

Intrapartum care for healthy women and babies

Clinical guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations](#) wherever possible.

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This guideline replaces CG55.

This guideline is partially replaced by NG229.

This guideline is the basis of QS105.

Overview

This guideline covers the care of healthy women and their babies, during labour and immediately after the birth. It focuses on women who give birth between 37 and 42 weeks of pregnancy ('term'). The guideline helps women to make an informed choice about where to have their baby. It also aims to reduce variation in areas of care such as fetal monitoring during labour and management of the third stage of labour.

The [Royal College of Obstetricians and Gynaecologists](#) has produced guidance on [COVID-19 and intrapartum care](#) for all midwifery and obstetric services.

Who is it for?

- Healthcare professionals
- Commissioners and providers
- Healthy women who have had a straightforward pregnancy and give birth between 37 and 42 weeks of pregnancy

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in [NICE's information on making decisions about your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Place of birth

Choosing planned place of birth

Women at low risk of complications

- 1.1.1 Explain to both multiparous and nulliparous women who are at low risk of complications that giving birth is generally very safe for both the woman and her baby. **[2014]**
- 1.1.2 Explain to both multiparous and nulliparous women that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth:
 - Advise low-risk multiparous women that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.

- Advise low-risk nulliparous women that planning to give birth in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby. **[2014]**

1.1.3 Using [table 1](#) and [table 2](#), explain to low-risk multiparous women that:

- planning birth at home or in a freestanding midwifery unit is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside midwifery unit, and these 3 settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit
- planning birth in an obstetric unit is associated with a higher rate of interventions, such as instrumental vaginal birth, caesarean section and episiotomy, compared with planning birth in other settings
- there are no differences in outcomes for the baby associated with planning birth in any setting. **[2014]**

Table 1

Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth: low-risk multiparous women (sources: Birthplace 2011; Blix et al. 2012)

	Home (number of incidences per 1,000 multiparous women giving birth)	Freestanding midwifery unit (number of incidences per 1,000 multiparous women giving birth)	Alongside midwifery unit (number of incidences per 1,000 multiparous women giving birth)	Obstetric unit (number of 1,000 incidences per multiparous women giving birth)
-				
Spontaneous vaginal birth	984*	980	967	927*

-	Home (number of incidences per 1,000 multiparous women giving birth)	Freestanding midwifery unit (number of incidences per 1,000 multiparous women giving birth)	Alongside midwifery unit (number of incidences per 1,000 multiparous women giving birth)	Obstetric unit (number of 1,000 incidences per multiparous women giving birth)
Transfer to an obstetric unit	115*	94	125	10**
Regional analgesia (epidural and/or spinal)***	28*	40	60	121*
Episiotomy	15*	23	35	56*
Caesarean birth	7*	8	10	35*
Instrumental birth (forceps or ventouse)	9*	12	23	38*
Blood transfusion	4	4	5	8

* Figures from [Birthplace 2011](#) and [Blix et al. 2012](#) (all other figures from Birthplace 2011).

** Estimated transfer rate from an obstetric unit to a different obstetric unit owing to lack of capacity or expertise.

*** Blix reported epidural analgesia and Birthplace reported spinal or epidural analgesia.

Table 2

Outcomes for the baby for each planned place of birth: low-risk multiparous women (source: Birthplace 2011)

Outcomes	Home (number of babies per 1,000 births)	Freestanding midwifery unit (number of babies per 1,000 births)	Alongside midwifery unit (number of babies per 1,000 births)	Obstetric unit (number of babies per 1,000 births)
Babies without serious medical problems	997	997	998	997
Babies with serious medical problems*	3	3	2	3

* Serious medical problems were combined in the study: neonatal encephalopathy and meconium aspiration syndrome were the most common adverse events, together accounting for 75% of the total. Stillbirths after the start of care in labour and death of the baby in the first week of life accounted for 13% of the events. Fractured humerus and clavicle were uncommon outcomes (less than 4% of adverse events). For the frequency of these events (how often any of them actually occurred), see [appendix A](#).

1.1.4 Using [table 3](#) and [table 4](#), explain to low-risk nulliparous women that:

- planning birth at home or in a freestanding midwifery unit is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside midwifery unit, and these 3 settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit
- planning birth in an obstetric unit is associated with a higher rate of interventions, such as instrumental vaginal birth, caesarean section and episiotomy, compared with planning birth in other settings

- there are no differences in outcomes for the baby associated with planning birth in an alongside midwifery unit, a freestanding midwifery unit or an obstetric unit
- planning birth at home is associated with an overall small increase (about 4 more per 1,000 births) in the risk of a baby having a serious medical problem compared with planning birth in other settings. [2014]

Table 3

Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth: low-risk nulliparous women (sources: Birthplace 2011; Blix et al. 2012)

	Home (number of incidences per 1,000 nulliparous women giving birth)	Freestanding midwifery unit (number of incidences per 1,000 nulliparous women giving birth)	Alongside midwifery unit (number of incidences per 1,000 nulliparous women giving birth)	Obstetric unit (number of incidences per 1,000 nulliparous women giving birth)
–				
Spontaneous vaginal birth	794*	813	765	688*
Transfer to an obstetric unit	450*	363	402	10**
Regional analgesia (epidural and/or spinal)***	218*	200	240	349*
Episiotomy	165*	165	216	242*
Caesarean birth	80*	69	76	121*

	Home (number of incidences per 1,000 nulliparous women giving birth)	Freestanding midwifery unit (number of incidences per 1,000 nulliparous women giving birth)	Alongside midwifery unit (number of incidences per 1,000 nulliparous women giving birth)	Obstetric unit (number of incidences per 1,000 nulliparous women giving birth)
–				
Instrumental birth (forceps or ventouse)	126*	118	159	191*
Blood transfusion	12	8	11	16

* Figures from [Birthplace 2011](#) and [Blix et al. 2012](#) (all other figures from Birthplace 2011).

** Estimated transfer rate from an obstetric unit to a different obstetric unit owing to lack of capacity or expertise.

*** Blix reported epidural analgesia and Birthplace reported spinal or epidural analgesia.

Table 4

Outcomes for the baby for each planned place of birth: low-risk nulliparous women (source: Birthplace 2011)

Outcomes	Home (number of babies per 1,000 births)	Freestanding midwifery unit (number of babies per 1,000 births)	Alongside midwifery unit (number of babies per 1,000 births)	Obstetric unit (number of babies per 1,000 births)
Babies without serious medical problems	991	995	995	995

Outcomes	Home (number of babies per 1,000 births)	Freestanding midwifery unit (number of babies per 1,000 births)	Alongside midwifery unit (number of babies per 1,000 births)	Obstetric unit (number of babies per 1,000 births)
Babies with serious medical problems*	9	5	5	5

* Serious medical problems were combined in the study: neonatal encephalopathy and meconium aspiration syndrome were the most common adverse events, together accounting for 75% of the total. Stillbirths after the start of care in labour and death of the baby in the first week of life accounted for 13% of the events. Fractured humerus and clavicle were uncommon outcomes – less than 4% of adverse events. For the frequency of these events (how often any of them actually occurred), see [appendix A](#).

- 1.1.5 Ensure that all healthcare professionals involved in the care of pregnant women are familiar with the types and frequencies of serious medical problems that can affect babies (see [appendix A](#)), in order to be able to provide this information to women if they request it. **[2014]**
- 1.1.6 Commissioners and providers (this can also include networks of providers) should ensure that all 4 birth settings are available to all women (in the local area or in a neighbouring area). **[2014]**
- 1.1.7 Give the woman the following information, including local statistics, about all local birth settings:
- Access to midwives, including:
 - the likelihood of being cared for in labour by a familiar midwife
 - the likelihood of receiving one-to-one care throughout labour (not necessarily being cared for by the same midwife for the whole of labour).
 - Access to medical staff (obstetric, anaesthetic and neonatal).
 - Access to pain relief, including birthing pools, Entonox, other drugs and regional analgesia.

- The likelihood of being transferred to an obstetric unit (if this is not the woman's chosen place of birth), the reasons why this might happen and the time it may take. Refer to table 5 if no local data are available. [2014]

Table 5
Primary reasons for transfer to an obstetric unit (source: Birthplace 2011)

Primary reason for transfer to an obstetric unit*	Number of women transferred from home (n=3,529)	Number of women transferred from a freestanding midwifery unit (n=2,457)	Number of women transferred from an alongside midwifery unit (n=4,401)
Delay during first or second stage of labour	1,144 (32.4%)	912 (37.1%)	1,548 (35.2%)
Abnormal fetal heart rate	246 (7.0%)	259 (10.5%)	477 (10.8%)
Request for regional analgesia	180 (5.1%)	163 (6.6%)	585 (13.3%)
Meconium staining	432 (12.2%)	301 (12.2%)	538 (12.2%)
Retained placenta	250 (7.0%)	179 (7.3%)	203 (4.6%)
Repair of perineal trauma	386 (10.9%)	184 (7.5%)	369 (8.4%)
Neonatal concerns (postpartum)	180 (5.1%)	63 (2.6%)	5 (0.0%)
Other	711 (20.1%)	396 (16.2%)	676 (16.3%)

* Main reason for transfer to an obstetric unit for each woman (there may be more than 1 reason).

