

Midwifery care in  
labour guidance for all  
women in all settings



THE ROYAL  
COLLEGE OF  
**MIDWIVES**

RCM  
Midwifery  
Blue Top  
Guidance  
**No.1 Nov 2018**

[www.rcm.org.uk](http://www.rcm.org.uk)



# Table of Contents

---

<b>Introduction</b> .....	<b>4</b>
<b>Making decisions on place of birth</b> .....	<b>6</b>
<b>Women's decision making about mode of birth following caesarean section</b> .....	<b>8</b>
<b>Early labour</b> .....	<b>10</b>
<b>Birth environment for women labouring in obstetric units</b> .....	<b>12</b>
<b>Eating and drinking in labour</b> .....	<b>14</b>
<b>Positions for labour and birth</b> .....	<b>16</b>
<b>Fetal heart rate assessment</b> .....	<b>18</b>
<b>Coping and comfort in labour</b> .....	<b>19</b>
Immersion in water during labour and birth .....	<b>19</b>
Women's decision making and experience of epidural .....	<b>20</b>
Other methods and therapies for coping in labour .....	<b>21</b>
<b>Birth companions</b> .....	<b>23</b>
<b>Preventing severe genital trauma</b> .....	<b>25</b>
<b>Third stage of labour</b> .....	<b>26</b>

# Introduction

---

This document comprises a summary of the evidence and recommendations for the midwifery care of women in labour in all settings in the UK. It aims to provide an accessible version of systematically produced evidence for aspects of care related to labour and birth. The methods used to derive the summaries are outlined below. Full information detailing the scientific methods and processes utilised in the production of this guidance is available in the accompanying Technical Manual. A companion version to this document is also available for women and those supporting them.

The philosophy underlying this work is that midwifery care can make a significant difference to clinical outcomes and experiences for women and their infants<sup>1</sup>. The work draws on recent high-quality and systematically-derived approaches including the concepts of 'Too much too soon/too little too late'<sup>2</sup> and seeks to enable an inclusive approach to supporting all women in the UK who receive midwifery care, whatever the woman's health, maternity, personal or social circumstances. The guidance also seeks to support midwives in their vital work in the provision of high-quality contemporary maternity care. This guidance should be viewed as complementing other robust sources of evidence-based information such as that produced by the National Institute for Health and Care Excellence, the Scottish Intercollegiate Guidelines Network and local guidance supporting the provision of safe care that achieves optimal clinical and psychosocial outcomes. Recommendations apply to all women except where we signal that adaptation may be needed according to women's health, social or maternity status.

As with all guidance, recommendations should form the basis of discussion between healthcare providers, women receiving care and those supporting them. Women's own views, preferences and choices should define the care provided and women should be treated as individuals and with respect at all times and consent obtained for all procedures. A recent systematic review commissioned by the World Health Organisation confirmed important aspects of women's experiences: an environment that feels clinically and psychologically safe; support from their companions and kindness and competence from those providing care and involvement in decision-making<sup>3</sup>.

Following an initial mapping of areas to be included, research questions were framed and scoping searches conducted to identify aspects of care for which high-quality, systematic review evidence existed. The products of these searches were developed into evidence summaries. New systematic reviews were completed for areas where recent, existing high-quality reviews were not available and where work in progress was not identified. This document includes a short summary of the evidence for 13 aspects of care, recommendations for practice (derived from the evidence) and Good Practice Points that signal additional considerations for all or certain groups of women, where appropriate. As all recommendations are drawn from good quality reviews or new systematic reviews, we have not reported the strength of the evidence in each summary.

We have instead used the following phrases to signal the strength of the recommendations:

- Where there is strong, good quality evidence we have used the phrase... **"There is good evidence to recommend..."**
- Where the evidence is medium quality or limited evidence available we have used the phrase... **"There is some evidence to suggest..."**
- Where there is low quality evidence or very limited evidence is available we have used the phrase... **"There is low-quality evidence"**

These phrases follow strength of recommendations guidelines from JBI <sup>4</sup>, WHO <sup>5</sup>, NICE <sup>6</sup> and Cochrane Review standards<sup>7</sup>.

