National Women & Infants Health Programme

QUICK SUMMARY DOCUMENT

Intrapartum Care for Women on the Supported Care Pathway

This QSD is a resource for all clinicians working in maternity settings in Ireland who are involved in the care of women with normal-risk pregnancies on the Supported Care Pathway (SCP) in spontaneous labour up to the immediate postpartum period. It may also include any woman deemed suitable for the SCP at labour onset by a Consultant Obstetrician who received antenatal care on the assisted or specialised pathway.

Following a comprehensive literature review a number of evidence-based recommendations for management of normal-risk pregnancies on the Supported Care Pathway were agreed upon.

Key Recommendations

No.	Section 1: Birth environment and supportive strategies in labour
1.	Women on the Supported Care Pathway (SCP) should have access to birth environments including home, Alongside Birth Centres (ABCs) or a designated space, with the appropriate environment and processes, within a maternity unit.
2.	Supportive birth environments should provide comfortable, low-technology birth equipment and access to labour aids e.g. birthing balls, stools, mats and pools to promote safe physiological labour and birth.
3.	Respectful maternity care that maintains the woman's dignity, privacy and advocates for informed choice should be provided; this includes offering emotional support and aiming for freedom from harm for both the women and her family. The woman's consent should be sought before any procedures or observation.
4.	Women should have support throughout labour and birth from a companion of her choice.
5.	One-to-one care provided by a midwife is recommended for all women during labour and birth, preferably one known to her.
6.	Maternity service provision should include the development of midwifery continuity of care models.
	Section 2: Stratifying the pathway of care
7.	A clinical assessment should be undertaken when pregnant women present in early or established labour to ensure the Supported Care Pathway is appropriate to her needs.
8.	The initial midwifery assessment should include history taking, maternal and fetal observations, clinical examination, monitoring of the woman and her unborn baby and the woman's planned place of birth.
9.	A pregnant woman with no antenatal care, presenting in labour, requires an obstetric assessment. The SCP is not considered an appropriate pathway of care.
10.	On-going clinical assessment considers observation of the woman, the unborn baby and the woman's wishes for care.
11.	Clinical features can change, a woman originally deemed suitable for the SCP may need to transfer, either temporarily or permanently, to another care pathway because of an emerging risk. She may also choose to transfer to another care pathway, e.g. if she wants an epidural, or if she chooses to be under the care of an obstetrician.

12. Women on the Assisted or Specialised Care Pathway who commence labour spontaneously may have their care transferred to the Supported Care Pathway if they are deemed to be normal risk for labour by a Consultant Obstetrician or a Registered Advanced Midwife Practitioner. This decision should be documented in the healthcare record.

13. All clinicians when transferring care should apply the core principles of safe and effective transfer of care: early recognition, transfer of care, preparation of the woman, clinical handover of care and continuity of carer.

14. **Principles of early recognition**:

Escalation and de-escalation of care should be based on continuous risk assessment during labour and clinical judgement to prompt early recognition of when transfer is required.

15. **Principles of transfer of care:**

a. The woman may require physical transfer of location with handover of clinical responsibility or solely handover of clinical responsibility.

b. Transfer of care should be classified as urgent or non-urgent, depending on the clinical situation.

c. In an emergency, it may be necessary to bring critical services to the woman in the Alongside Birth Centre and the clinical handover transfers the responsibility of care to the obstetrician.

d. Depending on the indications for transfer, its urgency, time, distance to a maternity unit/hospital, the midwife caring for a woman in the home environment should use their clinical judgement to decide on the most appropriate mode of transport for transfer. If emergency transfer is indicated from the home, an ambulance must be called.

e. Robust local protocols should be in place for transfer of care between birth settings (such as home, ABC, home-from-home rooms within a maternity unit or in the event specialist care is required e.g. neonatal intensive care).

f. Skills and drills training should include 'dry runs' on a regular basis to ensure staff are aware of the shortest and fastest route to emergency facilities if required.

16. **Principles of preparation of the woman:**

a. Women and families should be informed of their individual level of risk in relation to pregnancy and be included in decision making about their care.

b. Women should be prepared both psychologically and physically to ensure respect and dignity is maintained during transfer of care.

c. Clinical assessment of the woman and her baby should be maintained during physical transfer, alongside professional standards of care.

17. **Principles of clinical handover of care:**

a. When arranging transfer of care from the Supported Care Pathway to the Assisted or Specialist Care Pathway, the coordinating midwife in the maternity unit should be informed of the transfer and make appropriate arrangements to receive the imminent transfer.

b. At all stages of transferring care, clear communication of clinical information between healthcare professionals is required. Communicating care should be as per national communication guidelines using the ISBAR[3] clinical handover tool.