1.1.8 If further discussion is wanted by either the midwife or the woman about

the choice of planned place of birth, arrange this with a consultant midwife or supervisor of midwives, and/or a consultant obstetrician if there are obstetric issues. **[2014]**

- 1.1.9 When discussing the woman's choice of place of birth with her, do not disclose personal views or judgements about her choices. **[2014]**

Medical conditions and other factors that may affect planned place of birth

- 1.1.10 Use tables 6, 7, 8 and 9 as part of an assessment for a woman choosing her planned place of birth:

- [Table 6](#) and [table 7](#) show medical conditions or situations in which there is increased risk for the woman or baby during or shortly after labour, where care in an obstetric unit would be expected to reduce this risk.
- The factors listed in [table 8](#) and [table 9](#) are not reasons in themselves for advising birth within an obstetric unit, but indicate that further consideration of birth setting may be required.
- Discuss these risks and the additional care that can be provided in the obstetric unit with the woman so that she can make an informed choice about planned place of birth. **[2007, amended 2014]**

Table 6

Medical conditions indicating increased risk suggesting planned birth at an obstetric unit

Disease area	Medical condition
Cardiovascular	<ul style="list-style-type: none"> • Confirmed cardiac disease • Hypertensive disorders
Respiratory	<ul style="list-style-type: none"> • Asthma requiring an increase in treatment or hospital treatment • Cystic fibrosis

Disease area	Medical condition
Haematological	<ul style="list-style-type: none"> • Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major • History of thromboembolic disorders • Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100×10^9/litre • Von Willebrand's disease • Bleeding disorder in the woman or unborn baby • Atypical antibodies which carry a risk of haemolytic disease of the newborn
Endocrine	<ul style="list-style-type: none"> • Hyperthyroidism • Diabetes
Infective	<ul style="list-style-type: none"> • Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended • Hepatitis B/C with abnormal liver function tests • Carrier of/infected with HIV • Toxoplasmosis – women receiving treatment • Current active infection of chicken pox/rubella/genital herpes in the woman or baby • Tuberculosis under treatment
Immune	<ul style="list-style-type: none"> • Systemic lupus erythematosus • Scleroderma

Disease area	Medical condition
Renal	<ul style="list-style-type: none"> • Abnormal renal function • Renal disease requiring supervision by a renal specialist
Neurological	<ul style="list-style-type: none"> • Epilepsy • Myasthenia gravis • Previous cerebrovascular accident
Gastrointestinal	<ul style="list-style-type: none"> • Liver disease associated with current abnormal liver function tests
Psychiatric	<ul style="list-style-type: none"> • Psychiatric disorder requiring current inpatient care

Table 7

Other factors indicating increased risk suggesting planned birth at an obstetric unit

Factor	Additional information
Previous complications	<ul style="list-style-type: none"> • Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty • Previous baby with neonatal encephalopathy • Pre-eclampsia requiring preterm birth • Placental abruption with adverse outcome • Eclampsia • Uterine rupture • Primary postpartum haemorrhage requiring additional treatment or blood transfusion • Retained placenta requiring manual removal in theatre • Caesarean section • Shoulder dystocia

Factor	Additional information
Current pregnancy	<ul style="list-style-type: none"> • Multiple birth • Placenta praevia • Pre-eclampsia or pregnancy-induced hypertension • Preterm labour or preterm prelabour rupture of membranes • Placental abruption • Anaemia – haemoglobin less than 85 g/litre at onset of labour • Confirmed intrauterine death • Induction of labour • Substance misuse • Alcohol dependency requiring assessment or treatment • Onset of gestational diabetes • Malpresentation – breech or transverse lie • BMI at booking of greater than 35 kg/m² • Recurrent antepartum haemorrhage • Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound) • Abnormal fetal heart rate/doppler studies • Ultrasound diagnosis of oligo-/polyhydramnios
Previous gynaecological history	<ul style="list-style-type: none"> • Myomectomy • Hysterotomy

Table 8

Medical conditions indicating individual assessment when planning place of birth

Disease area	Medical condition
Cardiovascular	Cardiac disease without intrapartum implications
Haematological	<ul style="list-style-type: none"> • Atypical antibodies not putting the baby at risk of haemolytic disease • Sickle-cell trait • Thalassaemia trait • Anaemia – haemoglobin 85 to 105 g/litre at onset of labour
Infective	Hepatitis B/C with normal liver function tests
Immune	Non-specific connective tissue disorders
Endocrine	Unstable hypothyroidism such that a change in treatment is required
Skeletal/ neurological	<ul style="list-style-type: none"> • Spinal abnormalities • Previous fractured pelvis • Neurological deficits
Gastrointestinal	<ul style="list-style-type: none"> • Liver disease without current abnormal liver function • Crohn's disease • Ulcerative colitis

Table 9

Other factors indicating individual assessment when planning place of birth

Factor	Additional information
Previous complications	<ul style="list-style-type: none"> • Stillbirth/neonatal death with a known non-recurrent cause • Pre-eclampsia developing at term • Placental abruption with good outcome • History of previous baby more than 4.5 kg • Extensive vaginal, cervical, or third- or fourth-degree perineal trauma • Previous term baby with jaundice requiring exchange transfusion
Current pregnancy	<ul style="list-style-type: none"> • Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation) • BMI at booking of 30 to 35 kg/m² • Blood pressure of 140 mmHg systolic or 90 mmHg diastolic or more on 2 occasions • Clinical or ultrasound suspicion of macrosomia • Para 4 or more • Recreational drug use • Under current outpatient psychiatric care • Age over 35 at booking
Fetal indications	Fetal abnormality

Factor	Additional information
Previous gynaecological history	<ul style="list-style-type: none"> • Major gynaecological surgery • Cone biopsy or large loop excision of the transformation zone • Fibroids

Women's experience in all birth settings

- 1.1.11 For all women giving birth in all birth settings, follow the principles in the [NICE guideline on patient experience in adult NHS services](#). **[2014]**
- 1.1.12 Providers, senior staff and all healthcare professionals should ensure that in all birth settings there is a culture of respect for each woman as an individual undergoing a significant and emotionally intense life experience, so that the woman is in control, is listened to and is cared for with compassion, and that appropriate informed consent is sought. **[2014]**
- 1.1.13 Senior staff should demonstrate, through their own words and behaviour, appropriate ways of relating to and talking about women and their birth companion(s), and of talking about birth and the choices to be made when giving birth. **[2014]**

One-to-one care in all birth settings

- 1.1.14 Maternity services should:
- provide a model of care that supports one-to-one care in labour for all women **and**
 - benchmark services and identify overstaffing or understaffing by using workforce planning models and/or woman-to-midwife ratios. **[2014]**

Service organisation and clinical governance

- 1.1.15 Ensure that all women giving birth have timely access to an obstetric unit if they need transfer of care for medical reasons or because they request regional analgesia. **[2014]**
- 1.1.16 Commissioners and providers (this can also include networks of providers) should ensure that there are:
- robust protocols in place for transfer of care between settings (see also the [section on general principles for transfer of care](#))
 - clear local pathways for the continued care of women who are transferred from one setting to another, including:
 - when crossing provider boundaries
 - if the nearest obstetric or neonatal unit is closed to admissions or the local midwifery-led unit is full. **[2014]**
- 1.1.17 Commissioners and providers (this can also include networks of providers) should ensure that there are multidisciplinary clinical governance structures in place to enable the oversight of all birth settings. These structures should include, as a minimum, midwifery (including a supervisor of midwives), obstetric, anaesthetic and neonatal expertise, and adequately supported user representation. **[2014]**

1.2 Care throughout labour

Communication

- 1.2.1 Treat all women in labour with respect. Ensure that the woman is in control of and involved in what is happening to her, and recognise that the way in which care is given is key to this. To facilitate this, establish a rapport with the woman, ask her about her wants and expectations for labour, and be aware of the importance of tone and demeanour, and of the actual words used. Use this information to support and guide her through her labour. **[2007]**

1.2.2 To establish communication with the woman:

- Greet the woman with a smile and a personal welcome, establish her language needs, introduce yourself and explain your role in her care.
- Maintain a calm and confident approach so that your demeanour reassures the woman that all is going well.
- Knock and wait before entering the woman's room, respecting it as her personal space, and ask others to do the same.
- Ask how the woman is feeling and whether there is anything in particular she is worried about.
- If the woman has a written birth plan, read and discuss it with her.
- Assess the woman's knowledge of strategies for coping with pain and provide balanced information to find out which available approaches are acceptable to her.
- Encourage the woman to adapt the environment to meet her individual needs.
- Ask her permission before all procedures and observations, focusing on the woman rather than the technology or the documentation.
- Show the woman and her birth companion(s) how to summon help and reassure her that she may do so whenever and as often as she needs to. When leaving the room, let her know when you will return.
- Involve the woman in any handover of care to another professional, either when additional expertise has been brought in or at the end of a shift. **[2007]**

Mobilisation

- 1.2.3 Encourage and help the woman to move and adopt whatever positions she finds most comfortable throughout labour. **[2007]**

Support

- 1.2.4 Encourage the woman to have support from birth companion(s) of her choice. **[2007]**

Hygiene measures

- 1.2.5 Tap water may be used if cleansing is required before vaginal examination. [2007]
- 1.2.6 Routine hygiene measures taken by staff caring for women in labour, including standard hand hygiene and single-use non-sterile gloves, are appropriate to reduce cross-contamination between women, babies and healthcare professionals. [2007]
- 1.2.7 Selection of protective equipment must be based on an assessment of the risk of transmission of microorganisms to the woman, and the risk of contamination of the healthcare worker's clothing and skin by women's blood, body fluids, secretions or excretions. This is in accordance with the following health and safety legislation (current at the time NICE's guideline on healthcare-associated infections was published [March 2012]): [Health and Safety at Work Act 1974](#), [Management of Health and Safety at Work Regulations 1999](#), [Health and Safety Regulations 2002](#), [Control of Substances Hazardous to Health Regulations 2002](#), [Personal Protective Equipment Regulations 2002](#) and [Health and Social Care Act 2008](#). [2007, amended 2014]

This recommendation is adapted from [NICE's guideline on healthcare-associated infections](#).

1.3 Latent first stage of labour

Definitions of the latent and established first stages of labour

- 1.3.1 For the purposes of this guideline, use the following definitions of labour:
- Latent first stage of labour – 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 4 cm.