In developing the guidance, we have drawn on research from settings beyond the UK where it seemed that there are similarities of care provision, availability of maternity care and the health of the childbearing population. The majority of the evidence utilised is drawn from settings and systems where women may not have access to continuity of midwifery carer. This difference should be noted in the context of contemporary maternity policy that advocates increasing women's access to continuity models<sup>8,9</sup>.

This work has been carried out over a 14-month period from 1<sup>st</sup> September 2017- 31<sup>st</sup> October 2018. We acknowledge the significant support and contributions throughout of the members of our multi-disciplinary and cross-sectoral Expert Advisory Group, the Nottingham Maternity Research Network and the Royal College of Midwives (RCM) who funded this work. The RCM did not influence the guidance development process or individual recommendations. The guidance development group recommend review and updating within three years of publication.

## October 2018

### References:

1. Renfrew MJ, McFadden A, Bastos M H et al (2014) Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *Lancet* 384, 1129-1145
2. Miller S, Abalos E, Chamillard M et al (2016) Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. *Lancet* 388: 2176-2192
3. Downe S, Finlayson K, Oladapo O, Bonet M, Gulmezoglu M (2018) What matters to women during childbirth: A systematic qualitative review *PLOS ONE* <https://doi.org/10.1371/journal.pone.0194906>
4. JBI. 2013. New JBI Grades of Recommendation. University of Adelaide, Australia: Joanna Briggs Institute
5. WHO. 2012. WHO Handbook for Guideline Development. World Health Organization, Geneva: WHO Press
6. NICE. 2014b. Developing NICE guidelines: the manual. London, UK: National Institute for Health and Care Excellence.
7. Higgins, J., & Green, S. 2011. *Cochrane Handbook for Systematic Reviews of Interventions*. In: Higgins, J. & Green, S. (Eds.). The Cochrane Collaboration
8. NHS England (2016). National Maternity Review: Better Births: Improving outcomes of maternity services in England. A five-year forward view for maternity care. London: NHS England
9. Scottish Government (2017). The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care in Scotland. Edinburgh. The Scottish Government.

# Making decisions on place of birth

---

## Evidence summary

All women should be supported to make choices about the place of birth that is right for them. There is high-quality evidence that midwifery units are associated with lower rates of medical interventions during labour and birth and better outcomes for mothers who do not require obstetric care<sup>1</sup>. Compared to obstetric units, midwifery units are associated with higher levels of satisfaction for women, with no increased risk of poor outcomes for babies<sup>1</sup>.

There is currently no clear evidence to favour a planned home birth *or* planned maternity unit birth in terms of outcomes for women and babies who do not need obstetric care, but more research needs to be done<sup>2</sup>.

Women prefer local services, being attended by a known midwife and being involved in deciding the place of birth<sup>3</sup>. Currently, most women appear to favour hospital birth in a hospital setting where medical staff are available, though not necessarily involved in care (such as an alongside MU)<sup>3</sup>. The availability of pain relief options is very important to women<sup>3</sup>.

Women who prefer midwifery units and home births can encounter obstacles to these choices<sup>4</sup>. It is a crucial part of providing quality care that services and support are in place to meet all women's choices of place of birth<sup>4</sup>.

## Recommendations for practice

There is good evidence to recommend that:

- Midwives should inform women that giving birth in a midwifery unit may improve the outcomes and experiences for those who do not need obstetric care
- All birth place options, including facilities available and pain relief options, should be discussed with all women to enable them to make informed choices

## Good Practice Points

- Give women local information on place of birth during pregnancy, and facilitate the option to view birth settings
- Individual travel times for transfer during labour should be carefully considered in planning place of birth; women living in rural areas will wish to consider distance, terrain and local conditions
- There is no need to ask women to make a firm decision on place of birth early in pregnancy. Delaying the decision on place of birth until later in pregnancy or early in labour may give women more time to make informed decisions

---

**The evidence and recommendations presented in this section were derived from existing high quality systematic reviews as referenced below:**

1. Hodnett ED, Downe S, Walsh D. Alternative versus conventional institutional settings for birth. Cochrane Database of Systematic Reviews 2012, Issue 8. Art. No.: CD000012. DOI: 10.1002/14651858.CD000012.pub4.
2. Olsen O, Clausen JA. Planned hospital birth versus planned home birth. Cochrane Database of Systematic Reviews 2012, Issue 9. Art. No.: CD000352. DOI: 10.1002/14651858.CD000352.pub2.
3. Hollowell J, Li Y, Malouf R, Buchanan J. Women's birth place preferences in the United Kingdom: a systematic review and narrative synthesis of the quantitative literature. BMC Pregnancy Childbirth. 2016;16(1):213
4. Coxon, K., et al. (2017). "What influences birth place preferences, choices and decision-making amongst healthy women with straightforward pregnancies in the UK? A qualitative evidence synthesis using a 'best fit' framework approach." BMC Pregnancy and Childbirth 17(1): 103.

