a consultant-led pathway should be seen by a senior obstetrician as soon as possible ideally within 30 minutes.

The CTMUHB escalation guideline will support all clinicians in managing incidents relating to clinical escalation wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/escalation/

Complete admission bundle, which should include:

- Purpose T risk assessment (risk assessment framework designed to identify adults at risk of pressure ulcer development)
- Venous thrombo-embolism (VTE) risk assessment (All women should have an updated VTE risk assessment completed after birth (see Appendix 1 wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/venous-thromboembolism-vte-risk-assessment-prophylaxis-and-treatment-in-pregnancy-and-puerperium/)

5. Fetal Heart Rate Monitoring in Labour

For guidance on the choice and method of fetal monitoring during labour, including risk assessment and indications for continuous cardiotocography, please refer to the CTMUHB Fetal Monitoring Guideline; wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/fetal-monitoring-guideline/

6. Spontaneous Rupture of Membranes

For guidance on the management of spontaneous rupture of membranes $\geq 37+0$ gestation, please refer to the CTMUHB Management of Pre-labour Spontaneous Rupture of Membranes (SRM) at Term Guideline wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/management-of-pre-labour-spontaneous-rupture-of-membranes-srom-at-term-37-0-gestation/

7. Pre-Labour Rupture of Membranes

For guidance on the management of pre-term pre-labour spontaneous rupture of membranes (PPROM), please refer to the CTMUHB Management of Pre-term Pre-labour Spontaneous Rupture of Membranes (PPROM) Guideline [Pre Labour Rupture of Membranes \(PPROM\) Guideline](#)

8. Controlling gastric acidity

Consider proton pump inhibitors (for example, omeprazole) for women who receive opioids, or who have or develop risk factors that make a caesarean birth more likely.

9. Eating and drinking

Inform the woman that she can drink during labour when she is thirsty, but there is no benefit to drinking more than normal.

Isotonic drinks may be more beneficial than water.

Inform the woman that she can eat a light diet in established labour

Advise the woman that diet is not recommended if she has received opioids or she develops risk factors that make a caesarean birth more likely.

10. Vaginal Examination

Prior to performing a vaginal examination, an abdominal palpation should

be undertaken and documented.

When conducting a vaginal examination:

- Tap water may be used if cleansing is needed before vaginal examination
- Routine hygiene should include standard hand hygiene measures and single-use, sterile gloves.
- 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 for a woman, especially if she is already in pain, highly anxious and in an unfamiliar environment
- Explain the reason for the examination and what will be involved
- Ensure the woman's informed consent, privacy, dignity and comfort
- Explain sensitively the findings of the examination and any impact on the birth plan to the woman and her birth companion(s)
- Advise the woman that she can decline the examination before it starts, or ask to stop at any stage during the examination

When performing a vaginal examination, determine (and document):

- the station of the presenting part
- the position of the presenting part
- the presence or absence of caput or moulding
- cervical effacement
- cervical dilatation
- presence or absence of membranes
- fetal heart rate on completion

11. Intrapartum Care of the Bladder during labour and birth

During the first stage of labour, encourage the woman to pass urine at 2-4 hourly intervals and document frequency and volume passed on the partogram. For women with IV fluids in progress; this should also be documented on a fluid balance chart.

If the woman is unable to pass good amounts of urine on two occasions (less than 25–50mls) and if on abdominal palpation the bladder is palpable, then an in/out catheter should be recommended.

Maintain a fluid balance chart if catheterisation of the bladder is required, recording fluid input and output, to continue until normal sensation is resumed, the catheter has been removed and the woman has passed urine ([Bladder Care - Post Natal CTMUHB](#)).

Ensure the balloon is deflated and catheter removed prior to pushing and birth.

12. Presence of meconium

As part of ongoing assessment, document the presence or absence of meconium.

Be aware that meconium is more common after full term but should still trigger a full risk assessment and discussion with the woman about the option of transfer to obstetric-led care.