- Established first stage of labour – when:
 - there are regular painful contractions **and**
 - there is progressive cervical dilatation from 4 cm. **[2007]**

Education and early assessment

1.3.2 Give all nulliparous women information antenatally about:

- what to expect in the latent first stage of labour
- how to work with any pain they experience
- how to contact their midwifery care team and what to do in an emergency. **[2014]**

1.3.3 Offer all nulliparous women antenatal education about the signs of labour, consisting of:

- how to differentiate between Braxton Hicks contractions and active labour contractions
- the expected frequency of contractions and how long they last
- recognition of amniotic fluid ('waters breaking')
- description of normal vaginal loss. **[2014]**

1.3.4 Consider an early assessment of labour by telephone triage provided by a dedicated triage midwife for all women. **[2014]**

1.3.5 Consider a face-to-face early assessment of labour for all low-risk nulliparous women, either:

- at home (regardless of planned place of birth) **or**
- in an assessment facility in her planned place of birth (midwifery-led unit or obstetric unit), comprising one-to-one midwifery care for at least 1 hour. **[2014]**

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

- ask the woman how she is, and about her wishes, expectations and any concerns she has
- ask the woman about the baby's movements, including any changes
- give information about what the woman can expect in the latent first stage of labour and how to work with any pain she experiences
- give information about what to expect when she accesses care
- agree a plan of care with the woman, including guidance about who she should contact next and when
- provide guidance and support to the woman's birth companion(s). **[2014]**

1.3.7 The triage midwife should document the guidance that she gives to the woman. **[2014]**

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

- recognise that a woman may experience painful contractions without cervical change, and although she is described as not being in labour, she may well think of herself as being 'in labour' by her own definition
- offer her individualised support, and analgesia if needed
- encourage her to remain at or return home, unless doing so leads to a significant risk that she could give birth without a midwife present or become distressed. **[2014]**

Pain relief

1.3.9 Advise the woman and her birth companion(s) that breathing exercises, immersion in water and massage may reduce pain during the latent first stage of labour. (See also the [recommendation on timing of regional analgesia](#).) **[2014]**

1.3.10 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, respect her wishes. **[2014]**

1.4 Initial assessment

- 1.4.1 When performing an initial assessment of a woman in labour, listen to her story and take into account her preferences and her emotional and psychological needs. **[2014]**
- 1.4.2 Carry out an initial assessment to determine if midwifery-led care in any setting is suitable for the woman, irrespective of any previous plan. The assessment should comprise the following:
- Observations of the woman:
 - Review the antenatal notes (including all antenatal screening results) and discuss these with the woman.
 - Ask her about the length, strength and frequency of her contractions.
 - Ask her about any pain she is experiencing and discuss her options for pain relief.
 - Record her pulse, blood pressure and temperature, and carry out urinalysis.
 - Record if she has had any vaginal loss.
 - Observations of the unborn baby:
 - Ask the woman about the baby's movements in the last 24 hours.
 - Palpate the woman's abdomen to determine the fundal height, the baby's lie, presentation, position, engagement of the presenting part, and frequency and duration of contractions.
 - Auscultate the fetal heart rate for a minimum of 1 minute immediately after a contraction. Palpate the woman's pulse to differentiate between the heartbeats of the woman and the baby.

In addition (see also recommendation 1.4.5):

- If there is uncertainty about whether the woman is in established labour, a vaginal examination may be helpful after a period of assessment, but is not always necessary.

- If the woman appears to be in established labour, offer a vaginal examination. **[2014]**

1.4.3 Transfer the woman to obstetric-led care, following the [section on the general principles for transfer of care](#), if any of the following are observed on initial assessment:

- Observations of the woman:
 - pulse over 120 beats/minute on 2 occasions 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 30 minutes apart
 - a reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (90 mmHg or more) or raised systolic blood pressure (140 mmHg or more)
 - temperature of 38°C or above on a single reading, or 37.5°C or above on 2 consecutive readings 1 hour apart
 - any vaginal blood loss other than a show
 - rupture of membranes more than 24 hours before the onset of established labour (see the [section on babies born to women with prelabour rupture of the membranes at term](#))
 - the presence of significant meconium (see the [section on presence of meconium](#))
 - pain reported by the woman that differs from the pain normally associated with contractions
 - any risk factors recorded in the woman's notes that indicate the need for obstetric led care.

- Observations of the unborn baby:
 - any abnormal presentation, including cord presentation
 - transverse or oblique lie
 - 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
 - fetal heart rate below 110 or above 160 beats/minute
 - a deceleration in fetal heart rate heard on intermittent auscultation
 - reduced fetal movements in the last 24 hours reported by the woman.

If none of these are observed, continue with midwifery-led care unless the woman requests transfer (see also the [section on measuring fetal heart rate as part of initial assessment](#)). **[2014]**

1.4.4 If any of the factors in recommendation 1.4.3 are observed but birth is imminent, assess whether birth in the current location is preferable to transferring the woman to an obstetric unit and discuss this with the coordinating midwife. **[2014]**

1.4.5 When conducting a vaginal examination:

- be sure that the examination is necessary and will add important information to the decision-making process
- recognise that a vaginal examination can be very distressing 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). **[2014]**

Measuring fetal heart rate as part of initial assessment

- 1.4.6 Offer auscultation of the fetal heart rate at first contact with a woman in suspected or established labour, and at each further assessment:
- Use either a Pinard stethoscope or doppler ultrasound.
 - Carry out auscultation immediately after a contraction for at least 1 minute and record it as a single rate.
 - Record accelerations and decelerations if heard.
 - Palpate the maternal pulse to differentiate between the maternal and fetal heartbeats. **[2017]**
- 1.4.7 Be aware that for women at low risk of complications there is insufficient evidence about whether cardiotocography as part of the initial assessment either improves outcomes or results in harm for women and their babies, compared with intermittent auscultation alone. **[2017]**
- 1.4.8 If a woman at low risk of complications requests cardiotocography as part of the initial assessment:
- discuss the risks, benefits and limitations of cardiotocography with her, and support her in her choice
 - explain that, if she is in a setting where cardiotocography is not available, she will need to be transferred to obstetric-led care. **[2017]**
- 1.4.9 Offer continuous cardiotocography if any of the risk factors listed in [recommendation 1.4.3 in the section on initial assessment](#) are identified on initial assessment, and explain to the woman why this is being offered. (See also the [NICE guideline on fetal monitoring in labour](#) for further guidance on fetal monitoring.) **[2017]**
- 1.4.10 Offer cardiotocography if intermittent auscultation indicates possible fetal heart rate abnormalities, and explain to the woman why this is being offered. If the trace is normal (see the [section on the use of cardiotocography for monitoring during labour in the NICE guideline on fetal monitoring in labour](#)) after 20 minutes, return to intermittent

auscultation unless the woman asks to stay on continuous cardiotocography. [2017]

- 1.4.11 If fetal death is suspected despite the presence of an apparently recorded fetal heart rate, offer real-time ultrasound assessment to check fetal viability. [2017]

1.5 Ongoing assessment

- 1.5.1 Transfer the woman to obstetric-led care (following the [general principles for transfer of care](#)) if any of the following are observed at any point, unless the risks of transfer outweigh the benefits:

- Observations of the woman:
 - pulse over 120 beats/minute on 2 occasions 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 30 minutes apart
 - a reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (90 mmHg or more) or raised systolic blood pressure (140 mmHg or more)
 - temperature of 38°C or above on a single reading, or 37.5°C or above on 2 consecutive occasions 1 hour apart
 - any vaginal blood loss other than a show
 - the presence of significant meconium (see the [section on presence of meconium](#))
 - pain reported by the woman that differs from the pain normally associated with contractions
 - confirmed delay in the first or second stage of labour
 - request by the woman for additional pain relief using regional analgesia
 - obstetric emergency – including antepartum haemorrhage, cord prolapse, postpartum haemorrhage, maternal seizure or collapse, or a need for advanced neonatal resuscitation
 - retained placenta
 - third-degree or fourth-degree tear or other complicated perineal trauma that needs suturing.

- Observations of the unborn baby:
 - any abnormal presentation, including cord presentation
 - transverse or oblique lie
 - 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
 - fetal heart rate below 110 or above 160 beats/minute
 - a deceleration in fetal heart rate heard on intermittent auscultation.

If none of these are observed, continue with midwifery-led care unless the woman requests transfer (see also [recommendation 1.4.6 in the section on measuring fetal heart rate as part of initial assessment](#)). **[2014]**

Presence of meconium

- 1.5.2 As part of ongoing assessment, document the presence or absence of significant meconium. This is defined as dark green or black amniotic fluid that is thick or tenacious, or any meconium-stained amniotic fluid containing lumps of meconium. **[2014]**
- 1.5.3 If significant meconium is present, ensure that:
- healthcare professionals trained in fetal blood sampling are available during labour **and**
 - healthcare professionals trained in advanced neonatal life support are readily available for the birth. **[2014]**
- 1.5.4 If significant meconium is present, transfer the woman to obstetric-led care provided that it is safe to do so and the birth is unlikely to occur before transfer is completed. Follow the general principles for transfer of care described in section 1.6. **[2014]**

1.6 General principles for transfer of care

Transfer of care refers to the transfer between midwifery-led care and obstetric-led care. This may or may not involve transport from one location to another. Women who are receiving midwifery-led care in an obstetric unit can have their care transferred to obstetric-led care without being moved.

- 1.6.1 Base any decisions about transfer of care on clinical findings, and discuss the options with the woman and her birth companion(s). **[2014]**
- 1.6.2 If contemplating transfer of care:
- talk with the woman and her birth companion(s) about the reasons for this and what they can expect, including the time needed for transfer
 - address any concerns she has and try to allay her anxiety
 - ensure that her wishes are respected and her informed consent is obtained. **[2014]**
- 1.6.3 When arranging transfer of care, the midwife attending the labour should contact the ambulance service (if appropriate) and the coordinating midwife in the obstetric unit. The coordinating midwife should then alert the relevant healthcare professionals (obstetric, anaesthetic and neonatal). **[2014]**
- 1.6.4 When arranging transfer from one location to another, ensure the following:
- Before transfer, the woman is dressed, wrapped in a blanket or otherwise covered in a way that she feels is comfortable and appropriate.
 - The woman is made to feel as comfortable as possible before and during transfer.
 - Any ambulance staff or other personnel involved are aware that some positions may make the woman uncomfortable or afraid and could affect her labour, so she should be encouraged to choose how to move and what position to adopt if possible, in accordance with ambulance service protocols.