# Women's decision making about mode of birth following caesarean section

## Evidence summary

There is good evidence that women need good quality information in order to help them make an informed choice between vaginal birth after caesarean section (VBAC) and an elective caesarean section (CS). Decision aids, such as information booklets, can increase women's knowledge of birth choices and help decision-making. Information is most helpful to women if it is individualised, detailed, good quality, and provided at the right time. If decision aids are too complex this may raise further questions and cause some women to feel anxious about making decisions.

Safety for mother and/or baby is cited by women as an important reason for choice of birth. However, some women may not have detailed understanding of probabilities or individual risk factors when they make their decisions.

Health care professionals (HCPs) can have a strong influence on women's decision making. The way information is presented is very important as women may perceive the HCP's personal preference. Women find unbiased, individualised, and supportive information helpful for their decision-making. Women value balanced information about the benefits and risks of VBAC and repeat CS. Confusing or conflicting information is not helpful. Some women prefer to follow HCPs advice rather than make their own choice. There may be cultural differences in how much guidance women want from HCPs.

Women can feel an increased sense of control when they are involved in the decision-making process. However, some women may feel over-burdened by the choices they have to make and prefer to follow healthcare professionals' advice. Women may also change their mind during pregnancy.

Personal, social and cultural factors influence women's decision-making as do their previous birth experiences. Women may choose VBAC because they wish to experience birth or because they have a high personal motivation for VBAC. Women perceive that VBAC will enable an easier and quicker recovery, so they can resume their usual family activities sooner and help them to bond with their baby. Women who have previously experienced both vaginal birth and CS and women with previous negative experiences of CS may prefer to choose a VBAC.

Some women decide against VBAC as they feel the odds are against them for a successful labour and may perceive that they are not able to achieve a vaginal birth. Fear of labour or fear of failure are reported as strong reasons for choosing an elective CS, thus avoiding the possibility of an emergency CS. For these women, the predictability of elective CS can enhance their sense of control, enabling them to have a calm, predictable birth. Some women feel an elective CS is a safer option, and can be influenced by family, friends and HCPs opinions.

---

## Recommendations for practice

There is some evidence to recommend that:

- Clear, individualised information about the benefits and risks of different modes of birth is provided to women to support their decision-making
- Decision aids should be of good quality, clear, and accessible
- HCPs should ensure their personal views do not influence the information they provide so that they can support a woman to make a choice that is right for her
- Women should be supported in their choice whether electing to plan for a repeat CS or a vaginal birth. Women should be supported if they change their mind during pregnancy

## Good Practice Points

- Consider providing information about birth choices both in the postnatal period following a CS and during subsequent pregnancies; some women may start making decisions about future births immediately after CS
- Some women may require support with making use of information materials
- Discussion of women's previous birth experiences may help to put women's fears or uncertainty into context and help the midwife to provide individualised information
- Cultural and social factors may affect women's decision making

**The evidence and recommendations presented in this section were derived from a new systematic review developed for these guidelines. This is awaiting publication but the protocol is referenced below:**

- Helen Spiby, Phoebe Pallotti, Gina Sands, Catrin Evans, Kerry Evans, Jeanette Eldridge, Mandy Forrester, Lia Brigante. Decision-making about mode of birth following a caesarean section; women's information needs and experiences of supportive interventions: a systematic umbrella review. PROSPERO 2018 CRD42018103758 Available from: [http://www.crd.york.ac.uk/PROSPERO/display\\_record.php?ID=CRD42018103758](http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42018103758)

# Early labour

---

## Evidence summary

Early labour can be an uncertain time for women, who may experience difficulty accessing guidance and support<sup>1</sup>.

