

## Understanding NICE guidance

---

Information for people who use NHS services

# Care of women and their babies during labour

*NICE 'clinical guidelines' advise the NHS on caring for people and the treatments they should receive.*

This booklet is about the care of women and their babies during labour in the NHS in England and Wales. It explains guidance (advice) from NICE (the National Institute for Health and Clinical Excellence). It is written for women who are preparing to give birth but it may also be useful for their families or carers.

The booklet aims to help you understand the care that should be available in the NHS during labour. On page 9 there are examples of questions you could ask to help you. Some sources of further information and support are on the back page.



## Contents

Care and communication	3
Planning for labour and birth	4
Care during labour	7
What happens during labour	8
Complications	10
More information about giving birth	12
About NICE	12

### **The advice in the NICE guideline covers:**

- healthy women who are giving birth at 37–42 weeks (known as ‘term’).

### **It does not specifically look at women:**

- who are giving birth before 37 weeks
- whose unborn baby is not growing properly
- who have conditions such as pre-eclampsia (high blood pressure during pregnancy) or diabetes, or infections such as group B streptococcus, HIV or genital herpes virus
- who are having more than one baby
- who need a caesarean section.

NICE has also published guidelines on the care of women during pregnancy, the care that women and their babies should receive during the first 6–8 weeks after birth, the care of women who have their labour induced and the care of women who have a caesarean section. All of these guidelines are available at [www.nice.org.uk](http://www.nice.org.uk)

## Care and communication

Your care should take into account your personal needs and preferences. Every woman's experience of labour and birth is unique and the way labour progresses can affect the choices made. You should be fully informed about all the options available and be able to make decisions in partnership with your healthcare team and your birth partner.

Any information, and discussions you have with your midwife, should include explanations and details about the care and treatments you receive, and about their possible advantages and disadvantages. You can ask any questions you want and can always change your mind. Your own preference is important and your healthcare team should support your choice of care wherever possible.

All healthcare professionals should treat you and your baby with respect, dignity, kindness and understanding, and explain your care simply and clearly.

Your care and the information you are given should take account of any religious, ethnic or cultural needs you may have. It should also take into account any additional factors, such as physical or learning disabilities, sight or hearing problems, or difficulties with reading or speaking English. A member of your healthcare team should be able to arrange for you to have an interpreter or an advocate (someone who supports you in asking for what you want), if that is what you need. Your interpreter or advocate will keep anything you tell them private.

*Some care may not be suitable for you, depending on your individual circumstances. If you have questions about the care and treatment covered in this booklet, please talk to your healthcare team.*

## Planning for labour and birth

### Choosing where you have your baby

You can plan to give birth at home, in a unit run by midwives or in a hospital. Giving birth is generally very safe for both you and your baby wherever you choose. There is not much evidence available comparing how safe the different places that you can choose are. What information there is suggests that women who give birth in a unit run by midwives or at home are more likely to have a normal birth and less likely to need assistance, for example using forceps.

If you choose to give birth at home or in a unit run by midwives, you should be given information about the likelihood of being transferred to hospital during labour and an estimate of how long this will take. You should also be aware that if something goes seriously wrong during your labour (which is rare) it could be worse for you or your baby than if you were already in hospital with access to specialised care.

Certain conditions which you already have or develop during your pregnancy may mean that you are advised to give birth in a hospital.

### Preparation for labour

Wherever you plan to give birth, you may want to arrange a birth partner to be with you to support and encourage you during your labour. This might be your partner or a relative or friend, for example. You can also plan to play your choice of music in the labour ward. If there are no problems, you will be able to drink during labour when you want to; isotonic drinks (sports drinks) may be more beneficial than water. You may also eat a light snack if you are hungry.

### Coping with pain

Most women use some methods to help them cope with pain during labour, and you will be able to ask for pain relief at any time. You can choose one method or several different ones, and you might change from one to another as your labour progresses. You should be told about the advantages and disadvantages of each so that you can make an informed decision about what is right for you. The options are shown on page 5.

