GUIDELINES

Care of healthy women and their babies during childbirth: summary of NICE guidance

S Kenyon,¹ R Ullman,² R Mori,² M Whittle² on behalf of the Guideline Development Group

¹Reproductive Sciences Section, Department of Cancer Studies and Molecular Medicine, University of Leicester, Leicester LE2 7LX

²National Collaborating Centre for Women's and Children's Health, Royal College of Obstetricians and Gynaecologists, Kings Court, London W1T 2 QA

Correspondence to: S Kenyon oracle@le.ac.uk

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This is one of a series of BMJ summaries of new guidelines, which are based on the best available evidence; they will highlight important recommendations for clinical practice, especially where uncertainty or controversy exists

Further information about the guidance and the members of the development group are on bmj.com

Why read this summary?

This article summarises the most recent guidance from the National Institute for Health and Clinical Excellence (NICE) for healthcare professionals caring for women during labour and birth.¹ It defines the care that women who are at low risk of complications in labour at term should expect to receive, and therefore it relates to most women giving birth in the United Kingdom.

Recommendations

NICE recommendations are based on systematic reviews of the best available evidence. When minimal evidence is available, a range of consensus techniques is used to develop recommendations. In this summary, recommendations derived primarily from consensus techniques are indicated with an asterisk (*).

General principles

- Provide information with clear explanation so that women are fully involved in decision making and supported through labour. Good communication with the healthcare team is valued by women and may improve their psychological wellbeing after birth.
- Provide supportive one to one care to women in established labour and ensure they are not left alone except for short periods—women receiving one to one care throughout their labour are significantly less likely to have a caesarean section or instrumental vaginal birth, will be more satisfied, and will have a positive experience of childbirth.
- Ensure that labour and birth progress without intervention, provided that labour is progressing normally and the woman and baby are well.*

Place of birth

- Inform women that birth is generally very safe but that the available evidence on advantages and disadvantages or cost effectiveness of different places of birth is of poor quality. Current options for birth include obstetric

units, midwife led units (either standalone or alongside obstetric units), or home, although availability of midwife led units may vary locally and most births take place in hospital nowadays.

- Inform women who plan to give birth at home or in a midwife led unit that these are associated with a higher likelihood of a normal birth, with less intervention, but inform them that if something goes unexpectedly seriously wrong during labour under these circumstances, the outcome for the woman and baby could be worse than in the obstetric unit, which has access to specialised care. Inform women of the likelihood of transfer locally and how long transfer is likely to take.*

Pain relief

A woman's desire for and choice of pain relief during labour are influenced by many factors, including her expectations, the complexity of her labour, and the severity of her pain. Flexible expectations and being prepared for labour may influence her psychological wellbeing after birth, as may good communication with the healthcare team.

- Offer the option of labouring in water, as this has been shown to reduce pain and the need for regional analgesia, with no differences in adverse outcomes.
- Inform women considering epidural analgesia that it provides the most effective pain relief in labour but also carries risks (such as longer second stage and increased likelihood of instrumental birth) and implications for their labour (such as increased monitoring of both mother and baby).

Delay in labour

Provide clear definitions, referral points, and actions for the recognition and management of delay in both the first and second stages of labour.

First stage

- Delay in labour is redefined in this new guideline as "suspected" if cervical dilation

is less than 2 cm in four hours, taking into account descent and rotation of the fetal head and the strength, duration, and frequency of contractions.*

- Delay is confirmed if progress of less than 1 cm cervical dilation is found at assessment two hours later.*
- Whenever delay is diagnosed, support and effective pain relief should be offered and the baby monitored continuously.*
- Once delay is confirmed, nulliparous women should be offered oxytocin, having been informed that this will shorten their labour and increase the frequency and strength of contractions but not influence mode of birth. Parous women should be offered oxytocin only after review by an obstetrician.
- After oxytocin is started, assessment should take place every four hours. If progress of less than 2 cm cervical dilation occurs then caesarean section should be considered.*

Second stage

- If progress is inadequate after an hour of active pushing in nulliparous women, delay should be suspected. Amniotomy should be advised at this point, together with support and analgesia or anaesthesia.*
- If progress is inadequate after two hours of active pushing in nulliparous women and one hour in parous women, delay should be diagnosed.*
- Once delay has been diagnosed, obstetric assessment and ongoing review should occur every 15-30 minutes.* Birth would be expected to take place within a total of three hours for nulliparous women and two hours for parous women.
- Instrumental birth should be undertaken only with tested, effective anaesthesia, and the choice of instrument depends on the balance of clinical circumstance and the practitioner's experience.*

After birth

If genital trauma is identified after birth, further detailed systematic assessment should be carried out to identify accurately the extent of the trauma and ensure appropriate repair. This should include:

- Confirmation by the woman that tested effective local or regional analgesia is in place
- Visual assessment of the extent of perineal trauma (including the structures involved, the apex of the injury, and assessment of bleeding)
- A rectal examination to assess whether any damage has occurred to the external or internal anal sphincter if there is any suspicion that the perineal muscles are damaged.

Rupture of membranes before labour

The new guideline contains changes in recommendations for women at term whose membranes rupture

before the onset of labour.

- Induction of labour is appropriate about 24 hours after membrane rupture to reduce the risk of serious neonatal infection from 1% to 0.5%. (Previous advice was that women should be offered a choice of immediate induction or expectant management, with the latter not exceeding 96 hours.)
- The well woman and baby do not require any investigation or prophylaxis, but both should be observed for signs of developing infection and treated if necessary.

Improving information on safety around place of birth
Including place of birth in the guideline is politically and professionally sensitive, but collecting safety data should now be a matter of priority, so that women can be more adequately informed of the advantages and disadvantages of each place of birth.

To support this, the guideline recommends the collection, audit, and oversight of maternal and neonatal mortality and serious morbidity data relating to each place of birth and the development of clear pathways for referral to the obstetric unit should that be required.

These events are rare so the guideline also recommends the establishment of national surveillance of this information, which should include a national registry of all deaths resulting from events occurring during labour at term, and of neonatal encephalopathy.

Overcoming barriers

Barriers to implementation are complex and varied, and some recommendations seem more expensive than others to implement. For example, adopting the recommendation for women to labour in water may require changes in service provision if maternity units do not have sufficient baths or pools; it will also require support and possible additional training for midwives and other healthcare professionals, as well as for the women themselves. However, if maternity units are prepared to embrace change and to implement such recommendations health outcomes will improve, as will clarity and consistency of care.

NICE has developed tools to help organisations implement the guidance (see www.nice.org.uk?page.aspx?0=tools).

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1 National Institute for Health and Clinical Excellence. *Intrapartum care: care of healthy women and their babies during childbirth*. London: NICE, 2007. (<http://guidance.nice.org.uk/CG055>)