There is some low-quality evidence that women receiving early labour advice and support at home are less likely to receive oxytocin for labour augmentation and are less likely to have an epidural compared to women who have an immediate admission<sup>2</sup>. Women may also be more satisfied with their care and spend less of their labour duration in hospital<sup>2</sup>. There are no clear differences in rates of caesarean or instrumental birth, or in neonatal outcomes.

There is good evidence that one-to-one structured care in early labour compared with standard care is similarly effective for maternal and neonatal outcomes<sup>2</sup>. One-to-one structured care includes assessment of fetal position, advice to improve fetal position, reduce pain and emotional distress.

There is some evidence that algorithms used to support the confirmation of labour onset do not affect outcomes for women and babies when compared with usual midwifery assessments. However, women are less likely to be admitted at their first presentation to hospital<sup>2</sup>.

There is currently no review level evidence about support and assessment in early labour for women planning homebirths.

Women and their companions need realistic information about what to expect and how early labour may be recognised and experienced and when to travel to their planned place of birth. Communications with women in early labour need to be friendly, clear and sympathetic and any advice (including to remain at home) should be accompanied by a rationale<sup>3</sup>.

Women access a range of sources of information including web-based materials, textbooks, and antenatal classes, but these may be less useful if their labour does not follow the 'normal' pattern<sup>3</sup>.

Birth companions may help to support women to stay at home, but for some their anxiety about seeing the woman in pain may also encourage her to go to hospital sooner<sup>1,3</sup>.

## Recommendations for practice

There is some evidence to recommend that:

- Women can be offered assessment either at home or in the maternity unit in early labour, unless their clinical needs require immediate admission
- Midwives' communications with women in early labour should be clear, friendly and compassionate
- Advice, including remaining at home, should be accompanied by the rationale

---

## Good Practice Points

- Different women will be comfortable and confident in different settings. Advice should be individualised for each woman and the circumstances of her pregnancy and labour
- Information about early labour may need to be tailored depending on women's social circumstances and cultural backgrounds
- Women who have insecure or unsuitable housing (for example women in asylum seekers' accommodation or homeless women in hostels) should have personalised plans for the location of early labour made with them
- Women and their birth companions should be provided with education in pregnancy about the latent phase of labour

**The evidence and recommendations presented in this section were derived from existing high quality systematic reviews as referenced below:**

1. Beake S, Chang Y-S, Cheyne H, Spiby H, Sandall J, Bick D. 2017. Experiences of early labour management from perspectives of women, labour companions and health professionals: A systematic review of qualitative evidence. *Midwifery*, 57, 69-84.
2. Kobayashi S, Hanada N, Matsuzaki M, Takehara K, Ota E, Sasaki H, Nagata C, Mori R. Assessment and support during early labour for improving birth outcomes. *Cochrane Database of Systematic Reviews* 2017, Issue 4. Art. No.: CD011516. DOI: 10.1002/14651858.CD011516.pub2.
3. Eri T S; Bondas T, Gross M, Janssen P, Green JM. 2015. A balancing act in an unknown territory: A metasynthesis of first-time mothers' experiences in early labour. *Midwifery* 31: e58-e67

# Birth environment for women labouring in obstetric units

## Evidence summary

There is some evidence that the flexibility, space and comfort of the environment may help facilitate straightforward low-intervention labour and birth. Birthing pools and other aids (such as birth chairs, floor mats and bean bags) are highly valued by women to support different birthing positions. However, many women may not have access to these, particularly in obstetric settings or if they are restricted by monitoring equipment. Space to mobilise is supported by providing storage for both personal possessions and equipment, so preventing rooms becoming too cluttered. Well-designed rooms may feel more spacious than larger rooms. Comfortable furniture (such as double beds or armchairs) can also help support women and their companions through long labours, and enable different birthing positions to be adopted.

Women prefer a private space where they can control who enters the room and be out of sight of other people. Transition spaces (e.g. partition walls) in doorways may help to achieve this by reducing visual exposure. Alcoves, such as window seats, can provide flexible space and make the room feel homelier. Adaptable lighting can help a space feel more relaxing whilst also facilitating the lighting needs for clinical assessments and procedures. Women like to have control over the lighting where possible. Women also like to have control over the temperature and ventilation, however the temperature needs of new-born babies may need to be considered. Large openable exterior windows are preferred by women to help provide natural light and ventilation, but full length windows may make women feel exposed. Women prefer rooms to be insulated from noise and particularly do not want to be overheard or hear other women giving birth. Women may feel more relaxed if they are able to stay in the same room for their whole stay in the unit and are able to personalise their space.