Pain-relieving method	Effects	Where is it available?
Breathing and relaxation techniques	May help you cope with labour No unwanted effects	At home, in a unit run by midwives or in a hospital
Being in water during labour, in a bath or birthing pool	Provides good pain relief You can leave the water at any time Reduces the need for an epidural No unwanted effects	At home, in a unit run by midwives or in a hospital (a birthing pool may not always be available)
Massage by your birth partner	May relieve pain No unwanted effects	At home, in a unit run by midwives or in a hospital
Gas and oxygen ('Entonox'), a drug which you breathe in	Gives some pain relief Can be used while you are in water, can be stopped easily if you don't like it and side effects quickly wear off Could make you feel sick and light-headed	At home, in a unit run by midwives or in a hospital
Pethidine or similar drugs which are given as injections	Gives limited pain relief Could make you feel drowsy Could make you feel sick but you will be offered a drug to help this You will not be able to get into water for 2 hours or longer if you feel sleepy Could affect your baby's breathing immediately after birth Could make the baby drowsy for several days which may interfere with breastfeeding	At home, in a unit run by midwives or in a hospital
Epidural – a local anaesthetic (a drug that makes part of your body numb to pain) which is injected into your spine A fine tube is left in place in your spine which makes it easier for the anaesthetist to give you more pain relief if needed	The most effective type of pain relief; it should give total pain relief within 30 minutes You and your baby will need careful monitoring (see page 6) Does not increase your chances of a longer first stage of labour or caesarean section Could make the second stage of your labour longer and increase the chance of assisted birth (for example, using forceps) Is not linked to long-term backache If your epidural is in place for a long time, it could affect your baby's breathing immediately after birth and make the baby drowsy	Only in a hospital because it is given by an anaesthetist

Some women find acupuncture, acupressure or hypnosis helpful, and they may arrange this for themselves.

Starting to use a transcutaneous electrical nerve stimulation (TENS) machine once you are in established labour (see page 8) will not help your pain.

## More information about epidurals

If you choose to have an epidural, you and your baby will need to be monitored more closely. This means your blood pressure will be checked more frequently and a small tube (called a cannula) will be placed in your arm in case a drip is needed. Your baby's heart rate will also need to be monitored using a machine for the first 30 minutes of the epidural and with each additional dose of anaesthetic.

If you are still in pain after 30 minutes of starting the epidural or each additional dose, the anaesthetist should be asked to come and assess you again.

NICE recommends the use of low-dose anaesthetic for an epidural. This means you should be able to move around and adopt whatever position you find most comfortable. However, as you receive extra doses over the course of your labour, your mobility is likely to be reduced.

Once started, your epidural should be maintained until after your baby is born, your placenta is delivered and any stitching has been done if you need it.

If you have had an epidural, you should not start pushing for at least 1 hour unless you feel the urge to push or your baby's head is visible. This helps reduce the risk of an assisted birth (forceps or ventouse). Your baby should be born within 4 hours following full dilation (see page 8) if you have an epidural.

## Care during labour

You shouldn't be left on your own during labour unless you wish to be. Your birth partner should be encouraged to provide support and you should be offered supportive one-to-one care. Your midwife will ask you about your wants and expectations for labour and use this information to help support and guide you during labour. You should be encouraged to move around and change position to find the most comfortable one for you.

## Checks during labour

Your midwife will check you and your baby's progress by monitoring your blood pressure, temperature and pulse, and checking when you have emptied your bladder, how often you are having contractions and how far your labour has progressed. The midwife will also check your baby's heartbeat (see box 1).

### ***Box 1: Your baby's heartbeat***

Your midwife will listen to your baby's heartbeat at regular intervals during established labour (called 'intermittent auscultation').

At first, your baby's heartbeat should be checked every 15 minutes. Later your midwife will listen more frequently. They will use a small hand-held listening device to listen to your baby's heartbeat. There is no need for you to be connected to a monitoring machine even for a short period unless there is concern about your baby.

# What happens during labour

## The first stage

A sign that labour is starting may be that your waters break. The membranes around the baby break and the fluid inside leaks out. Sometimes the waters break before labour starts (see page 10); more commonly, this happens during labour.

During the first stage of labour, you will have increasingly regular and painful contractions, and your cervix will start dilating (see box 2). When it has dilated to about 4 cm, the first stage of labour is said to have become established.

If you are having painful contractions but your cervix has not yet dilated to 4 cm, you may be asked to stay at or return home because you are not yet in established labour. If you are finding labour very uncomfortable or painful at this point, discuss this with your midwife.

The first stage of labour usually lasts about 8 hours for a first baby and is unlikely to be longer than 18 hours. For a woman who has already had a baby, the first stage lasts about 5 hours and is usually no longer than 12 hours.