- Communication and companionship are maintained. Explain the arrangements for transfer to the woman and her birth companion(s). A midwife who has been involved in her care up to that point should travel with her and carry out a handover of care that involves the woman.
- Arrangements are in place to enable the woman's birth companion(s) to travel with her in the ambulance if that is what she wants. If this is not possible or not wanted, check that the birth companion(s) have or can arrange their own transport. **[2014]**

1.6.5 If a woman is transferred to an obstetric unit after the birth (see the [section on care of the woman after birth](#)), ensure that her baby goes with her. **[2014]**

1.7 Care in established labour

Support in labour

- 1.7.1 Provide a woman in established labour with supportive one-to-one care. **[2007]**
- 1.7.2 Do not leave a woman in established labour on her own except for short periods or at the woman's request. **[2007]**
- 1.7.3 For guidance on ensuring continuity of care, see [recommendation 1.4.1 in the NICE guideline on patient experience in adult NHS services](#). **[2016]**

Controlling gastric acidity

- 1.7.4 Do not offer either H₂-receptor antagonists or antacids routinely to low-risk women. **[2007]**
- 1.7.5 Either H₂-receptor antagonists or antacids should be considered for women who receive opioids or who have or develop risk factors that make a general anaesthetic more likely. **[2007]**
- 1.7.6 Inform the woman that she may drink during established labour and that isotonic drinks may be more beneficial than water. **[2007]**

- 1.7.7 Inform the woman that she may eat a light diet in established labour unless she has received opioids or she develops risk factors that make a general anaesthetic more likely. **[2007]**

1.8 Pain relief in labour: non-regional

Attitudes to pain and pain relief in childbirth

- 1.8.1 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. **[2007]**

Pain-relieving strategies

- 1.8.2 If a woman chooses to use breathing and relaxation techniques in labour, support her in this choice. **[2007]**
- 1.8.3 If a woman chooses to use massage techniques in labour that have been taught to birth companions, support her in this choice. **[2007]**
- 1.8.4 Offer the woman the opportunity to labour in water for pain relief. **[2007]**
- 1.8.5 For women labouring in water, monitor the temperature of the woman and the water hourly to ensure that the woman is comfortable and not becoming pyrexial. The temperature of the water should not be above 37.5°C. **[2007]**
- 1.8.6 Keep baths and birthing pools clean using a protocol agreed with the microbiology department and, in the case of birthing pools, in accordance with the manufacturer's guidelines. **[2007]**
- 1.8.7 Do not use injected water papules. **[2007]**
- 1.8.8 Do not offer acupuncture, acupressure or hypnosis, but do not prevent women who wish to use these techniques from doing so. **[2007]**
- 1.8.9 Support the playing of music of the woman's choice in labour. **[2007]**

Non-pharmacological analgesia

- 1.8.10 Do not offer transcutaneous electrical nerve stimulation (TENS) to women in established labour. **[2007]**

Inhalational analgesia

- 1.8.11 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. **[2007]**

Intravenous and intramuscular opioids

- 1.8.12 Ensure that pethidine, diamorphine or other opioids are 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 (drowsiness, nausea and vomiting) and her baby (short-term respiratory depression and drowsiness which may last several days). **[2007]**
- 1.8.13 Inform the woman that pethidine, diamorphine or other opioids may interfere with breastfeeding. **[2007]**
- 1.8.14 If an intravenous or intramuscular opioid is used, also administer an antiemetic. **[2007]**
- 1.8.15 Women should not enter water (a birthing pool or bath) within 2 hours of opioid administration or if they feel drowsy. **[2007]**

1.9 Pain relief in labour: regional analgesia

Information about regional analgesia

- 1.9.1 If a woman is contemplating regional analgesia, talk with her about the risks and benefits and the implications for her labour, including the arrangements and time involved for transfer of care to an obstetric unit if she is at home or in a midwifery unit (follow the [general principles for transfer of care](#)). **[2007, amended 2014]**

1.9.2 Provide information about epidural analgesia, including the following:

- It is available only in obstetric units.
- It provides more effective pain relief than opioids.
- It is not associated with long-term backache.
- It is not associated with a longer first stage of labour or an increased chance of a caesarean birth.
- It is associated with a longer second stage of labour and an increased chance of vaginal instrumental birth.
- It will be accompanied by a more intensive level of monitoring and intravenous access, and so mobility may be reduced. **[2007, amended 2014]**

Timing of regional analgesia

1.9.3 If a woman in labour asks for regional analgesia, comply with her request. This includes women in severe pain in the latent first stage of labour. **[2007]**

Care and observations for women with regional analgesia

1.9.4 Always secure intravenous access before starting regional analgesia. **[2007]**

1.9.5 Preloading and maintenance fluid infusion need not be administered routinely before establishing low-dose epidural analgesia and combined spinal–epidural analgesia. **[2007]**

1.9.6 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/opioid solution, recall the anaesthetist.
 - Assess the level of the sensory block hourly. **[2007]**
- 1.9.7 Encourage women with regional analgesia to move and adopt whatever upright positions they find comfortable throughout labour. **[2007]**
- 1.9.8 Once established, continue regional analgesia until after completion of the third stage of labour and any necessary perineal repair. **[2007]**
- 1.9.9 Upon confirmation of full cervical dilatation in a woman with regional analgesia, unless the woman has an urge to push or the baby's head is visible, pushing should be delayed for at least 1 hour and longer if the woman wishes, after which actively encourage her to push during contractions. **[2007]**
- 1.9.10 After diagnosis of full dilatation in a woman with regional analgesia, agree a plan with the woman in order to ensure that birth will have occurred within 4 hours regardless of parity. **[2007]**
- 1.9.11 Do not routinely use oxytocin in the second stage of labour for women with regional analgesia. **[2007]**
- 1.9.12 Perform continuous cardiotocography for at least 30 minutes during establishment of regional analgesia and after administration of each further bolus of 10 ml or more. **[2007, amended 2014]**

Establishing and maintaining regional analgesia

- 1.9.13 Use either epidural or combined spinal–epidural analgesia for establishing regional analgesia in labour. **[2007]**
- 1.9.14 If rapid analgesia is required, use combined spinal–epidural analgesia. **[2007]**
- 1.9.15 Establish combined spinal–epidural analgesia with bupivacaine and fentanyl. **[2007]**

- 1.9.16 Establish epidural analgesia with a low-concentration local anaesthetic and opioid solution with, for example, 10 to 15 ml of 0.0625 to 0.1% bupivacaine with 1 to 2 micrograms per ml fentanyl. The initial dose of local anaesthetic plus opioid is essentially a test dose, so administer cautiously to ensure that inadvertent intrathecal injection has not occurred. **[2007]**
- 1.9.17 Use low-concentration local anaesthetic and opioid solutions (0.0625 to 0.1% bupivacaine or equivalent combined with 2.0 micrograms per ml fentanyl) for maintaining epidural analgesia in labour. **[2007]**
- 1.9.18 Do not use high concentrations of local anaesthetic solutions (0.25% or above of bupivacaine or equivalent) routinely for either establishing or maintaining epidural analgesia. **[2007]**
- 1.9.19 Either patient-controlled epidural analgesia or intermittent bolus given by healthcare professionals are the preferred modes of administration for maintenance of epidural analgesia. **[2007]**

1.10 Monitoring during labour

The recommendations in this section have been withdrawn. For advice on monitoring during labour, see the [NICE guideline on fetal monitoring in labour](#).

1.11 Prelabour rupture of membranes at term

- 1.11.1 Do not carry out a speculum examination if it is certain that the membranes have ruptured. **[2007]**
- 1.11.2 If it is uncertain whether prelabour rupture of the membranes has occurred, offer the woman a speculum examination to determine whether the membranes have ruptured. Avoid digital vaginal examination in the absence of contractions. **[2007]**
- 1.11.3 Advise women presenting with prelabour rupture of the membranes at term that:

- the risk of serious neonatal infection is 1%, rather than 0.5% for women with intact membranes
- 60% of women with prelabour rupture of the membranes will go into labour within 24 hours
- induction of labour (see [NICE's guideline on inducing labour](#)) is appropriate approximately 24 hours after rupture of the membranes. **[2007]**

1.11.4 Until the induction is started or if expectant management beyond 24 hours is chosen by the woman:

- do not offer lower vaginal swabs and measurement of maternal C-reactive protein
- to detect any infection that may be developing, advise the woman to record her temperature every 4 hours during waking hours and to report immediately any change in the colour or smell of her vaginal loss
- inform the woman that bathing or showering is not associated with an increase in infection, but that having sexual intercourse may be. **[2007]**

1.11.5 Assess fetal movement and heart rate at initial contact and then every 24 hours after rupture of the membranes while the woman is not in labour, and advise the woman to report immediately any decrease in fetal movements. **[2007]**

1.11.6 If labour has not started 24 hours after rupture of the membranes, advise the woman to give birth where there is access to neonatal services and to stay in hospital for at least 12 hours after the birth. **[2007]**

1.12 First stage of labour

See the [recommendation on definitions of the latent and established first stages of labour](#).

1.12.1 Do not offer or advise clinical intervention if labour is progressing normally and the woman and baby are well. **[2007]**

1.12.2 In all stages of labour, women who have left the normal care pathway because of the development of complications can return to it if/when the

complication is resolved. **[2007]**

Duration of the first stage

1.12.3 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. **[2007]**

Observations during the established first stage

1.12.4 Do not routinely use verbal assessment using a numerical pain score. **[2007]**

1.12.5 Use a pictorial record of labour (partogram) once labour is established. **[2007]**

1.12.6 Where the partogram includes an action line, use the World Health Organization (WHO) recommendation of a 4-hour action line (the WHO partograph in management of labour, published in 1994 as part of the Maternal Health and Safe Motherhood Programme. Lancet 343: 1399 to 404). **[2007]**

See also the [WHO Multicountry Survey on Maternal and Newborn Health](#).