18. **Principles of continuity of carer:**

In so far as is practical and possible, it should be aimed for the same midwife to continue the women's care as part of the integrated team after transfer of care to the Assisted or Specialised Care Pathway has occurred.

	Section 3: First stage of labour
19.	It is recommended standardised definitions, as outlined by the National Institute for Health and Care Excellence (NICE), are used to confirm the latent and established first stage of labour in conjunction with individual clinical assessment of the woman and with due regard to the signs of labour a woman reports.
20.	Women with prolonged rupture of membranes greater than 18 hours and who require intrapartum antibiotic prophylaxis (IAP) for the prevention of GBS in term infants, can remain on the SCP only if IAP and postnatal neonatal observation can be provided in line with National Clinical Practice Guidelines for the Prevention of Early-onset Group B Streptococcal Disease in in Term Infants: Ireland (2023)
21.	Women with prolonged rupture of membranes greater than 24 hours should be transferred to the Assisted or Specialised Care Pathway. If birth is imminent, the woman may remain on the SCP, following discussion with a senior clinician and including the woman.
22.	Women should be informed of the benefits and risks of non-pharmacological and pharmacological pain-relieving strategies. Care should be individualised and have consideration for the woman's preferences and choice.
23.	The provision of both non-pharmacological and pharmacological pain-relieving strategies should be made available to women in labour, including immersion in water.
24.	When a woman contacts the maternity service, a detailed history should be taken and the woman's preferences taken into consideration.
25.	Women should be listened to and an individualised plan of care is made in partnership with her.
26.	A face to face early assessment of labour for all women contacting the midwife should be offered as appropriate.
27.	Women presenting in the latent phase of labour should have a plan of care agreed with the midwife to include advice on coping strategies, accessing the maternity service and who to contact.
28.	For the woman intending to birth at home who is not in established labour following assessment by a midwife, one of the following decisions should be made in collaboration with the woman within 12 hours of assessment: • Remains at home • Established labour is confirmed • Care is transferred to the Assisted or Specialised Care Pathway
29.	In the event of a woman being admitted to Alongside Birth Centre (ABC) or maternity unit, who is not in established labour following assessment by a midwife, one of the following decisions should be made in collaboration with the woman within 12 hours of initial assessment: • The woman is discharged home • Established labour is confirmed and documented • Care is transferred to the Assisted or Specialised Care Pathway
30.	An initial risk assessment should be carried out to determine if the woman is suitable for the SCP, irrespective of previous plans.
31.	Digital vaginal examination at intervals of four hours should be offered for assessment of active first stage of labour, following abdominal palpation and assessment of vaginal loss. Vaginal examination includes assessment of dilation of the cervix, fetal position, descent and rotation.
32.	Expected progress of cervical dilatation in the established first stage of labour is 2 cms in 4 hours for women on the Supported Care Pathway.

33.	Use of a partogram is recommended for the recording and provision of a pictorial overview of progression in labour and to alert healthcare professionals when the need for escalation or transfer of care is required.
34.	Plotting cervical dilation on a partogram should commence from the diagnosis of active first stage of labour at 4cm.
35.	If there is a concern about the condition of the mother or the fetus, offer vaginal examinations more frequently following abdominal palpation and assessment of vaginal loss.
36.	Maternal wellbeing should be assessed and recorded during the established first stage of labour. Every 30 minutes the frequency, strength and duration of uterine contractions should be recorded. Every 60 minutes maternal pulse should be recorded. Every four hours maternal temperature, blood pressure, respirations and frequency and ability to pass urine should be recorded.
37.	Fetal wellbeing during the established first stage of labour should be assessed and recorded in line with the national clinical practice guideline on intrapartum fetal heart rate monitoring.
38.	Routine amniotomy for spontaneous onset of labour with normal progress should not be performed.
39.	The benefit of amniotomy should be discussed with the woman and if delay in established labour is suspected.
40.	A delay in established first stage of labour should be suspected if progress of less than 2cm in 4 hours is confirmed on vaginal examination.
41.	Women with suspected delay in progress with the membranes intact should be offered amniotomy, following explanation of the procedure and a discussion on the benefits and risks.
42.	Women with suspected delay in the first stage of labour should be advised to have a vaginal examination two hours later regardless of having had an amniotomy performed or not.
43.	Delay in the established first stage of labour should be confirmed if cervical dilation is less than 1cm after two hours of suspected delay. Care should be transferred to the Assisted or Specialised Care Pathway.
44.	Transfer of care should be completed using the principles of safe and effective handover of care, including MDT communication and documentation.
	Section 4: Second stage of Labour
45.	It is recommended the following definitions of second stage of labour are used in clinical practice: • **Passive second stage of labour:** full dilatation of the cervix (determined by either vaginal examination or recognition of other external signs) before or in the absence of involuntary or active pushing. • **Active second stage of labour:** the baby is visible or there is involuntary or active pushing with full dilatation of the cervix.
46.	Women in the active phase of the second stage of labour should be encouraged and supported to follow their own urge to push.
47.	Maternal wellbeing assessment in the second stage of labour includes monitoring of uterine contractions, vital signs, frequency and ability of passing urine, vaginal loss including bleeding or discharge, psychological wellbeing and hourly vaginal examinations.
48.	Fetal wellbeing assessment in the second stage of labour should include auscultation of the fetal heart (noting there is an increase in the frequency of monitoring in the second stage of labour), with the assessment of vaginal loss, including liquor if membranes have ruptured.
49.	Assessment of progress also includes the woman's behaviour and ability to cope, the effectiveness of pushing on descent and rotation.

