NICE National Institute for Health and Care Excellence

NICE Pathways

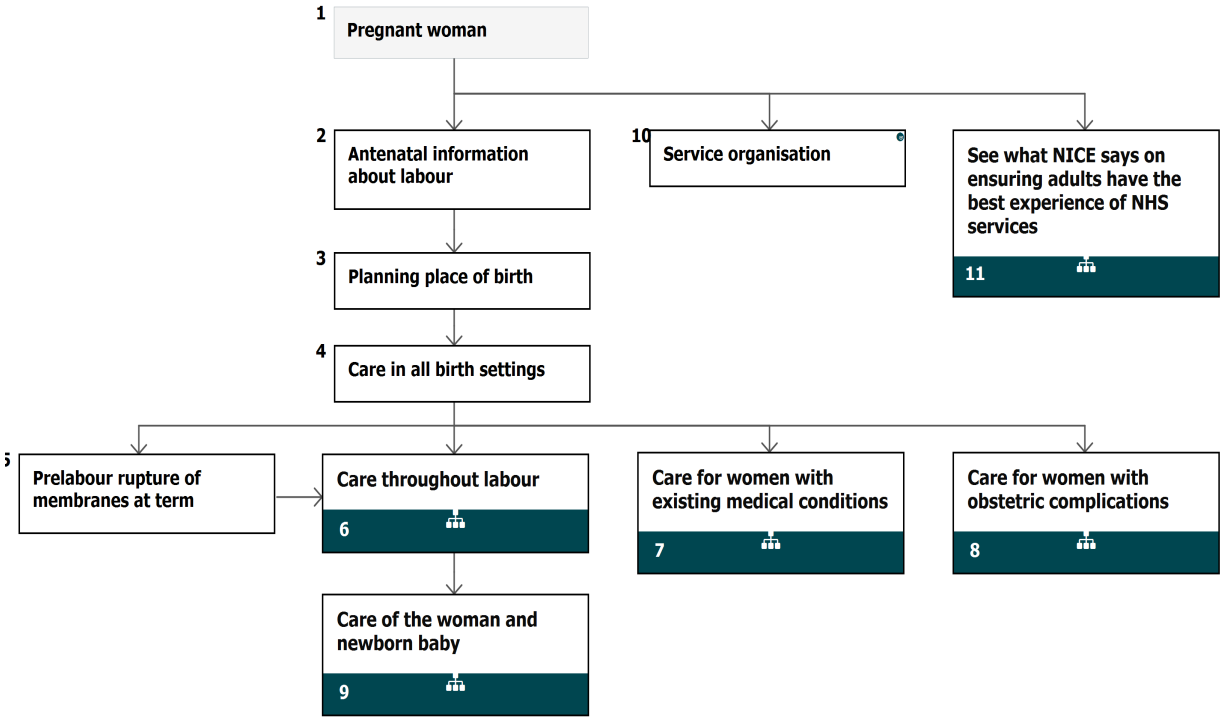
Intrapartum care overview

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/intrapartum-care
NICE Pathway last updated: 02 April 2019

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



1 Pregnant woman

No additional information

2 Antenatal information about labour

For more information on antenatal care, see what NICE says on antenatal care for uncomplicated pregnancies.

All women

Latent phase of labour and signs of labour

Give all nulliparous women information antenatally about

- what to expect in the latent phase of labour
- how to work with any pain they experience
- how to contact their midwifery care team and what to do in an emergency.

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.

Managing third stage of labour

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.

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.

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 1000 women
- is associated with an approximate risk of 13 in 1000 of a haemorrhage of more than 1 litre
- is associated with an approximate risk of 14 in 1000 of a blood transfusion.

Explain to the woman that physiological management:

- is associated with nausea and vomiting in about 50 in 1000 women
- is associated with an approximate risk of 29 in 1000 of a haemorrhage of more than 1 litre
- is associated with an approximate risk of 40 in 1000 of a blood transfusion.