1.12.7 Record the following observations during the first stage of labour:

- half-hourly documentation of frequency of contractions
- hourly pulse
- 4-hourly temperature and blood pressure
- frequency of passing urine

- offer a vaginal examination (see [recommendation 1.4.5 in the section on initial assessment](#)) 4-hourly or if there is concern about progress or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss). **[2007]**

If any of the indications for transfer are met (see the [recommendation on ongoing assessment](#)), transfer the woman to obstetric-led care. Follow the [general principles for transfer of care](#). **[2014]**

- 1.12.8 Give ongoing consideration to the woman's emotional and psychological needs, including her desire for pain relief. **[2007]**
- 1.12.9 Encourage the woman to communicate her need for analgesia at any point during labour. **[2007]**

Possible routine interventions in the first stage

- 1.12.10 Do not routinely offer the package known as active management of labour (one-to-one continuous support; strict definition of established labour; early routine amniotomy; routine 2-hourly vaginal examination; oxytocin if labour becomes slow). **[2007]**
- 1.12.11 In normally progressing labour, do not perform amniotomy routinely. **[2007]**
- 1.12.12 Do not use combined early amniotomy with use of oxytocin routinely. **[2007]**

Delay in the first stage

- 1.12.13 If delay in the established first stage is suspected, take the following into account:
- parity
 - cervical dilatation and rate of change
 - uterine contractions

- station and position of presenting part
- the woman's emotional state
- referral to the appropriate healthcare professional.

Offer the woman support, hydration, and appropriate and effective pain relief. **[2007]**

1.12.14 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.

[2007]

If delay is diagnosed, transfer the woman to obstetric-led care. Follow the general principles for transfer of care. **[2014]**

1.12.15 If delay in the established first stage of labour is suspected, amniotomy should be considered for all women with intact membranes, after explanation of the procedure and advice that it will shorten her labour by about an hour and may increase the strength and pain of her contractions. **[2007]**

1.12.16 Whether or not a woman has agreed to an amniotomy, 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. **[2007]**

1.12.17 For women with intact membranes in whom delay in the established first stage of labour is confirmed, advise the woman to have an amniotomy, and to have a repeat vaginal examination 2 hours later whether her membranes are ruptured or intact. **[2007]**

- 1.12.18 For all women with confirmed delay in the established first stage of labour:
- transfer the woman to obstetric-led care for an obstetric review and a decision about management options, including the use of oxytocin (follow the [general principles for transfer of care](#)) [2014]
 - explain to her that 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 other outcomes. [2007]
- 1.12.19 For a multiparous woman with confirmed delay in the established first stage of labour, an obstetrician should perform a full assessment, including abdominal palpation and vaginal examination, before a decision is made about using oxytocin. [2007]
- 1.12.20 Offer all women with delay in the established first stage of labour support and effective pain relief. [2007]
- 1.12.21 Inform the woman that oxytocin will increase the frequency and strength of her contractions and that its use will mean that her baby should be monitored continuously. Offer the woman an epidural before oxytocin is started. [2007]
- 1.12.22 If oxytocin is used, ensure that the time between increments of the dose is no more frequent than every 30 minutes. Increase oxytocin until there are 4 to 5 contractions in 10 minutes. (See also recommendation 1.12.14 and [recommendation 1.3.8 in the NICE guideline on fetal monitoring in labour.](#)) [2007]
- 1.12.23 Advise the woman to have a vaginal examination 4 hours after starting oxytocin in established labour:
- If cervical dilatation has increased by less than 2 cm after 4 hours of oxytocin, further obstetric review is required to assess the need for caesarean section.
 - If cervical dilatation has increased by 2 cm or more, advise 4-hourly vaginal examinations. [2007]

1.13 Second stage of labour

Definition of the second stage

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

- Passive second stage of labour:
 - the finding of full dilatation of the cervix before or in the absence of involuntary expulsive contractions.
- Onset of the active second stage of labour:
 - the baby is visible
 - expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix
 - active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions. **[2007]**

Observations during the second stage

1.13.2 Carry out the following observations in the second stage of labour, record all observations on the partogram and assess whether transfer of care may be needed (see the [recommendation on ongoing assessment](#)). **[2007, amended 2014]:**

- half-hourly documentation of the frequency of contractions **[2007]**
- hourly blood pressure **[2007]**
- continued 4-hourly temperature **[2007]**
- frequency of passing urine **[2007]**

- offer a vaginal examination (see [recommendation 1.4.5 in the section on initial assessment](#)) hourly in the active second stage, or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss). **[2007]**

In addition:

- Continue to take the woman's emotional and psychological needs into account. **[2007]**
- 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 examination and any need for transfer to obstetric led care. **[2007, amended 2014]**
- 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 15 minutes to differentiate between the two heartbeats. **[2007, amended 2014]**
- Ongoing consideration should be given to the woman's position, hydration, coping strategies and pain relief throughout the second stage. **[2007]**

Duration of the second stage and definition of delay

1.13.3 For a nulliparous woman:

- birth would be expected to take place within 3 hours of the start of the active second stage in most women
- diagnose delay in the active second stage when it has lasted 2 hours and refer the woman to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent. **[2007]**

1.13.4 For a multiparous woman:

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

- diagnose delay in the active second stage when it has lasted 1 hour and refer the woman to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent. **[2007]**
- 1.13.5 For a nulliparous woman, suspect delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 1 hour of active second stage. Offer vaginal examination and then offer amniotomy if the membranes are intact. **[2007, amended 2014]**
- 1.13.6 For a multiparous woman, suspect delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 30 minutes of active second stage. Offer vaginal examination and then offer amniotomy if the membranes are intact. **[2014]**
- 1.13.7 If full dilatation of the cervix has been confirmed in a woman without regional analgesia, but she does not get an urge to push, carry out further assessment after 1 hour. **[2007]**

Oxytocin in the second stage

- 1.13.8 Consideration should be given to the use of oxytocin, with the offer of regional analgesia, for nulliparous women if contractions are inadequate at the onset of the second stage. **[2007]**

The woman's position and pushing in the second stage

- 1.13.9 Discourage the woman from lying supine or semi-supine in the second stage of labour and encourage her to adopt any other position that she finds most comfortable. **[2007]**
- 1.13.10 Inform the woman that in the second stage she should be guided by her own urge to push. **[2007]**
- 1.13.11 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. **[2007]**

Intrapartum interventions to reduce perineal trauma

- 1.13.12 Do not perform perineal massage in the second stage of labour. **[2007]**
- 1.13.13 Either the 'hands on' (guarding the perineum and flexing the baby's head) or the 'hands poised' (with hands off the perineum and baby's head but in readiness) technique can be used to facilitate spontaneous birth. **[2007]**
- 1.13.14 Do not offer lidocaine spray to reduce pain in the second stage of labour. **[2007]**
- 1.13.15 Do not carry out a routine episiotomy during spontaneous vaginal birth. **[2007]**
- 1.13.16 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. **[2007]**
- 1.13.17 Do not offer episiotomy routinely at vaginal birth after previous third- or fourth-degree trauma. **[2007]**
- 1.13.18 In order for a woman who has had previous third- or fourth-degree trauma to make an informed choice, talk with her about the future mode of birth, encompassing:
- current urgency or incontinence symptoms
 - the degree of previous trauma
 - risk of recurrence
 - the success of the repair undertaken
 - the psychological effect of the previous trauma
 - management of her labour. **[2007]**
- 1.13.19 Inform any woman with infibulated genital mutilation of the risks of difficulty with vaginal examination, catheterisation and application of

fetal scalp electrodes. Inform her of the risks of delay in the second stage and spontaneous laceration together with the need for an anterior episiotomy and the possible need for defibulation in labour. [2007]

- 1.13.20 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. [2007]
- 1.13.21 Perform an episiotomy if there is a clinical need, such as instrumental birth or suspected fetal compromise. [2007]
- 1.13.22 Provide tested effective analgesia before carrying out an episiotomy, except in an emergency because of acute fetal compromise. [2007]

Water birth

- 1.13.23 Inform women that there is insufficient high-quality evidence to either support or discourage giving birth in water. [2007]

Delay in the second stage

- 1.13.24 If there is delay in the second stage of labour, or if the woman is excessively distressed, support and sensitive encouragement and the woman's need for analgesia/anaesthesia are particularly important. [2007]
- 1.13.25 An obstetrician should assess a woman with confirmed delay in the second stage (after transfer to obstetric-led care, following the [general principles for transfer of care](#)) before contemplating the use of oxytocin. [2014]
- 1.13.26 After initial obstetric assessment of a woman with delay in the second stage, maintain ongoing obstetric review every 15 to 30 minutes. [2007]

Instrumental birth and delayed second stage

- 1.13.27 Think about offering instrumental birth if there is concern about the

baby's wellbeing or there is a prolonged second stage. [2007]

- 1.13.28 Recognise that, on rare occasions, the woman's need for help in the second stage may be an indication to assist by offering instrumental birth when supportive care has not helped. [2007]
- 1.13.29 The choice of instrument depends on a balance of clinical circumstance and practitioner experience. [2007]
- 1.13.30 Because instrumental birth is an operative procedure, advise the woman to have tested effective anaesthesia. [2007]
- 1.13.31 If a woman declines anaesthesia, offer a pudendal block combined with local anaesthetic to the perineum during instrumental birth. [2007]
- 1.13.32 If there is concern about fetal compromise, offer either tested effective anaesthesia or, if time does not allow this, a pudendal block combined with local anaesthetic to the perineum during instrumental birth. [2007]
- 1.13.33 Advise the woman to have a caesarean section if vaginal birth is not possible (see the [NICE guideline on caesarean birth](#)). [2007] .