50.	Women should be encouraged to adopt a position that is most comfortable and effective for her.
51.	For women in the second stage of labour, techniques to reduce perineal trauma and facilitate spontaneous birth (including perineal massage and warm compresses) are recommended, based on a woman's preferences and available options.
52.	Emergency equipment must be checked to ensure it is in good working order, with spare parts readily available in case of faulty equipment for all births. Standardised protocols for emergency equipment checking and neonatal resuscitation provide a consistent and higher standard of care.
53.	Women with a normal risk pregnancy may have delayed pushing for 1 hour in the presence of maternal and fetal wellbeing, known as the passive second stage.
54.	After one hour of passive second stage, if a woman has no expulsive contractions or there are no signs of descent or rotation of the fetal head, it is recommended to perform a vaginal examination and consider artificial rupture of membranes if intact.
55.	Vaginal examination is recommended hourly or earlier if clinically indicated in the second stage of labour or sooner if there is a clinical suspicion of delay in progress. If there is no evidence of progress, such as descent and rotation an amniotomy should be considered if the membranes are intact.
56.	Women should be encouraged with pushing, to change positions regularly, while also taking into consideration hydration, analgesia and bladder care.
57.	If birth is not imminent after two hours pushing for a primiparous woman on the Supported Care Pathway, care should be escalated for diagnosed delay in the active second stage.
58.	If birth is not imminent after one hour pushing for a multiparous woman on the Supported Care Pathway, care should be escalated for diagnosed delay in the active second stage.
59.	Escalation and transfer of care to the Assisted or Specialised Care Pathway in the second stage should consider the principles of safe and effective transfer of care.
	Section 5: Third stage of labour
60.	Women should be informed of the benefits and risks of both active and physiological management of the third stage. Active management is the recommended practice for the management of the third stage of labour. The components of active management involves a package of care comprising of: a. routine use of uterotonic drugs b. deferred clamping of the cord c. controlled cord traction after signs of separation of the placenta.
61.	Women who choose physiological management should be advised that it may be necessary to revert to active management if either of the following occurs: a. haemorrhage b. the placenta is not delivered within one hour from the birth of the baby
62.	Prolonged third stage of labour should be diagnosed if it is not complete within 30 minutes of birth with active management or within 60 minutes of the birth with physiological management
63.	In the event of a retained placenta: a. Secure intravenous access b. Provide the woman with an explanation as to what is happening c. In the event of excessive bleeding, intravenous oxytocic agents and resuscitative measures should be administered.

64.	If the placenta is retained and there is a concern about the woman's condition: a. offer a vaginal examination to assess the need to undertake manual removal of the placenta b. Provide the woman with effective analgesia c. If uterine exploration is required and the woman is not in an obstetric unit, arrange urgent transfer using the principles of safe and effective transfer of care.
65.	In the event of a postpartum haemorrhage, a retained placenta, incomplete placenta, maternal collapse, or any other concerns about the woman's wellbeing care should be escalated to a senior obstetrician. Transfer of care to the Assisted or Specialised Care Pathway should take place using the principles for safe and effective transfer of care.
	Section 6: Immediate postnatal care of the mother and infant
66.	All women and babies should have safe uninterrupted skin-to-skin contact. If a woman's condition does not allow for this or the woman declines, safe skin-to-skin contact should be facilitated with the birthing partner.
67.	All postpartum women should have assessment of vaginal bleeding, uterine contraction, fundal height, and vital signs recorded on an IMEWS and escalation of care if abnormalities are identified within the first hour after birth.
68.	All women should have a venous thromboembolism (VTE) risk assessment following birth prior to clinical handover of care to another healthcare provider or the midwife on leaving the home environment.
69.	Clinical handover of care should include time and volume of any void post-delivery.
70.	Transfer the woman with her baby to the Assisted or Specialised Care Pathway if any obstetric emergency is identified, if there is incomplete expulsion of the placenta, or if there is a clinical deterioration or concern for maternal wellbeing.
71.	After vaginal birth, all women should have a systematic assessment of the vagina, perineum and anorectal area to identify the extent of bleeding, perineal trauma and repair significant injuries as soon as possible after delivery. Adequate exposure, lighting and analgesia are essential for a thorough examination.
72.	Perineal tears should be classified using the accepted classification system recognised by the RCOG (2015) and NICE(2023): • First-degree tear: Injury to perineal skin and/or vaginal mucosa • Second-degree tear: Injury to perineum involving perineal muscles but not involving the anal sphincter • Third-degree tear: Injury to perineum involving the anal sphincter complex: – Grade 3a tear: Less than 50% of external anal sphincter (EAS) thickness torn – Grade 3b tear: More than 50% of EAS thickness torn – Grade 3c tear: Both EAS and internal anal sphincter (IAS) torn • Fourth-degree tear: Injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa
73.	Women that need further surgical or anaesthetic expertise for perineal repair should be transferred with her baby to Assisted or Specialised Care Pathway following the principles for safe and effective transfer of care.
74.	It is recommended to repair periclitoral, periurethral, and labial lacerations that are bleeding or alters anatomy. A clinician's decisions whether to suture a first or second degree tear or not should be based on clinical assessment and judgement of the extent, depth and approximation of the perineal tear, the extent of bleeding from the trauma and the woman's preference.
75.	Continuous suturing techniques for perineal closure are recommended compared with interrupted methods.
76.	Synthetic sutures are recommended due to the reduction in perineal pain experienced by women.