Significant meconium is defined as dark green or black amniotic fluid that is thick or tenacious, or any meconium stained amniotic fluid containing lumps 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/escalate to a senior obstetrician. Explain that meconium:

- may increase the risk to the baby
- means that continuous cardiotocography monitoring may be advised, see: wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/fetal-monitoring-guideline/
- may mean that healthcare professionals trained in advanced neonatal life support are needed as soon as the baby is born.

Take into account that the presence of other risk factors (in addition to meconium) may increase the urgency of escalation.

13. Water immersion during labour and birth

For guidance on the use of water immersion for labour and birth, please refer to the CTMUHB Water Immersion for Labour and Birth Guideline;

wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/water-immersion-for-labour-and-birth/

14. Pain relief during labour

Attitudes to pain and pain relief in childbirth.

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's choice.

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

- their cultural background and beliefs
- their socioeconomic status
- any neurodiverse conditions they may have.

Non-pharmacological pain-relieving strategies

Advise women that breathing exercises, having a shower or bath, and massage may reduce pain during the latent first stage of labour.

Do not offer or advise aromatherapy, yoga or acupuncture for pain relief during the latent first stage of labour. If a woman wants to use any of these techniques, support her choice.

If a woman chooses to use breathing and relaxation techniques in labour, support her choice.

If a woman chooses to use massage techniques in labour that have been taught to birth companions, support her choice.

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

- TENS devices are not provided by the NHS, but if a woman wants to use TENS to manage her comfort during labour, support her 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.

Do not offer acupuncture, acupuncture or hypnosis during labour. If a woman wants to use any of these techniques, support her choice.

Support the playing of music of the woman's choice in labour. Offer the woman the opportunity to labour in water for pain relief.

For care of women laboring in water, please see (wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/water-immersion-for-labour-and-birth/).

Inhalational analgesia

Ensure that Entonox (a 50:50 mixture of oxygen and nitrous oxide) is available in all birth settings as it may reduce pain in labour, but inform the woman that it may make her feel nauseous and light-headed.

Pharmacological analgesia

Ensure that pethidine is available in all birth settings. Inform the woman that these will provide limited pain relief during labour and may have significant side effects for both her (for example, drowsiness, nausea and vomiting) and her baby (for example, short-term respiratory depression and drowsiness, which may last several days and may make it more difficult to breastfeed).

If an intravenous or intramuscular opioid is used, an antiemetic is recommended.

Women should not enter water (a birthing pool or bath) within 2 hours of opioid administration or if they feel drowsy.

Regional analgesia

If a woman requests regional analgesia, talk with her about the benefits and risks and the effect it may have on her pain and her labour. Provide information to women about epidural analgesia, including the following:

- it is available only in obstetric units so transfer will be necessary if she is in another setting
- it provides more effective pain relief than opioids
- it may not always be fully effective and may need to be adjusted or replaced
- complications during insertion of the epidural may cause a severe postnatal headache
- it is not associated with long-term backache
- it is not associated with a longer first stage of labour or an increased chance of an unplanned caesarean birth
- it is associated with a longer second stage of labour and an increased chance of intervention, for example episiotomy and birth with forceps or ventouse
- it will be accompanied by a more intensive level of monitoring and intravenous access, so mobility may be reduced.

If, after a discussion of the benefits and risks, a woman in labour chooses regional analgesia, support her decision.

Care and observations for women with regional analgesia

Always secure intravenous access before starting regional analgesia.

Preloading and maintenance fluid infusion do not need to be administered routinely before establishing low-dose epidural analgesia and combined spinal–epidural analgesia.

Undertake the following additional observations for women with regional analgesia:

- during establishment of regional analgesia or after further boluses (10 ml or more of low-dose solutions), measure blood pressure every 5 minutes for 15 minutes
- if the woman is not pain-free 30 minutes after each administration of local anaesthetic or opioid solution, ask the anaesthetist to review
- assess the level of the sensory block hourly
- if the woman is not mobilising, assess the level of motor block hourly by asking the woman to do a straight leg raise. If she is unable to do this, ask the anaesthetist to review.