Expediting birth

- 1.13.34 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. Assessments should include:
- the degree of urgency
 - clinical findings on abdominal and vaginal examination
 - choice of mode of birth (and whether to use forceps or ventouse if an instrumental birth is indicated)
 - anticipated degree of difficulty, including the likelihood of success if instrumental birth 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. **[2014]**

1.13.35 Talk with the woman and her birth companion(s) about why the birth needs to be expedited and what the options are. **[2014]**

1.13.36 Inform the team about the degree of urgency. **[2014]**

1.13.37 Record the time at which the decision to expedite the birth is made. **[2014]**

1.14 Third stage of labour

1.14.1 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. **[2014]**

Definition of the third stage

1.14.2 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
 - deferred 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
 - delivery of the placenta by maternal effort. **[2014]**

Prolonged third stage

- 1.14.3 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. Follow the [recommendations on managing retained placenta](#). **[2014]**

Observations in the third stage

- 1.14.4 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. **[2014]**
- 1.14.5 If there is postpartum haemorrhage, a retained placenta or maternal collapse, or any other concerns about the woman's wellbeing:
- transfer her to obstetric-led care (following the [general principles for transfer of care](#))
 - carry out frequent observations to assess whether resuscitation is needed. **[2014]**

Active and physiological management of the third stage

- 1.14.6 Explain to the woman antenatally about what to expect with each package of care for managing the third stage of labour and the benefits and risks associated with each. **[2014]**

1.14.7 Explain to the woman that active management:

- shortens the third stage compared with physiological management
- is associated with nausea and vomiting in about 100 in 1,000 women
- is associated with an approximate risk of 13 in 1,000 of a haemorrhage of more than 1 litre
- is associated with an approximate risk of 14 in 1,000 of a blood transfusion. **[2014]**

1.14.8 Explain to the woman that physiological management:

- is associated with nausea and vomiting in about 50 in 1,000 women
- is associated with an approximate risk of 29 in 1,000 of a haemorrhage of more than 1 litre
- is associated with an approximate risk of 40 in 1,000 of a blood transfusion. **[2014]**

1.14.9 Discuss again with the woman at the initial assessment in labour (see the [section on initial assessment](#)) about the different options for managing the third stage and ways of supporting her during delivery of the placenta, and ask if she has any preferences. **[2014]**

1.14.10 Advise the woman to have active management of the third stage, because it is associated with a lower risk of a postpartum haemorrhage and/or blood transfusion. **[2014]**

1.14.11 If a woman at low risk of postpartum haemorrhage requests physiological management of the third stage, support her in her choice. **[2014]**

1.14.12 Document in the records the decision that is agreed with the woman about management of the third stage. **[2014]**

1.14.13 For active management, administer 10 IU of oxytocin by intramuscular injection with the birth of the anterior shoulder or immediately after the birth of the baby and before the cord is clamped and cut. Use oxytocin as it is associated with fewer side effects than oxytocin plus

ergometrine. **[2014]**

1.14.14 After administering oxytocin, clamp and cut the cord.

- 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/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 in her choice. **[2014]**

1.14.15 After cutting the cord, use controlled cord traction. **[2014]**

1.14.16 Perform controlled cord traction as part of active management only after administration of oxytocin and signs of separation of the placenta. **[2014]**

1.14.17 Record the timing of cord clamping in both active and physiological management. **[2014]**

1.14.18 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. **[2014]**

1.14.19 Offer a change from physiological management to active management if the woman wants to shorten the third stage. **[2014]**

1.14.20 Do not use either umbilical oxytocin infusion or prostaglandin routinely in the third stage of labour. **[2014]**

Retained placenta

1.14.21 Secure intravenous access if the placenta is retained, and explain to the woman why this is needed. **[2014]**

- 1.14.22 Do not use umbilical vein agents if the placenta is retained. **[2014]**
- 1.14.23 Do not use intravenous oxytocic agents routinely to deliver a retained placenta. **[2014]**
- 1.14.24 Give intravenous oxytocic agents if the placenta is retained and the woman is bleeding excessively. **[2014]**
- 1.14.25 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. **[2014]**
- 1.14.26 If the woman reports inadequate analgesia during the assessment, stop the examination and address this immediately. **[2014]**
- 1.14.27 If uterine exploration is necessary and the woman is not already in an obstetric unit, arrange urgent transfer (following the [general principles for transfer of care](#)). **[2014]**
- 1.14.28 Do not carry out uterine exploration or manual removal of the placenta without an anaesthetic. **[2014]**

Postpartum haemorrhage

Risk factors

- 1.14.29 Advise women with risk factors for postpartum haemorrhage to give birth in an obstetric unit, where more emergency treatment options are available.

- Antenatal risk factors:
 - previous retained placenta or postpartum haemorrhage
 - maternal haemoglobin level below 85 g/litre at onset of labour
 - BMI greater than 35 kg/m²
 - grand multiparity (parity 4 or more)
 - antepartum haemorrhage
 - overdistention of the uterus (for example, multiple pregnancy, polyhydramnios or macrosomia)
 - existing uterine abnormalities
 - low-lying placenta
 - maternal age of 35 years or older.
- Risk factors in labour:
 - induction
 - prolonged first, second or third stage of labour
 - oxytocin use
 - precipitate labour
 - operative birth or caesarean section. **[2007]**

1.14.30 If a woman has risk factors for postpartum haemorrhage, highlight these in her notes, and make and discuss with her a care plan covering the third stage of labour. **[2007]**

Management

1.14.31 If a woman has a postpartum haemorrhage:

- call for help

- give immediate clinical treatment:
 - emptying of the bladder **and**
 - uterine massage **and**
 - uterotonic drugs **and**
 - intravenous fluids **and**
 - controlled cord traction if the placenta has not yet been delivered
- continuously assess blood loss and the woman's condition, and identify the source of the bleeding
- give supplementary oxygen
- arrange for transfer of the woman to obstetric-led care (following the general principles for transfer of care). [2014]

1.14.32 Administer a bolus of one of the following as first-line treatment for postpartum haemorrhage:

- oxytocin (10 IU intravenous) **or**
- ergometrine (0.5 mg intramuscular) **or**
- combined oxytocin and ergometrine (5 IU/0.5 mg intramuscular). [2014]

1.14.33 Offer second-line treatment for postpartum haemorrhage if needed. No particular uterotonic drug can be recommended over any other; options include:

- repeat bolus of:
 - oxytocin (intravenous)
 - ergometrine (intramuscular, or cautiously intravenously)
 - combined oxytocin and ergometrine (intramuscular)
- misoprostol
- oxytocin infusion

- carboprost (intramuscular). **[2014]**
- 1.14.34 Assess the need for adjuvant options for managing significant continuing postpartum haemorrhage, including:
- tranexamic acid (intravenous)
 - rarely, in the presence of otherwise normal clotting factors, rFactor VIIa, in consultation with a haematologist. **[2014]**
- 1.14.35 Allocate a member of the healthcare team to stay with the woman and her birth companion(s), explain what is happening, answer any questions and offer support throughout the emergency situation. **[2014]**
- 1.14.36 If the haemorrhage continues:
- perform examination under anaesthetic
 - ensure that the uterus is empty and repair any trauma
 - consider balloon tamponade before surgical options. **[2014]**
- 1.14.37 Be aware that no particular surgical procedure can be recommended over any other for treating postpartum haemorrhage. **[2014]**
- 1.14.38 The maternity service and ambulance service should have strategies in place in order to respond quickly and appropriately if a woman has a postpartum haemorrhage in any setting. **[2014]**

1.15 Care of the newborn baby

Initial assessment of the newborn baby and mother–baby bonding

Recommendations 1.15.6, 1.15.8 and 1.15.9 have been adapted from [NICE's guideline on postnatal care](#); refer to this guideline for more information on immediate postnatal care (within 2 hours of birth).

- 1.15.1 Record the Apgar score routinely at 1 and 5 minutes for all births. **[2007]**

- 1.15.2 Record the time from birth to the onset of regular respirations. **[2014]**
- 1.15.3 If the baby is born in poor condition (on the basis of abnormal breathing, heart rate or tone):
- follow the recommendations in the section on neonatal resuscitation **and**
 - take paired cord-blood samples for blood gas analysis, after clamping the cord using 2 clamps.
- Continue to evaluate and record the baby's condition until it is improved and stable. **[2014]**
- 1.15.4 Do not take paired cord blood samples (for blood gas analysis) routinely. **[2014]**
- 1.15.5 Ensure that a second clamp to allow double-clamping of the cord is available in all birth settings. **[2014]**
- 1.15.6 Encourage women to have skin-to-skin contact with their babies as soon as possible after the birth. **[2007]**
- 1.15.7 In order to keep the baby warm, dry and cover him or her with a warm, dry blanket or towel while maintaining skin-to-skin contact with the woman. **[2007]**
- 1.15.8 Avoid separation of a 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. **[2007]**
- 1.15.9 Encourage initiation of breastfeeding as soon as possible after the birth, ideally within 1 hour. **[2007]**
- 1.15.10 Record head circumference, body temperature and birth weight soon after the first hour following birth. **[2007]**
- 1.15.11 Undertake an initial examination to detect any major physical abnormality and to identify any problems that require referral. **[2007]**

1.15.12 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. **[2007]**

Neonatal resuscitation

1.15.13 In the first minutes after birth, evaluate the condition of the baby – specifically respiration, heart rate and tone – in order to determine whether resuscitation is needed according to nationally accredited guidelines on neonatal resuscitation. **[2014]**

1.15.14 All relevant healthcare professionals caring for women during birth should attend annually a course in neonatal resuscitation that is consistent with nationally accredited guidelines on neonatal resuscitation. **[2014]**

1.15.15 In all birth settings:

- bear in mind that it will be necessary to call for help if the baby needs resuscitation, and plan accordingly
- ensure that there are facilities for resuscitation, and for transferring the baby to another location if necessary
- develop emergency referral pathways for both the woman and the baby, and implement these if necessary. **[2014]**

1.15.16 If a newborn baby needs basic resuscitation, start with air. **[2014]**

1.15.17 Minimise separation of the baby and mother, taking into account the clinical circumstances. **[2014]**

1.15.18 Throughout an emergency situation in which the baby needs resuscitation, allocate a member of the healthcare team to talk with, and offer support to, the woman and any birth companion(s). **[2014]**