77.	It is recommended as best practice that women are provided with information about the extent of the trauma, pain relief, diet, hygiene and the importance of pelvic-floor exercises following repair of perineal trauma. Provision of adequate pain relief is an essential principle of perineal repair.
	Section 7: Infant
78.	A second midwife skilled in neonatal resuscitation whose sole responsibility is management of the newborn should be in attendance at all births.
79.	Time of birth should be recorded and the onset of regular respirations for all babies.
80.	Immediately after birth the condition of the baby should be assessed to determine if resuscitation is required. This is done by evaluating-the baby's respiration, heart rate and tone. Resuscitation should be conducted in line with the American Heart Association (AHA)/American Academy of Paediatrics (AAP) Neonatal Resuscitation Programme (NRP).
81.	Apgar scores at 1 minute and 5 minutes should be evaluated, documented and used as a tool for conveying information about the overall condition of the baby at the birth.
82.	All babies should be risk assessed at birth to determine if neonatal observations are required, e.g. if there has been prolonged rupture of membranes for greater than 18 hours.
83.	Mothers and babies should have immediate, unhurried and uninterrupted safe skin-to-skin contact if there are no clinical concerns with either, which is continued for at least 60 minutes or until after the first feed, considering the need for baby to be given time to go through the instinctive post birth stages.
84.	All babies should be routinely monitored when in skin-to-skin contact with mother or birth companion in line with advice regarding Sudden Unexpected Postnatal Collapse (SUPC) of a Newborn Infant from Prof. John Murphy, National Clinical Lead for Neonatology, The National Women and Infants Health Programme (NWIHP) and Ms Angela Dunne, NWIHP Lead Midwife (Appendix 4)

Algorithm

Algorithm 1: Initial and On-going Assessment for Women in Labour

Initial and ongoing assessment for women in labour

Using this tool, assess the women to ensure that the Supported Care Pathway remains appropriate. The SCP is appropriate for normal-risk' women with uncomplicated singleton pregnancies, entering labour at low risk of developing intrapartum complications and between 37 and 42 weeks of pregnancy. It assumes labour starts spontaneously for the woman and that her unborn baby is in the vertex or head-down position.

Initial history taking to include:

Situation: Reason for and source of presentation and concerns.

Background history: parity, EDD, gestation, relevant social/demographic details, pregnancy, obstetric, medical, surgical and anaesthetic history, pregnancy screening results.

Assessment and findings: Vital signs, urine analysis, VTE score, abdominal palpation to include contraction length, strength and frequency, relevant system assessment dependant on complaint, maternal and fetal wellbeing assessment. **If there is any uncertainty, multidisciplinary discussion is necessary, with appropriate documentation.**

Initial assessment to determine appropriate pathway for labour

NB These lists are not exhaustive and an individualised assessment is recommended