Encourage women with regional analgesia to adopt whatever positions, including upright, they find comfortable throughout labour, except lying flat on their back.

Once established, continue regional analgesia until after completion of the third stage of labour and any necessary perineal repair.

Perform continuous cardiotocography for at least 30 minutes during establishment of regional analgesia, and following siting of regional analgesia.

15. First stage of Labour

Definitions of the latent and established first stages of labour

For the purposes of this guideline, use the following definitions of labour:

- latent first stage of labour is 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 is when:
 - there are regular contractions and
 - there is progressive cervical dilatation from 4 cm

Ongoing assessment of women in the first stage of labour

Use a pictorial record of labour (partogram) once labour is established

Record the following observations during the first stage of labour and document on the labour partogram:

- half-hourly documentation of frequency of contractions
- hourly pulse
- 4-hourly temperature, blood pressure and respiratory rate
- offer a 4-hourly vaginal examination or in response to the woman's wishes if there is concern about progress (after abdominal palpation and assessment of vaginal loss).

Carry out an hourly risk assessment of the woman and her baby, and if any of the following risks have developed, transfer the woman to obstetric-led care and/or escalate concerns to a senior obstetrician. Take into account that multiple risk factors may increase the urgency of the transfer or escalation, particularly if they have a cumulative effect:

- observations of the woman:
 - pulse over 120 beats/minute on 2 occasions 15 to 30 minutes apart
 - a single reading of either raised diastolic blood pressure of 110 mmHg or more or raised systolic blood pressure of 160 mmHg or more
 - 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
 - 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)
 - respiratory rate of less than 9 or more than 21 breaths per minute on 2 occasions 15 to 30 minutes apart
 - temperature of 38°C or above on a single reading, or 37.5°C or above on 2 consecutive occasions 1 hour apart;
 - fresh red bleeding or blood-stained liquor
 - the new appearance of meconium
 - pain reported by the woman that differs from the pain normally associated with contractions
 - confirmed delay in the first stage of labour
 - request by the woman for additional pain relief using regional analgesia – obstetric emergency, including antepartum haemorrhage, cord prolapse, maternal seizure or collapse, or a need for advanced neonatal resuscitation
- observations of the unborn baby:
 - any non-cephalic presentation, including cord presentation

- high (4/5 to 5/5 palpable) or free-floating head in a nulliparous woman
- suspected fetal growth restriction or macrosomia
- suspected anhydramnios or polyhydramnios
- any changes in the fetal heart rate pattern ([hyperlink to fetal monitoring guideline](#))

Review bladder care for women at least every 4 hours. This should include:

- frequency of passing urine and bladder sensation
- fluid balance monitoring if sensation is abnormal or absent, if there is an inability to pass urine, or the woman is receiving intravenous fluids (including oxytocin)
- offering to insert a catheter if there are any ongoing concerns over the woman's ability to pass urine.

Give ongoing consideration to the woman's emotional and psychological needs, including her desire for pain relief.

Encourage the woman to say if she needs more analgesia at any point during labour

Duration of the first stage

Inform women that, while the length of established first stage of labour varies between women:

- first labours last on average 8 hours and are unlikely to last over 18 hours
- second and subsequent labours last on average 5 hours and are unlikely to last over 12 hours.

Do not offer or advise clinical intervention if labour is progressing normally and the woman and baby are well.

In all stages of labour, women who have left the normal care pathway because of the development of complications can return to it if or when the complication is resolved.

Do not routinely perform amniotomy in normally progressing labour.

Do not routinely use combined early amniotomy with use of oxytocin.

Delay in the first stage

Offer the woman support, hydration, and appropriate and effective pain relief.

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.

If delay in the established first stage of labour is suspected, discuss the findings and the options available with the woman, and support her decision.

Offer all women with delay in the established first stage of labour support and effective pain relief. Advise all women 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 with intact membranes, after explanation of the procedure and advise that it will shorten labour by about an hour and may increase the strength and pain of contractions. Do not advise transfer to obstetric-led care for amniotomy alone.

After amniotomy, advise the woman to have a repeat vaginal examination 2 hours later.