Care of babies in the presence of meconium

1.15.19 In the presence of any degree of meconium:

- do not suction the baby's upper airways (nasopharynx and oropharynx) before birth of the shoulders and trunk
- do not suction the baby's upper airways (nasopharynx and oropharynx) if the baby has normal respiration, heart rate and tone
- do not intubate if the baby has normal respiration, heart rate and tone. **[2014]**

1.15.20 If there has been significant meconium (see [recommendation 1.5.2 in the section on presence of meconium](#)) and the baby does not have normal respiration, heart rate and tone, follow nationally accredited guidelines on neonatal resuscitation, including early laryngoscopy and suction under direct vision. **[2014]**

1.15.21 If there has been significant meconium and the baby is healthy, closely observe the baby within a unit with immediate access to a neonatologist. Perform these observations at 1 and 2 hours of age and then 2-hourly until 12 hours of age. **[2014]**

1.15.22 If there has been non-significant meconium, observe the baby at 1 and 2 hours of age in all birth settings. **[2014]**

1.15.23 If any of the following are observed after any degree of meconium, ask a neonatologist to assess the baby (transfer both the woman and baby if they are at home or in a freestanding midwifery unit, following the [general principles for transfer of care](#)):

- respiratory rate above 60 per minute
- the presence of grunting
- heart rate below 100 or above 160 beats/minute
- capillary refill time above 3 seconds
- body temperature of 38°C or above, or 37.5°C on 2 occasions 30 minutes apart
- oxygen saturation below 95% (measuring oxygen saturation is optional after non-significant meconium)

- presence of central cyanosis, confirmed by pulse oximetry if available. [2014]

Be aware that some pulse oximeters can underestimate or overestimate oxygen saturation levels, especially if the saturation level is borderline.

Overestimation has been reported in people with dark skin. See also the [NHS England Patient Safety Alert on the risk of harm from inappropriate placement of pulse oximeter probes](#).

- 1.15.24 Explain the findings to the woman, and inform her about what to look out for and who to talk to if she has any concerns. [2014]

Babies born to women with prelabour rupture of the membranes at term

- 1.15.25 Closely observe any baby born to a woman with prelabour rupture of the membranes (more than 24 hours before the onset of established labour) at term for the first 12 hours of life (at 1 hour, 2 hours, 6 hours and 12 hours) in all settings. Include assessment of:

- temperature
- heart rate
- respiratory rate
- presence of respiratory grunting
- significant subcostal recession
- presence of nasal flare
- presence of central cyanosis, confirmed by pulse oximetry if available
- skin perfusion assessed by capillary refill

- floppiness, general wellbeing and feeding.

If any of these are observed, ask a neonatologist to assess the baby (transfer both the woman and baby if they are at home or in a freestanding midwifery unit, following the [general principles for transfer of care](#)). **[2014]**

Be aware that some pulse oximeters can underestimate or overestimate oxygen saturation levels, especially if the saturation level is borderline.

Overestimation has been reported in people with dark skin. See also the [NHS England Patient Safety Alert on the risk of harm from inappropriate placement of pulse oximeter probes](#).

- 1.15.26 If there are no signs of infection in the woman, do not give antibiotics to either the woman or the baby, even if the membranes have been ruptured for over 24 hours. **[2007]**
- 1.15.27 If there is evidence of infection in the woman, prescribe a full course of broad-spectrum intravenous antibiotics. **[2007]**
- 1.15.28 Advise women with prelabour rupture of the membranes to inform their healthcare professionals immediately of any concerns they have about their baby's wellbeing in the first 5 days after birth, particularly in the first 12 hours when the risk of infection is greatest. **[2007]**
- 1.15.29 Do not perform blood, cerebrospinal fluid and/or surface culture tests in an asymptomatic baby. **[2007]**
- 1.15.30 Refer a baby with any symptom of possible sepsis, or born to a woman who has evidence of chorioamnionitis, to a neonatal care specialist immediately. **[2007]**

1.16 Care of the woman after birth

Initial assessment

- 1.16.1 Carry out the following observations of the woman after birth:

- Record her temperature, pulse and blood pressure. Transfer the woman (with her baby) to obstetric-led care if any of the relevant indications listed in the [recommendation on ongoing assessment](#) are met.
- Uterine contraction and lochia.
- Examine the placenta and membranes: assess their condition, structure, cord vessels and completeness. Transfer the woman (with her baby) to obstetric-led care if the placenta is incomplete.
- Early assessment of the woman's emotional and psychological condition in response to labour and birth.
- Successful voiding of the bladder. Assess whether to transfer the woman (with her baby) to obstetric-led care after 6 hours if her bladder is palpable and she is unable to pass urine.

If transferring the woman to obstetric-led care, follow the [general principles for transfer of care](#). **[2014]**

Perineal care

1.16.2 Define perineal or genital trauma caused by either tearing or episiotomy as follows:

- first degree – injury to skin only
- second degree – injury to the perineal muscles but not the anal sphincter
- third degree – injury to the perineum involving the anal sphincter complex:
 - 3a – less than 50% of external anal sphincter thickness torn
 - 3b – more than 50% of external anal sphincter thickness torn
 - 3c – internal anal sphincter torn.
- fourth degree – injury to the perineum involving the anal sphincter complex (external and internal anal sphincter) and anal epithelium. **[2007]**

1.16.3 Before assessing for genital trauma:

- explain to the woman what is planned 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. **[2007]**
- 1.16.4 Perform the initial examination gently and with sensitivity. It may be done in the immediate period after birth. **[2007]**
- 1.16.5 If genital trauma is identified after birth, offer further systematic assessment, including a rectal examination. **[2007]**
- 1.16.6 Include the following in a systematic assessment of genital trauma:
- further explanation of what is planned and why
 - confirmation by the woman that tested effective local or regional analgesia is in place
 - visual assessment of the extent of perineal trauma to include the structures involved, the apex of the injury and assessment of bleeding
 - a rectal examination to assess whether there has been any damage to the external or internal anal sphincter if there is any suspicion that the perineal muscles are damaged. **[2007]**
- 1.16.7 Ensure that the timing of this systematic assessment does not interfere with mother–baby bonding unless the woman has bleeding that requires urgent attention. **[2007]**
- 1.16.8 Assist the woman to adopt a position that allows adequate visual assessment of the degree of trauma and for repair. Only maintain this position for as long as necessary for systematic assessment and repair. If it is not possible to adequately assess the trauma, transfer the woman (with her baby) to obstetric-led care, following the general principles for transfer of care. **[2007, amended 2014]**
- 1.16.9 Seek advice from a more experienced midwife or obstetrician if there is

uncertainty about the nature or extent of the trauma. Transfer the woman (with her baby) to obstetric-led care (following the [general principles for transfer of care](#)) if the repair needs further surgical or anaesthetic expertise. **[2007, amended 2014]**

- 1.16.10 Document the systematic assessment and its results fully, possibly pictorially. **[2007]**
- 1.16.11 All relevant healthcare professionals should attend training in perineal/genital assessment and repair, and ensure that they maintain these skills. **[2007]**
- 1.16.12 Undertake repair of the perineum as soon as possible to minimise the risk of infection and blood loss. **[2007]**
- 1.16.13 When carrying out perineal repair:
- ensure that tested effective analgesia is in place, using infiltration with up to 20 ml of 1% lidocaine or equivalent
 - top up the epidural or insert a spinal anaesthetic if necessary. **[2007]**
- 1.16.14 If the woman reports inadequate pain relief at any point, address this immediately. **[2007]**
- 1.16.15 Advise the woman that in the case of first-degree trauma, the wound should be sutured in order to improve healing, unless the skin edges are well opposed. **[2007]**
- 1.16.16 Advise the woman that in the case of second-degree trauma, the muscle should be sutured in order to improve healing. **[2007]**
- 1.16.17 If the skin is opposed after suturing of the muscle in second-degree trauma, there is no need to suture it. **[2007]**
- 1.16.18 If the skin does require suturing, use a continuous subcuticular technique. **[2007]**
- 1.16.19 Undertake perineal repair using a continuous non-locked suturing

technique for the vaginal wall and muscle layer. **[2007]**

1.16.20 Use an absorbable synthetic suture material to suture the perineum. **[2007]**

1.16.21 Offer rectal non-steroidal anti-inflammatory drugs routinely after perineal repair of first- and second-degree trauma provided these drugs are not contraindicated. **[2007]**

1.16.22 Observe the following basic principles when performing perineal repairs:

- Repair perineal trauma using aseptic techniques.
- Check equipment and count swabs and needles before and after the procedure.
- Good lighting is essential to see and identify the structures involved.
- Ensure that difficult trauma is repaired by an experienced practitioner in theatre under regional or general anaesthesia.
- Insert an indwelling catheter for 24 hours to prevent urinary retention.
- Ensure that good anatomical alignment of the wound is achieved and that consideration is given to the cosmetic results.
- Carry out rectal examination after completing the repair to ensure that suture material has not been accidentally inserted through the rectal mucosa.
- After completion of the repair, document an accurate detailed account covering the extent of the trauma, the method of repair and the materials used.
- Give the woman information about the extent of the trauma, pain relief, diet, hygiene and the importance of pelvic-floor exercises (see the [NICE guideline on pelvic floor dysfunction](#)). **[2007]**

Putting this guideline into practice

NICE has produced [tools and resources to help you put this guideline into practice](#).

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed.

Implementing change is most effective when aligned with local priorities.

Changes recommended for clinical practice that can be done quickly – like changes in prescribing practice – should be shared quickly. This is because healthcare professionals should use guidelines to guide their work – as is required by professional regulating bodies such as the General Medical and Nursing and Midwifery Councils.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. **Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.
2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.
3. **Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.
4. **Think about what data you need to measure improvement** and plan how you will collect it. You may want to work with other health and social care organisations and specialist

groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. **For very big changes** include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.

8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our [into practice pages](#) for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) *Achieving high quality care – practical experience from NICE*. Chichester: Wiley.