	Green: Supported Care Pathway	**Red: Assisted or Specialised Pathway**
At labour presentation	• 37-42 weeks gestation • Maternal age ≥16 and ≤40 years • Last recorded Hb ≥10 g/dl • Spontaneous labour onset • Prolonged rupture of membranes < 18 hrs (* If IAP administration possible, may consider up to 24hrs on SCP, **NB:** neonatal observations in the postnatal period will also be required, in line with national guidance) • Any other woman in labour, deemed suitable for the SCP by a Consultant Obstetrician or Registered Advanced Midwife Practitioner	• Meconium stained liquor • HB <10.0g/dl • Prolonged rupture of membranes ≥ 18 hours (*if GBS status unknown/or IAP indicated – Refer to national guidance). • Prelabour ruptured membranes with known history of GBS • Placental or fetal abnormalities
	Fetal: • Singleton, cephalic presentation • Vertex engaged • Appropriate fetal growth on SFH or USS >10th centile or <90th centile (using a 3 or 4 biometric measurement) • Fetal heart rate in line with national guidance • Normal fetal movement	**Fetal:** • 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 on SFH or on USS that is <10th centile or >90th centile (using a 3 or 4 biometric measurement) • Suspected anhydramnios/oligohydramnios or polyhydramnios • Any fetal heart rate concerns

Medical factors (maternal)		• Confirmed cardiac disease • Asthma requiring increase in treatment/ hospital treatment in current pregnancy • Obstetric cholestasis • Platelets less than 100x10/L • Current active infection such as varicella/ rubella/genital herpes in the woman

Ongoing assessment and transfer criteria to the Assisted/Specialised Care Pathways,

With consideration that if birth appears imminent, assess the suitability and safety of transfer at that point.

	Green: Supported Care Pathway	**Red: Assisted or Specialised Pathway**
Observations of the woman		• Maternal pulse >120 bpm on 2 occasions 15-30 minutes apart
		• A single reading of either raised **systolic** BP ≥160 mmHg or raised **diastolic** BP ≥110 mmHg • Either raised **systolic** BP ≥140 mmHg or raised **diastolic** BP ≥90 mmHg on 2 consecutive readings taken 15-30 minutes apart
		• Respiratory rate of less than 9 or greater than 21 on two occasions 15-30 minutes apart
		• A reading of ≥2+ of protein on urinalysis
		• Temperature ≥38°C on a single reading, or ≥37.5°C on 2 consecutive readings 1 hour apart
		• Any vaginal blood loss other than a show
		• Rupture of membranes more than 18 hours. If *IAP administration possible, can remain up to 24hrs in SCP
	• Clear liquor	• Presence of meconium
		• Pain reported by the woman that differs from the pain normally associated with contractions
	• Coping with pain using non-pharmacological and pharmacological methods	• Request by the woman for additional pain relief using regional analgesia
	• Woman's preference to remain on the SCP	• Woman wishes to transfer care to Assisted/ Specialised Care Pathway

	Green: Supported Care Pathway	Red: Assisted or Specialised Pathway
Fetal wellbeing	• Fetal heart rate in line with national guidance	• Any fetal heart rate concerns
Progress in labour	**Established first stage of labour** • Progress of 2cm in 4 hours	**Confirmed delay in established first stage of labour if:** • progress of <1cm in 2 hours following promotion of physiological interventions such as mobilisation, emptying bladder and hydration **or** • progress of <1 cm in 2 hours following amniotomy
	Active second stage of labour • **Primiparous:** Birth anticipated within 2 hours of active second stage (See Algorithm 4) • **Multiparous:** Birth anticipated within 1 hour of active second stage (See Algorithm 5)	**Confirmed delay in the second stage if:** • **Primiparous:** Confirm delay after 2 hours of active 2nd stage of labour, birth would be expected to take place within 3 hours of the start of active 2nd stage • **Multiparous:** Confirm delay after 1 hour of active 2nd stage of labour, birth would be expected to have taken place within 2 hours of active 2nd stage
	Third stage of labour • **Placenta:** delivered within 30 minutes of active management **or** 60 minutes of physiological management • **Perineum:** Intact perineum/1st or 2nd degree tear	**Third stage of labour** • **Placenta:** undelivered after 30mins of active management **or** after 60mins of physiological management • **Perineum:** 3rd or 4th degree tear or other complex perineal trauma requiring suturing
Obstetric/ Neonatal Emergencies	• No recognised obstetric/neonatal emergencies	• Obstetric/neonatal emergencies including but not limited to: intrapartum haemorrhage, cord prolapse, postpartum haemorrhage, shoulder dystocia, uterine inversion, maternal seizure or collapse or the need for advanced neonatal resuscitation

Algorithm 2: Care in the first stage of labour

Care is woman centred and includes informed choice, consent, privacy and respectful communication. Contemporaneous documentation is essential.

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First stage in the normal-risk woman at term.

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Regular painful contractions and progressive cervical dilation from 4cm?