If there is no progress 2 hours after the amniotomy, diagnose delay and transfer the woman to obstetric-led care or request a senior obstetric review. For all women 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.

Discuss the use of oxytocin with the woman and make a decision with her about its use. Explain that:

- her choice to start, stop or restart the oxytocin will be supported
- using oxytocin after spontaneous or artificial rupture of the membranes will bring forward the time of birth but will not influence the mode of birth or neonatal outcomes
- oxytocin will increase the frequency and strength of contractions and that its use will mean that her contractions and her baby's heartbeat will be monitored continuously using cardiotocography (wisdom.nhs.wales/health-board-

[guidelines/cwm-taf-maternity-file/fetal-monitoring-guideline/](#))

- oxytocin can cause hyperstimulation, which may increase the chance of transient fetal hypoxia, and if hyperstimulation occurs the dose will be reduced or stopped.

Offer the woman an epidural before oxytocin is started or if she requests it later.

When starting intravenous oxytocin in the first stage of labour:

- do not start separate intravenous fluids without a clinical indication (for example, the woman is not drinking, is dehydrated, or is hypotensive)
- monitor fluid balance.

If oxytocin is used in the first stage of labour, refer to [wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/induction-of-labour-guideline-including-arrest-of-labour/](#)

Advise the woman to have a vaginal examination 4 hours after the oxytocin infusion has led to regular contractions in established labour:

- if cervical dilatation has increased by less than 2 cm after 4 hours of oxytocin, further obstetric review is needed to assess whether a caesarean birth is advisable
- if cervical dilatation has increased by 2 cm or more, advise 4-hourly vaginal examinations.

If oxytocin is restarted in the first stage of labour, base the timing of the next vaginal examination on a clinical assessment of the woman and her individual circumstances.

16. Second stage of labour

Definition of the second stage of labour

For the purposes of this guideline, use the following definitions of labour:

- 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
- the passive second stage of labour may be up to 2 hours when a woman with an epidural in place has been advised to delay pushing
- onset of the active second stage of labour is when:
 - the baby is visible or
 - there is involuntary or active pushing with full dilatation of the cervix.

Assessment of women during the second stage of labour

Continue with observations of the woman and baby, and assessment of risk as described for the first stage of labour, but be aware that the frequency of fetal monitoring should increase [wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/fetal-monitoring-guideline/](https://www.wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/fetal-monitoring-guideline/) perform intermittent auscultation of the fetal heart rate immediately after a contraction for at least 1 minute, at least every 5 minutes. Palpate the woman's pulse every 5 minutes to differentiate between the 2 heartbeats;

Offer a vaginal examination hourly in the active second stage, or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss).

To assess progress, the vaginal examination should include:

- position of the head
- station/descent
- caput and moulding.

During the second stage of labour:

- continue to take the woman's emotional and psychological needs into account
- assess progress, which should include the woman'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
- assess the frequency, strength and duration of contractions
- ongoing consideration should be given to the woman's position, hydration, coping strategies and pain relief throughout the second stage.

The woman's position and pushing in the second stage

Advise a woman with an epidural in place during the second stage of labour that:

- lying flat on her back can lead to a decrease in blood pressure and may reduce placental blood flow
- lying on her side may increase the chance of a spontaneous vaginal birth, but she can use any other position she finds comfortable to give birth, including upright positions.

Advise a woman without an epidural in place during the second stage of labour that:

- lying flat on her back can lead to a decrease in blood pressure and may reduce placental blood flow
- she can use any other position she finds comfortable to give birth
- upright positions and keeping mobile may be beneficial (as they may reduce fetal heart rate abnormalities, episiotomy rates and improve her birthing experience).

Advise women without an epidural in place that:

- spontaneous pushing may shorten the second stage of labour compared with directed pushing
- if directed pushing is used, pushing while exhaling may shorten the active second stage of labour for multiparous women.

If full dilatation of the cervix has been confirmed in a woman without an epidural in place, but she does not get an urge to push, offer to carry out further assessment after 1 hour.