### ***Box 2: Vaginal examinations***

Your midwife will need to examine your cervix (the neck of your uterus). During labour the cervix opens up (dilates), ready for the baby to pass into your vagina. It's important to know how far your cervix has dilated so your progress in labour can be monitored.

After asking your consent, your midwife will carry out a vaginal examination to feel how far your cervix is dilated and the position of the baby's head.

## The second stage

Once your cervix is fully dilated, your baby's head will start moving down your vagina. This is called the second stage of labour. It usually lasts up to 2 hours for a first baby and 1 hour for a woman who has already had a baby.

You should push whenever you feel a strong urge and you should not lie on your back but move into any other position you find comfortable. If pushing doesn't seem to be working or you are feeling tired, your midwife may advise you to change position or empty your bladder. Your midwife should monitor both you and your baby's progress closely.

## The birth

Once your baby is born, he or she will be passed to you to hold. The baby will be placed so their skin is in contact with yours and covered with a towel or blanket to keep them warm. If you would like to breastfeed, you can do so as soon as you wish, but ideally within 1 hour.

## The third stage

While you are holding your baby, your placenta (afterbirth) will be delivered. You will be advised to have an injection and your midwife will clamp and cut the umbilical cord, which will reduce the risk of bleeding and speed up the delivery of the placenta. The placenta will usually be delivered within 30 minutes. If you are at low risk of bleeding, you may choose to wait for the placenta to be delivered (known as physiological third stage). Delivery of the placenta will then normally take up to 1 hour.

## Once labour is complete

Once your placenta has been delivered, your midwife will check your blood pressure, pulse and temperature, check you are able to empty your bladder and ask how you are feeling.

You should have time with your baby (at least 1 hour) before your midwife checks your baby's weight, and measures his or her head and temperature.

If the area near your vagina (your perineum) was torn during the birth, your midwife will assess whether you need stitches or whether it will heal on its own. If you need stitches, you will be offered drugs to numb the area and the tear will be stitched up. You may need to put your legs into stirrups (lithotomy) while the stitching is carried out.

You may be offered a small anal suppository to help reduce inflammation and pain. You should be given information about painkillers, diet, hygiene and pelvic-floor exercises to help you heal quickly.

### Questions you might like to ask your midwife

- Is there a unit run by midwives in my local area?
- Can I have my baby at home?
- How long would it take if I needed to be transferred to hospital during labour from a unit run by midwives or from home?
- Do you have a birthing pool I can use to help the pain in labour?
- What positions are best for labouring and pushing?
- Can I give birth in water?

## Complications

While most women have a normal labour, some develop complications. The most common ones are listed below. If you are giving birth at home or in a unit run by midwives, you may have to be moved to a hospital during labour if you develop any of these complications.

What should happen	
<p>Your waters have broken but labour has not started.</p>	<p>You should contact your midwife to let them know what has happened. Most women (60%) go into labour within 24 hours.</p> <p>Your membranes breaking increases your baby's risk of serious infection from 0.5 to 1%. Therefore, you will be advised to take your temperature every 4 hours while you are awake and to tell your midwife if you develop a temperature. You should report immediately any change in the colour or smell of your vaginal discharge or any decrease or change in your baby's movements. You can have a shower or a bath but should be advised against sexual intercourse because of the increased risk of infection.</p> <p>If you have not gone into labour on your own within 24 hours, the risk of infection increases. You should be offered drugs to start your labour artificially (this is called 'induced labour').</p> <p>You should only receive antibiotics if either you or your baby show signs of infection and no further tests should be done on your baby unless they are showing signs of being unwell. If you do have signs of infection, you will be given a course of antibiotics.</p> <p>NICE recommends that women who have not gone into labour within 24 hours of their waters breaking should give birth in hospital where there is access to neonatal services. You should also stay in hospital for at least 12 hours following birth so your baby can be monitored.</p> <p>Following the birth there is still a risk of infection for your baby (for up to 5 days but particularly in the first 12 hours). Contact your midwife, hospital or GP immediately if you are worried.</p>
<p>Your labour is not progressing as quickly as would be expected. This is called a 'delay' and could happen in any stage of labour.</p>	<p>If your waters have not yet broken, your midwife or obstetrician will offer to break them (sometimes called artificial rupture of the membranes), which will make your labour shorter and may make your contractions stronger.</p> <p>If you are giving birth for the first time and your labour becomes delayed in the first stage, you may also be offered a drip with oxytocin, which is a drug that makes your contractions stronger. You should also be offered an epidural and your baby will need to be monitored continuously (see below).</p>