NO →

Latent first stage

- Irregular painful contractions and some cervical effacement and dilatation less than 4cm
- Complete an initial assessment
- Reassure latent phase is normal
- Offer individualised support about rest, hydration, nutrition
- Advise mobilisation may establish contractions
- Discuss comfort strategies and their risks and benefits
- Involve support people/partner
- Offer admission or return/remain at home according to individual need/circumstances
- Provide information on when to return to hospital and/or notify healthcare professional
  - Increasing strength, frequency, duration of contractions
  - Requiring pain management
  - Vaginal bleeding, rupture of membranes
  - Reduced fetal movements
  - Any concerns
- Plan an agreed time for reassessment
- **Homebirth setting:** for women not in established labour following an assessment by a midwife, one of the following decisions should be made within 12 hours of assessment:
  - Remains at home
  - Established labour is diagnosed
  - Care is transferred to the Assisted/Specialised Care Pathway
- **Women admitted to hospital (on the SCP) if admitted and not in established labour**, within 12hrs one of the following decisions should be made:
  - Woman is discharged home
  - Labour is diagnosed
  - Transfer to the Assisted/Specialised Pathway

YES

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CONTINUED OVERLEAF

Established 1st Stage of Labour

Supportive care

- Consideration of emotional & psychological needs
- Labour companionship
- Pharmacological and non-pharmacological pain relief
- Nutrition and hydration
- Encouraging mobility
- Maternal choice of labour/childbirth position
- Continuous support

Monitor maternal condition

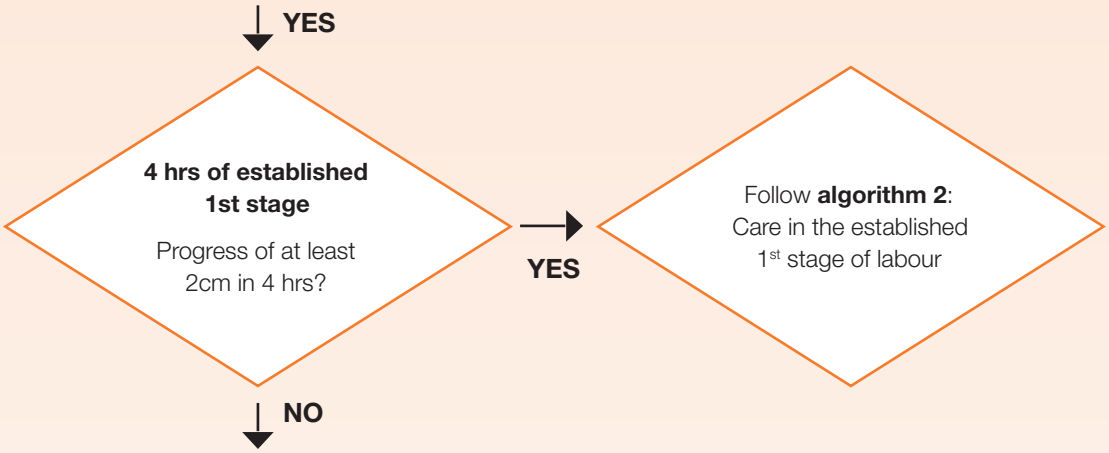
- Commence partogram for recording & provision of pictorial overview of progress in labour
- Hourly pulse
- 4 hourly temperature, blood pressure and respirations
- Frequency of passing urine
- Abdominal palpation: 4 hourly, prior to VE and as required to monitor progress
- Contractions: frequency, strength and duration of contractions every 30 minutes for 10 minutes
- Vaginal loss: hourly
- Offer VE: 4 hourly or as indicated
- Parameters of cervical dilation of:
  Primiparous: minimum of 2cm in 4 hours
  Multiparous: minimum of 2cm in 4 hours

Monitor fetal condition

- Fetal position,descent and rotation
- FHR: Auscultate every 15 minutes in line with national fetal monitoring guideline
- Colour and amount of amniotic fluid if membranes are ruptured
- fetal movement

Algorithm 3: Expected Progress in the Established 1st Stage of Labour for Primiparous and Multiparous women

Offer a vaginal examination within 2 hours of admission to the Supported Care Pathway with obvious signs of labour. If established labour is diagnosed i.e. regular painful contractions and progressive cervical dilation from 4cm, provide one to one midwifery care and commence partogram



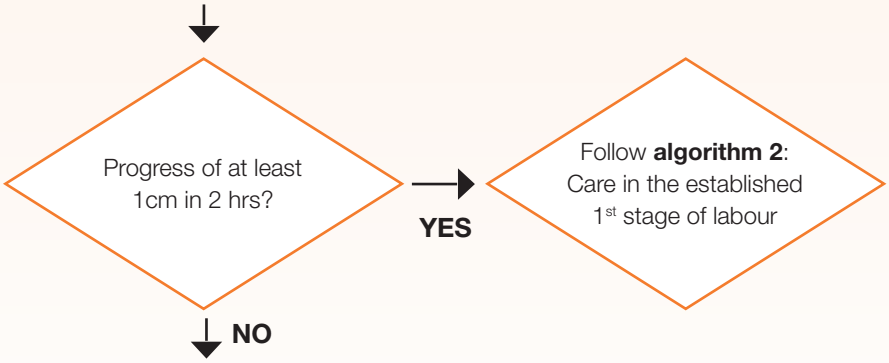
Suspect delay in established 1st stage of labour when cervical dilation <2cm in 4hrs