Advise nulliparous women with an epidural that:

- directed pushing rather than spontaneous pushing may reduce the likelihood of having an unplanned caesarean birth
- delayed directed pushing (up to 2 hours after full dilatation) may shorten the active second stage of labour.

Advise multiparous women with an epidural that:

- delayed directed pushing (by 1 hour after full dilatation) may reduce the likelihood of needing birth with forceps or ventouse
- delayed directed pushing (by 1 hour after full dilatation) may shorten the active second stage of labour.

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

Duration of the active second stage and definition of delay

For a nulliparous woman without an epidural:

- birth would be expected to take place within 3 hours of the start of the active second stage in most women
- after 1 hour of active pushing, reassess the clinical picture, including progress, contractions, and maternal and fetal wellbeing:
 - if there are signs of progress (in terms of rotation or descent of the presenting part), encourage the woman to continue pushing

- if there are no signs of progress, offer vaginal examination and consider amniotomy if the membranes are intact; if there is still no progress, diagnose delay and escalate for senior review
- if birth is not imminent after 2 hours of pushing, refer the woman for a senior review and a decision on place and mode of birth.

For a multiparous woman without an epidural:

- birth would be expected to take place within 2 hours of the start of the active second stage in most women
- after 30 minutes of active pushing, reassess clinical picture, including progress, contractions, and maternal and fetal wellbeing:
 - if there are signs of progress (in terms of rotation or descent of the presenting part), encourage the woman to continue pushing
 - if there are no signs of progress, offer vaginal examination and consider amniotomy if the membranes are intact; if there is still no progress, diagnose delay and escalate for senior review
- if birth is not imminent after 1 hour of pushing, refer the woman for senior review and decision on place and mode of birth.

For a nulliparous woman with an epidural:

- birth would be expected to take place within 3 hours of the start of the active second stage in most women, but be aware that these women 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 the clinical picture, including progress, contractions, and maternal and fetal wellbeing:
 - if there are signs of progress (in terms of rotation or descent of the presenting part), encourage the woman to continue pushing
 - if there are no signs of progress, offer vaginal examination and consider amniotomy if the membranes are intact; if there is still no progress, diagnose delay and escalate for senior review
- if birth is not imminent after 2 hours of pushing, refer the woman for a senior review and decision on place and mode of birth.

For a multiparous woman with an epidural:

- birth would be expected to take place within 2 hours of the start of the active second stage in most women, but be aware

- that these women 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 clinical picture, including progress, contractions, and maternal and fetal wellbeing:
 - if there are signs of progress (in terms of rotation or descent of the presenting part), encourage the woman to continue pushing
 - if there are no signs of progress, offer vaginal examination and consider amniotomy if the membranes are intact; if there is still no progress, diagnose delay and escalate for senior review
 - if birth is not imminent after 1 hour of pushing, refer the woman for a senior review and decision on place and mode of birth.

Delay in the second stage

If there is delay in the second stage of labour, or if the woman is excessively distressed, provide support and sensitive encouragement and ask her if she needs analgesia or anaesthesia.

An obstetrician should carry out an in-person assessment of a woman with confirmed delay in the second stage 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 heart rates
- confirmation that there are no signs of obstructed labour
- confirmation that contractions are infrequent or ineffective.

If the decision is made to start oxytocin in the second stage of labour, ensure that the time between increments of the dose is not more frequent than every 30 minutes ([wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/induction-of-labour-guideline-including-arrest-of-labour/](https://www.wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/induction-of-labour-guideline-including-arrest-of-labour/))

After initial obstetric assessment of a woman with delay in the second stage, maintain ongoing obstetric review every 15 to 30 minutes.

17. 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. 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's preferences.

Talk with the woman and her birth companion(s) about why the birth needs to be expedited and what the options are.

Inform the team about the degree of urgency specifying the anticipated timeframe for birth for example birth by 12pm.

Record the time at which the decision to expedite the birth is made.