Context

Giving birth is a life-changing event. The care that a woman receives during labour has the potential to affect her – both physically and emotionally, in the short and longer term – and the health of her baby. Good communication, support and compassion from staff, and having her wishes respected, can help her feel in control of what is happening and contribute to making birth a positive experience for the woman and her birth companion(s).

This guideline covers the care of healthy women who go into labour at term (37⁺⁰ to 41⁺⁶ weeks). About 700,000 women give birth in England and Wales each year, of whom about 40% are having their first baby. Most of these women are healthy and have a straightforward pregnancy. Almost 90% of women will give birth to a single baby after 37 weeks of pregnancy, with the baby presenting head first. About two-thirds of women go into labour spontaneously. Therefore, most women giving birth in England and Wales are covered by this guideline.

Since the original guideline was published in 2007, the number of women giving birth in England and Wales each year has risen, the rate of intervention (instrumental births and caesarean section) has increased slightly, and there has been some reconfiguration of services. The decision to update the guideline in 2014 was made based on developments in the NHS and new evidence becoming available that could affect the recommendations from 2007.

It is important that the woman is given information and advice about all available settings when she is deciding where to have her baby, so that she is able to make a fully informed decision. This includes information about outcomes for the different settings. It is also vital to recognise when transfer of care from midwifery-led care to obstetric-led care is indicated because of increased risk to the woman and/or her baby resulting from complications that have developed during labour.

Uncertainty and inconsistency of care has been identified in a number of areas, such as choosing place of birth, care during the latent first stage of labour, fetal assessment and monitoring during labour (particularly cardiotocography compared with intermittent auscultation) and management of the third stage of labour. These and other related topics are addressed in the guideline.

The guideline is intended to cover the care of healthy women with uncomplicated pregnancies entering labour at low risk of developing intrapartum complications. In addition, recommendations are included that address the care of women who start labour as 'low risk' but who go on to develop complications. These include the care of women with prelabour rupture of membranes at term, care of the woman and baby when meconium is present, indications for continuous cardiotocography, interpretation of cardiotocograph traces, and management of retained placenta and postpartum haemorrhage. Aspects of intrapartum care for women at risk of developing intrapartum complications are covered by a range of NICE guidelines on specific conditions and a further guideline is planned on the intrapartum care of women at high risk of complications during pregnancy and the intrapartum period.

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Models of midwifery-led care

In December 2021, we stood down this recommendation for research as continuity of care in maternity services is now a national policy in the UK following on from the [National Maternity Review on Better Births](#) and the subsequent [Maternity Transformation Programme](#).

2 Effect of information giving on place of birth

How does the provision of accurate, evidence-based information affect women's decision-making processes and choice of place of birth?

Why this is important

A report by Coxon et al. (2013) identifies in detail why women make choices about where to give birth and how these choices can be influenced. Influences may include written and verbal information (both online and from midwives and doctors), previous experience, and word-of-mouth advice from friends and family. The Birthplace study concluded that giving birth outside an obstetric unit is the optimal choice for low-risk women. This finding should be used to restructure the way in which information is provided, so that it is presented in a more accurate, less risk-based way in order to support women's choices. This change should be evaluated in a quantitative observational study and/or qualitative study that records any changes in women's choice-making about place of birth. Outcomes include understanding why and how women make choices about where to give birth and how this can influence the provision of appropriate and accessible information, a measure of informed decision-making, and fearfulness and absence of fearfulness when choosing place of birth.

3 Long-term consequences of planning birth in different settings

What are the long-term consequences for women and babies of planning birth in different settings?

Why this is important

The long-term consequences of birth experiences and birth outcomes are poorly understood, particularly in relation to place of birth. A large population-based observational study would compare women's experiences and outcomes in different birth settings (with subgroup analysis by mode of birth) in relation to the wellbeing of the women and their children over different periods of time (for example, 2, 5, 10, 15, 20 and 30 years). A secondary analysis could compare different providers where birth philosophies are different. Outcomes would be compared by accessing medical records and through qualitative interviews. Primary outcomes are long-term physical morbidity, pain after birth, readmission to hospital, infection, psychological morbidity (for example, postnatal depression, bonding, relationship breakdown with partner, fear of giving birth in future) and breastfeeding rates. Secondary outcomes are impact on attachment between mother and child, obesity in children, autoimmune disease, chronic illness, educational achievement and family functioning.

4 Education about the latent first stage of labour

Does enhanced education specifically about the latent first stage of labour increase the number of nulliparous women who wait until they are in established labour before attending the obstetric or midwifery unit (or calling the midwife to a home birth), compared with women who do not receive this education?

Why this is important

Studies show that antenatal education about labour and birth in general makes a difference to some birth outcomes, but there is limited evidence focusing on education about the latent first stage of labour specifically. The aim of this study (randomised controlled trial or prospective observational study) would be to compare 2 groups of women experiencing their first labour and birth: a group who receive an education session in late pregnancy covering what to expect in the latent first stage of labour and how to

recognise the onset of established labour, and a group who have not received this focused education. Primary outcomes would be mode of birth, satisfaction with the birth experience and the woman's physical and emotional wellbeing after birth. Secondary outcomes would be use of pharmacological pain relief, use of oxytocin to augment labour, and time from first contact in confirmed established labour to birth.

5 Postpartum haemorrhage

What is the most effective treatment for primary postpartum haemorrhage?

Why this is important

There is uncertainty about the most effective drug treatments and dosage regimes, and about which other treatments should be used, for women who develop a postpartum haemorrhage. The most effective sequencing of interventions is also uncertain. The psychological impact of postpartum haemorrhage for women can be significant, and identifying the approach that minimises this impact is important. Randomised controlled trials comparing different dosage regimes for oxytocin and misoprostol, as well as comparisons with ergometrine and carboprost, are needed. Trials of mechanical measures such as intrauterine balloons or interventional radiology as early second-line treatment (rather than an alternative drug treatment) are also needed. Alternatively, a trial comparing the effectiveness of a complex intervention (for example, an educational component, sequence of interventions, immediate feedback and quality improvements) compared with standard care could be undertaken. Important outcomes include blood and blood product transfusion, need for further intervention, need for hysterectomy and psychological outcomes for the woman.

Appendix A: Adverse outcomes

Adverse outcome: in order to be able to count enough adverse events to be able to say that the results recorded are not just a result of chance, the [Birthplace UK \(2011\) study](#) used a composite definition of 'adverse outcome'. The definition includes the following outcomes: stillbirth during labour, death of the baby in the first week after birth, neonatal encephalopathy (disordered brain function caused by oxygen deprivation before or during birth), meconium aspiration syndrome, and physical birth injuries (brachial plexus injury and bone fractures). The term 'serious medical problems' has been used to describe this composite outcome in the guideline recommendations.

Table A1 Numbers and proportions of the individual components of the composite adverse outcomes measure recorded in the Birthplace UK (2011) study

Outcome	Actual number of babies affected out of (63,955 to 64,535*; number per 1,000)	Percentage of all adverse outcomes measured
Stillbirth after start of care in labour	14 out of 64,535 (0.22 per 1,000)	5%
Death of the baby in the first week after birth	18 out of 64,292 (0.28 per 1,000)	7%
Neonatal encephalopathy (disordered brain function caused by oxygen deprivation before or during birth) (clinical diagnosis)	102 out of 63,955 (1.6 per 1,000)	40%
Meconium aspiration syndrome (the baby breathes meconium into their lungs)	86 out of 63,955 (1.3 per 1,000)	34%
Brachial plexus injury	24 out of 63,955 (0.38 per 1,000)	9%
Bone fractures	11 out of 63,955 (0.17 per 1,000)	4%

<p>Total (of all outcomes included in the 'adverse outcome' composite measure)</p>	<p>255 out of 63,955 to 64,535 (approximately 4 per 1,000)</p>	<p>99%**</p>
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Note: Each of the categories above are mutually exclusive and outcomes listed higher in the table take precedence over outcomes listed lower down. For example, if a baby with neonatal encephalopathy died within 7 days the outcome is classified as an early neonatal death.

* Denominator varies because of missing values.

** Does not equal 100% because of rounding.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the [NICE topic page on intrapartum care](#). For full details of the evidence and the guideline committee's discussions, see the [full guideline](#). You can also find information about [how the guideline was developed](#), including [details of the committee](#).

NICE has produced [tools and resources to help you put this guideline into practice](#). For general help and advice on putting our guidelines into practice, see [resources to help you put NICE guidance into practice](#).

Update information

December 2022: We removed section 1.10 on monitoring during labour because these recommendations have been replaced by the [NICE guideline on fetal monitoring in labour](#). We also updated the links in recommendations 1.4.9, 1.4.10 and 1.12.22.

February 2017: The evidence has been reviewed for the sections on measuring fetal heart rate as part of the initial assessment and on fetal monitoring during labour. Recommendations for which the evidence was reviewed are labelled **[2017]**. Recommendations were added or amended, or the committee agreed that no changes were needed to the recommended actions.

Where recommendations end **[2007]**, **[2007, amended 2014]**, **[2014]** or **[2016]**, the evidence has not been reviewed.

As part of this update, the committee has also removed a research recommendation on intermittent auscultation compared with cardiotocography. Details can be found in [addendum 190.1](#).

November 2016: A recommendation about team midwifery was deleted, and a new recommendation was added (labelled **[2016]**) that cross-refers to information about continuity of care in the NICE guideline on patient experience in NHS services.

Minor changes since publication

October 2022: We added text to indicate that pulse oximetry may be less reliable in people with dark skin. We also added a link to the NHS patient safety alert on the risk of harm from inappropriate placement of pulse oximeter probes. See recommendations 1.15.23 and 1.15.25.

December 2021: We added a link to NICE's guideline on pelvic floor dysfunction in recommendation 1.16.22. We also stood down the recommendation for research on models of midwifery-led care as continuity of care in maternity services is now a national policy in the UK following on from the [National Maternity Review on Better Births](#) and the subsequent [Maternity Transformation Programme](#).

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