Assessment:

- Maternal and fetal condition
- Progress and descent of presenting part to include flexion, rotation and descent
- Uterine contractions – palpate length, strength, resting tone and frequency of contractions in a 10 minute period
- Auscultate fetal heart every 15 minutes[2]
- Coping strategies and pain relief
- Consider discussion with senior colleague

Actions:

- Mobilise
- Bladder: monitor and encourage voiding
- Hydration and nutrition: offer oral fluids between contractions
- Consider ARM if membranes intact
- Re-examine in 2hours



Diagnose delay in 1st stage

Transfer to Assisted/Specialised Care Pathway

Algorithm 4: Expected progress in 2nd stage – primiparous woman

Wait maximum of 1 hour in the presence of maternal and fetal wellbeing

Passive second stage

Normal risk women may have delayed pushing for 1 hour in the presence of maternal and fetal wellbeing, known as the passive second stage.

Actions:

- Mobilise
- Rest
- Hydration
- Bladder care
- Coping strategies and pain relief as required

1st hour of active 2nd stage

Active second stage – pushing

If clinically indicated offer VE at start of active 2nd stage
Are contractions expulsive?
Is there descent/rotation of presenting part?

→ **NO**

Actions:

- Mobilise
- Encourage voiding
- Offer oral fluids
- Coping strategies and pain relief
- Recommend ARM if membranes intact
- Consider consulting with senior midwifery colleagues
- Commence active pushing and reassess in 60 minutes

↓ **YES – commence pushing**

2nd hour of active 2nd stage

Reassess after 60 minutes offer VE
Are contractions expulsive?
Is there descent/rotation
Birth of baby expected within **2 hours of active 2nd stage?**

→ **NO**

Actions:

- Recommend ARM, if membranes intact
- Consult with senior colleagues
- Consider transfer to Assisted/Specialised Pathway

↓ **YES – continue pushing**

Birth of Baby within **2** hours of active second stage?

→ **NO**

Actions:

- Confirmed delay in 2nd stage
- Transfer to Assisted/ Specialised Care Pathway

↓ **YES**

Immediate postpartum care of mother and baby

3rd hour of active 2nd stage

Confirmed delay in second stage-transfer to Assisted/ Specialised Care Pathway

Actions:

- Birth would be anticipated within **3 hours** of the active 2nd stage of labour

Algorithm 5: Expected progress in 2nd stage – multiparous woman

Wait maximum of 1 hour with no urge to push in the presence of maternal and fetal wellbeing

Passive second stage

Normal risk women may have delayed pushing for 1 hour in the presence of maternal and fetal wellbeing, known as the passive second stage.

Actions:

- Mobilise
- Rest
- Hydration
- Bladder care
- Coping strategies and pain relief as required

First 30 minutes of active 2nd stage

Active second stage – pushing

If clinically indicated offer VE at start of active 2nd stage
Are contractions expulsive?
Is there descent/ rotation of presenting part?

→ **NO**

Actions:

- Mobilise
- Encourage voiding
- Offer oral fluids
- Coping strategies and pain relief
- Recommend ARM, if membranes intact
- Consider consulting with senior midwifery colleagues
- Commence active pushing and reassess in 30 minutes

↓ **YES – commence pushing**

Second 30 minutes of active 2nd stage

Reassess after 30 minutes – offer VE
Are contractions expulsive?
Is there descent/rotation
Birth of baby expected within **1 hour of active 2nd stage?**

→ **NO**

Actions:

- Continue routine care (as above)
- Recommend ARM, if membranes intact
- Consult with senior colleagues
- Consider transfer to Assisted/Specialised Pathway

↓ **YES – continue pushing**

Birth of Baby within **1** hour of active second stage?

→ **NO**

Actions:

- Confirmed delay in 2nd stage
- Transfer to Assisted/ Specialised Care Pathway

↓ **YES**

Immediate postpartum care of mother and baby

2nd hour of active 2nd stage

Confirmed delay in second stage-transfer to Assisted/ Specialised Care Pathway

Actions:

- Birth would be anticipated within **2 hours** of the active 2nd stage of labour

Algorithm 6: Management of the third stage of labour

Care is woman centred and includes informed choice, consent, privacy and respectful communication. Contemporaneous documentation is essential.