Birth with forceps or ventouse in delayed second stage

Offer birth with forceps or ventouse if there is concern about the baby's wellbeing, there is a prolonged second stage or the woman requests assistance, see CTMUHB Assisted Vaginal Birth Guideline: ([Guidelines Template March 2011](#)).

If a woman declines a birth with forceps or ventouse:

- discuss her remaining options (vaginal birth, caesarean birth or reconsidering her decision about forceps or ventouse)
- advise her that her choices may be limited by clinical safety or degree of urgency (for example, if a caesarean birth is no longer an option because the baby's head is too low in the pelvis)
- support her decision.

Advise the woman to have a caesarean birth if vaginal birth is not possible

18. Intrapartum interventions to reduce perineal trauma

Discuss the woman's preferences for techniques to reduce perineal trauma during birth and support her choices.

Once the presenting part distends the perineum in the second stage of labour, offer to apply a warm wet compress to the perineum and continue this until birth. Check the temperature of the compress is comfortable for the woman.

Consider massage of the perineum with a water-soluble lubricant in the second stage of labour, if perineal massage is acceptable to the woman and she prefers this to a warm compress.

Do not carry out a routine episiotomy during spontaneous vaginal birth, including those after previous third- or fourth degree tear.

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

If an episiotomy is performed, the recommended technique is a mediolateral episiotomy originating at the vaginal fourchette and usually directed to the right side. The angle to the vertical axis should be between 45 and 60 degrees at the time of the episiotomy.

Perform an episiotomy if there is a clinical need, such as birth with forceps or ventouse or suspected fetal compromise. Provide tested, effective analgesia before carrying out an episiotomy, except in an emergency because of acute fetal compromise.

19. Third stage of labour

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

Definition of the third stage

For the purposes of this guideline, use the following definitions:

- the third stage of labour is the time from the birth of the baby to the expulsion of the placenta and membranes
- active management of the third stage 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
- physiological management of the third stage involves a package of care that includes the following components:
 - no routine use of uterotonic drugs
 - no clamping of the cord until pulsation has stopped, or after delivery of the placenta
 - delivery of the placenta spontaneously or by maternal effort.

Observations in the third stage

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

- her general physical condition, as shown by her colour, respiration and her own report of how she feels
- vaginal blood loss

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

- carry out frequent observations to assess whether resuscitation is needed

Management of the third stage

Discuss with the woman antenatally, during her 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 (Please see Table 10 and 11 within the National Institute for Health & Care Excellence (NICE) Guideline [Intrapartum care](#) for Outcomes that were more or less likely for women having active management of the third stage compared with physiological management).

Advise women that active management of the third stage of labour is associated with a lower risk of a postpartum haemorrhage or blood transfusion.

If a woman requests physiological management of the third stage:

- discuss her level of risk so she can make an informed decision and
- support her in her choice.

Document in her records the decision that is agreed with the woman about management of the third stage.

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

- oxytocin plus ergometrine may be more effective than oxytocin alone at reducing the risk of postpartum haemorrhage
- oxytocin plus ergometrine is advised if there are risk factors which could increase the risk of postpartum haemorrhage

- oxytocin plus ergometrine is more likely to lead to nausea and vomiting compared with oxytocin alone
- oxytocin plus ergometrine is contraindicated in women with severe hypertension, pre-eclampsia, eclampsia, or severe cardiac, hepatic or renal disease.

Offer antiemetics (for example, cyclizine) to women having oxytocin plus ergometrine.

For active management after vaginal birth, administer 10 units of oxytocin (by intramuscular injection), or 5 units of oxytocin plus 500 micrograms of ergometrine (by intramuscular injection) immediately after the birth of the baby and before the cord is clamped and cut.

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 requests that the cord is clamped and cut later than 5 minutes, support her choice.

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.

Record the timing of cord clamping in both active and physiological management.

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

- haemorrhage
- the placenta is not delivered within 1 hour of the birth of the baby.

Offer a change from physiological management to active management if the woman wants to shorten the third stage.

Prolonged third stage

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

20. Retained placenta

Secure intravenous access if the placenta is retained, and explain to the woman why this is needed.