<p>Electronic fetal monitoring.</p>	<p>Your midwife will offer to monitor your baby's heartbeat continuously (called 'electronic fetal monitoring'). Sensors will be placed on your abdomen and/or on your baby's scalp. These are attached to a machine which records your baby's heartbeat during labour. You will not be able to move around.</p>
<p>Why would electronic fetal monitoring be needed?</p>	<p>Your baby's heartbeat will be monitored continuously if abnormal changes are heard during intermittent auscultation (see page 7), if your baby is found to have passed meconium, if you start bleeding in labour, if you develop a temperature or your blood pressure goes up, if you need oxytocin to stimulate contractions or if you want your baby to be monitored all the time.</p>
<p>Your baby's heart rate is causing concern.</p>	<p>Your obstetrician may recommend taking a blood test from your baby's scalp (called 'fetal blood sampling'). This involves taking one or two drops of blood from your baby's scalp and testing how much oxygen is in it.</p>
<p>You are ready to have your baby (second stage) but your labour is delayed, your baby develops problems or you become exhausted.</p>	<p>You may be referred to someone, usually an obstetrician, who will consider using forceps or other instruments to assist with the birth of your baby. You should have effective pain relief during the procedure and you may need an episiotomy (see below).</p>
<p>You need an episiotomy.</p>	<p>An episiotomy is a surgical cut from your vagina at an angle into your perineum that makes the opening to your vagina bigger. This may need to be done if your baby is born using forceps or if your baby needs to be born quickly. You will be offered effective pain relief during the procedure.</p>
<p>You have a serious perineal tear.</p>	<p>Severe perineal tears affect the muscle or even the inside of the anus. If you have a serious tear, you will need to have it repaired by an operation shortly after your baby's birth.</p>
<p>Your placenta is not delivered within 30 minutes or part of it stays inside your uterus.</p>	<p>You may be offered an injection of oxytocin into the cord. Your obstetrician might recommend removing the placenta under anaesthetic.</p>
<p>You have heavy blood loss after giving birth.</p>	<p>Heavy blood loss is called a 'postpartum haemorrhage' and you may start to feel faint. Although it is an emergency and can be frightening, healthcare professionals are well trained to deal with it. You will be given oxytocin or ergometrine to help your uterus contract to stop the bleeding. You may also be given other drugs or a blood transfusion.</p>

## More information about giving birth

The organisations below can provide more information and support for pregnant women. Please note that NICE is not responsible for the quality or accuracy of any information or advice provided by these organisations.

- National Childbirth Trust, 0870 770 3236, [www.nct.org.uk](http://www.nct.org.uk)
- Association for Improvements in Maternity Services, 0870 765 1433, [www.aims.org.uk](http://www.aims.org.uk)
- Birthchoice UK, [info@birthchoiceuk.com](mailto:info@birthchoiceuk.com), [www.birthchoiceuk.com](http://www.birthchoiceuk.com)
- Maternity Health Links, 0117 902 7115
- Birth Trauma Association, [enquiries@birthtraumaassociation.org.uk](mailto:enquiries@birthtraumaassociation.org.uk), [www.birthtraumaassociation.org.uk](http://www.birthtraumaassociation.org.uk)

NHS Direct online ([www.nhsdirect.nhs.uk](http://www.nhsdirect.nhs.uk)) may be a good starting point for finding out more. Your local Patient Advice and Liaison Service (PALS) may also be able to give you further information and support.

### About NICE

NICE produces advice (guidance) for the NHS about preventing, diagnosing and treating different medical conditions. The guidance is written by independent experts including healthcare professionals and people representing patients and carers. They consider the best available evidence on the condition and treatments, the views of patients and carers, and the experiences of doctors, nurses and other healthcare professionals working in the field. Staff working in the NHS are expected to follow this guidance.

*To find out more about NICE, its work and how it reaches decisions, see [www.nice.org.uk/aboutguidance](http://www.nice.org.uk/aboutguidance)*

*This booklet and other versions of this guideline aimed at healthcare professionals are available at [www.nice.org.uk/CG55](http://www.nice.org.uk/CG55)*

*You can order printed copies of this booklet from the NHS Response Line (phone 0870 1555 455 and quote reference N1327).*