Active management of the third stage:
recommend for all births

- Oxytocin 10 IU IM after birth of baby
- Wait at least 1 minute and no more than 5 minutes after birth and then clamp and cut cord
- Controlled cord traction and uterine guarding after signs of separation
- **Prolonged after 30 minutes**

Physiological management of the third stage:

- Placenta birthed by maternal effort/gravity
- Oxytocin not administered
- Clamp cord after pulsation ceased
- Placenta delivered by maternal effort/gravity

Prolonged after 60 minutes

Ongoing care

- Encourage upright position
- Ensure bladder empty
- Maintain calm, warm and relaxed environment
- Support privacy and reduce unnecessary interruptions
- Observe general physical condition

>30 mins after birth with active management?

Prolonged Third Stage

>1 Hour after birth with physiological management?

If woman's condition is stable, i.e. not bleeding and placenta undelivered

Offer VE to assess need for manual removal

Use on-going care measures as detailed below: Upright position, empty bladder, skin-to-skin with newborn, consider breastfeeding; observe on-going physical condition

Revert to active management:

Give 10 IU Oxytocin IM or Syntometrine® 500 micrograms/5 IU

Following signs of separation and descent, apply controlled cord traction

Use on-going care measures: Upright position, empty bladder, skin-to-skin with newborn, consider breastfeeding; observe on-going physical condition.

Placenta delivered?

YES ← Routine postnatal care

NO → Secure IV access, transfer to the Assisted/Specialised Care Pathway

If at any stage there is excessive bleeding: secure IV access, administer IV Oxytocin and transfer to Assisted/Specialised Care Pathway

Auditable standards

Audit using the key recommendations as indicators should be undertaken to identify where improvements are required and to enable changes as necessary, and to provide evidence of quality improvement initiatives.

Auditable standards for this guideline include:

1. Women who accessed intrapartum care on the Supported Care Pathway were within the defined SCP criteria after initial assessment, with specific reference to Algorithm 1.
2. Women and/or infants transferred either in or out of the intrapartum SCP, that the reason for transfer was identified and recorded, and complied with principles outlined in the guideline, including the time from decision to actual transfer.
3. Maternal and neonatal outcomes, including but not limited to – place of birth, mode of delivery, water immersion for labour and/or birth, maternal position for birth, birthing aids used, use of intrapartum analgesia, amniotomy, perineal trauma, Apgar score, uninterrupted skin to skin contact, infant feeding.
4. Documentation of care in the first, second and third stage of labour is in line with this recommended clinical guidance and time parameters as guided by Algorithms 1 to 6
5. Numbers of women and infants who required escalation of care e.g. high dependency/intensive care, postnatal readmission, including indications for admission.

Recommended reading:

1. Health Service Executive (2022), National Centre for Clinical Audit Nomenclature – Glossary of Terms, National Quality and Patient Safety Directorate. Available from: www.hse.ie/eng/about/who/nqpsd/ ncca/nomenclature-a-glossary-of-terms-for-clinical-audit.pdf
2. HSE National Framework for developing Policies, Procedures, Protocols and Guidelines https://assets.hse.ie/media/documents/How_to_Develop_HSE_National_Policies_Procedures_Protocols_and_Guidelines_gQBQ4os.pdf
3. Department of Health (DOH) Creating a Better Future Together: National Maternity Strategy 2016-2026. Published online 2016. national-maternity-strategy-creating-a-better-future-together-2016-2026.pdf
4. Health Information and Quality Authority (HIQA) National Standards for Safer, Better Maternity Services. Published online 2016. national-standards-maternity-services.pdf
5. Health Service Executive (HSE) National Consent Policy. Published online 2022. HSE_Consent_Policy_2022_v1.2_-_Jan_2024.pdf
6. Nursing and Midwifery Board of Ireland (NMBI) The Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives. Published online 2025. NMBI-Code-of-Professional-Conduct-and-Ethics.pdf
7. World Health Organisation. Recommendations: intrapartum care for a positive childbirth experience. Published online 2018. 9789241550215-eng.pdf
8. National Institute for Health and Care Excellence (NICE) Intrapartum care NICE guideline NG 23. Published online 2023. Overview | Intrapartum care | Guidance | NICE
9. Guidelines and Audit Implementation Network. Guideline and Audit Implementation Network (GAIN) Guideline for Admission to Midwife-Led Units in Northern Ireland & Northern Ireland Normal Labour & Birth Care Pathway. Published online 2018. 3a7a37bb-d601-4daf-a902-6b60e5fa58c2.pdf
10. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Care in labour in the absence of pregnancy complications. Published online 2023. https://ranzcog.edu.au/wp-content/uploads/Care-Labour-Absence-Pregnancy-Complications.pdf

Authors

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https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/

https://www.rcpi.ie/faculties/obstetricians-and-gynaecologists/national-clinical-guidelines-in-obstetrics-and-gynaecology/