Do not use umbilical vein agents if the placenta is retained.

Do not use intravenous oxytocic agents routinely to deliver a retained placenta.

Give intravenous oxytocic agents if the placenta is retained and the woman is bleeding excessively.

If the placenta is retained and there is concern about the woman's condition:

- offer a vaginal examination to assess the need to undertake manual removal of the placenta
- explain that this assessment can be painful and advise her to have analgesia.

If the woman reports inadequate analgesia during the assessment, stop the examination and address this immediately.

Do not carry out uterine exploration or manual removal of the placenta without an anaesthetic.

21. Postpartum Haemorrhage

For risk factors, risk assessment and management of postpartum haemorrhage, please refer to [wisdom.nhs.wales/all-wales-guidelines/all-wales-guidelines/all-wales-pph-guideline-management-and-prevention/](https://www.wisdom.nhs.wales/all-wales-guidelines/all-wales-guidelines/all-wales-pph-guideline-management-and-prevention/)

Post-partum oxytocin infusions must **NOT** be pre-prepared in any clinical area (including labour ward and theatre) before birth due to risk of oxytocin overdose during labour and childbirth (PSA018/September 2024) - Appendix 1

A standard risk assessment should be completed for all women who present in labour, regardless of birth setting, using Stage 0 of the OBS Cymru PPH Management Checklist.

22. Care of the newborn baby

Initial assessment of the newborn baby and mother–baby bonding

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

When assessing the colour element of the Apgar score:

- assess central oxygenation by looking inside the mouth at the mucous membranes and tongue
- assess peripheral oxygenation by looking at the colour of the nail beds.

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

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.

Continue to evaluate and record the baby's condition until it is improved and stable.

Do not routinely take paired cord-blood samples (for blood gas analysis) [wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/indication-for-taking-paired-cord-blood-samples-following-birth/](https://www.wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/indication-for-taking-paired-cord-blood-samples-following-birth/)

Encourage women to have skin-to-skin contact with their babies as soon as possible after the birth. If the woman is not well enough, encourage her birth companion to have skin-to-skin contact instead. In order to keep the baby warm, dry and cover them with a warm, dry blanket or towel while maintaining skin-to-skin contact with the woman.

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 and her birth companion(s) how to maintain the baby's airway.

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

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

Record head circumference, and birth weight soon after the first hour following birth and plot on the centile chart.

Check the baby's body temperature is in the normal range.

Undertake an initial examination to detect any major physical abnormality

and to identify any problems that need referral.

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.

23. Neonatal Resuscitation

For guidance on Neonatal Resuscitation, please refer to the CTMUHB Neonatal Resuscitation Guideline: wisdom.nhs.wales/health-board-guidelines/cwm-taf-neonatal/neonatal-resuscitation-guidelinecwm-taf-neonatal-guideline-2022pdf1/

24. Care of the woman after birth

Initial assessment

Carry out the following observations of the woman after birth:

- record her temperature, pulse, blood pressure and respiratory rate on a MEOWs chart
- check uterine contraction and lochia
- examine the placenta and membranes: assess their condition, structure, cord vessels and completeness.
- make an early assessment of the woman's emotional and psychological condition in response to labour and birth
- check for successful voiding of the bladder; if, after 6 hours, her bladder is palpable and she is unable to pass urine, advise catheterization - [Bladder Care - Post Natal CTMUHB](#).

Check that women who have had regional analgesia or anaesthesia can perform a straight leg raise by 4 hours after the last anaesthetic dose. If not, contact the obstetric anaesthetist for urgent review.

25. Perineal Care

For guidance on perineal suturing, please refer to the CTMUHB Perineal Repair Guideline: [AQSM Guideline for Perineal repair](#)

26. References

National Institute for Health & Care Excellence (NICE) Intrapartum Care, 29 September 2023 [NG235] [Intrapartum care](#)

27. Appendix 1

Patient Safety Notice PSA018 / September 2024



PSA018 Oxytocin
overdose FINAL.pdf

Risk of oxytocin overdose during labour and childbirth