Women with previous perineal trauma or infibulated genital mutilation

For information to give women who have had previous third- or fourth-degree trauma or with infibulated genital mutilation see interventions to reduce perineal trauma.

Women with risk factors for postpartum haemorrhage

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.

- Antenatal risk factors:
  - previous retained placenta or postpartum haemorrhage
  - maternal haemoglobin level below 8.5 g/dl at onset of labour
  - BMI greater than 35 kg/m^2
  - 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.

3 Planning place of birth

For detailed information on planning place of birth, see what NICE says on planning place of birth in antenatal care for uncomplicated pregnancies.

4 Care in all birth settings

For all women giving birth in all birth settings, follow the principles in NICE's recommendations on patient experience.

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.

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.

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.

5 Prelabour rupture of membranes at term

Do not carry out a speculum examination if it is certain that the membranes have ruptured.

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.

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 is appropriate approximately 24 hours after rupture of the membranes.

For more information see what NICE says on early-onset neonatal infection and induction of labour.

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.

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.

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.

Vision Amniotic Leak Detector to assess unexplained vaginal wetness in pregnancy

The following recommendations are from NICE medical technologies guidance on Vision Amniotic Leak Detector to assess unexplained vaginal wetness in pregnancy.

The case for adopting the Vision Amniotic Leak Detector (ALD), when issued by a midwife or other healthcare worker, is supported by the evidence. The available evidence suggests that the device can reliably exclude amniotic fluid leak as a cause of vaginal wetness in pregnancy, avoiding the need for a speculum examination and its associated discomforts. Using the device in the community could prevent unnecessary referrals to secondary care antenatal day units or

maternity triage services for speculum examinations, releasing clinical time.

The Vision ALD should be considered for use in pregnant women with unexplained vaginal wetness.

Based on cost modelling, using the Vision ALD is estimated to be cost saving in scenarios considered to be clinically likely, by avoiding the need for referral to an antenatal day unit. When issued by a midwife or other healthcare worker in a primary care setting, cost savings per woman of up to £24.01 (for prelabour rupture of membranes; PROM) and £18.25 (for preterm prelabour rupture of membranes; PPROM) could be achieved. When issued by a community midwife in a woman's home, Vision ALD is associated with an estimated cost saving of up to £21.01 per woman for PROM and £15.25 per woman for PPROM.

6 Care throughout labour

See Intrapartum care / Care throughout labour

7 Care for women with existing medical conditions

See Intrapartum care for women with existing medical conditions

8 Care for women with obstetric complications

See Intrapartum care for women with obstetric complications

9 Care of the woman and newborn baby

See Intrapartum care / Care of the woman and newborn baby

10 Service organisation

Clinical governance

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.

Birth settings

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).

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 epidural analgesia.

Continuity of care

For guidance on ensuring continuity of care, see what NICE says on continuity of care and relationships in patient experience.

Transfer of care protocols

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 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.

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.

Safe midwifery staffing

For information about safe midwifery staffing requirements for maternity settings, based on the best available evidence, see what NICE says on safe midwifery staffing for maternity settings.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

1. Choosing birth setting

11 See what NICE says on ensuring adults have the best experience of NHS services

See Patient experience in adult NHS services

Glossary

Birth settings

(home, freestanding midwifery unit, alongside midwifery unit and obstetric unit)

Must

in accordance with current health and safety legislation (at the time of publication of NICE clinical guideline 139 [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

Transfer of care

(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)

Sources

Intrapartum care for healthy women and babies (2014 updated 2017) NICE guideline CG190

Vision Amniotic Leak Detector to assess unexplained vaginal wetness in pregnancy (2013) NICE medical technologies guidance 15

Your responsibility

Guidelines

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.

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.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so 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.

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.

Medical technologies guidance, diagnostics guidance and interventional procedures

guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance 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.