In birth environments there are different, and sometimes conflicting, priorities for women, their companions, midwives and doctors. Spaces need to be supportive for women to mobilise and adopt comfortable positions, but also need to work well for emergencies. This is particularly highlighted in terms of lack of storage, space, layout, and clutter posing a risk in emergency situations. Poor design of the room or ward may affect the care given by midwives, particularly if they need to spend time adapting the room before welcoming the woman or leaving the room to write notes. Workplace conditions can be challenging for midwives, with a lack of control over environmental factors, including noise. Midwives also may need to get into positions to assist births both in and out of the birth pool which are uncomfortable or not well supported by the physical environment. Midwives need a dedicated space to write during birth so that they do not need to leave the room to complete documentation.

---

## Recommendations for practice

There is some evidence to recommend that:

- Midwives discuss with women how they can adapt their birthing room to suit their needs
- Birthing aids such as balls, mats and beanbags should be easily available in all birth settings with dedicated storage
- Midwives discuss with women and their companions what adjustments are available for lighting, heating, and ventilation (if any) and how to use them
- Women should be shown the best places to store their belongings so that they can access them easily, but they do not cause a hazard
- All staff should respect women's privacy by asking permission to enter their room and encouraging others to do the same
- Midwives should be provided with adequate space within the room to complete paperwork in order to provide continuous care

## Good Practice Points

- Consider the use of wireless telemetry (if required) to support women to mobilise during labour
- Offer to show women and their companions how to use the available birthing equipment effectively together
- The use of moving and handling equipment and guidelines should be used to support your practice <https://www.rcm.org.uk/content/manual-handling>

**The evidence and recommendations presented in this section were derived from a new systematic review developed for these guidelines. This is awaiting publication but the protocol is referenced below:**

- Helen Spiby, Phoebe Pallotti, Catrin Evans, Gina Sands, Jeanette Eldridge, Kerry Evans, Mandy Forrester, Lia Brigante. Labour room environments for women with complicated pregnancies. PROSPERO 2018 CRD42018090013 Available from: [http://www.crd.york.ac.uk/PROSPERO/display\\_record.php?ID=CRD42018090013](http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42018090013)

# Eating and drinking in labour

## Evidence summary

Most women can eat and drink as they wish during labour<sup>1</sup>. Studies which compared restricted intake in labour with eating and drinking for women with no increased likelihood of needing anaesthesia in labour found no differences in the:

- Length of labour and birth outcomes
- Epidural analgesia or augmentation
- Infant APGAR scores or admission to Neonatal Intensive Care Unit
- Maternal ketosis, nausea and vomiting<sup>1</sup>

Therefore, there is no justification for restricting food and drink for women who are not at increased risk of needing anaesthesia.

The risk of acid aspiration syndrome is an extremely rare but very serious complication of anaesthesia. There is currently no evidence on which to base recommendations for women at increased likelihood of needing an anaesthetic during labour or birth<sup>1</sup>; more research is urgently needed.

There is some evidence to suggest that oral carbohydrates for all women (such as isotonic drinks) do not affect labour outcomes such as the rate of caesarean or instrumental birth, epidural use or duration of labour<sup>2</sup>.

There is some low-quality evidence to suggest that for the few women who are not able to drink freely during labour, additional intravenous fluids may reduce the duration of labour. There is no systematic evidence about women's views regarding receiving intravenous fluids in these circumstances<sup>3</sup>.

## Recommendations for practice

There is good evidence to recommend that:

- Most women in labour should be supported to eat and drink as they wish
- Women with increased likelihood of needing anaesthesia should discuss eating and drinking with the midwife and medical team and should be informed about the extremely rare but serious risk of acid aspiration syndrome

## Good Practice Points

- Explain to women and birth companions what food and drink are available locally (especially 'out of hours'), taking into account that some families may be on a very low income
- Discuss with women, in the context of local policies, what facilities are available for families' provisions
- Women's cultural traditions may influence the type and timing of food and drink they wish to consume

---

**The evidence and recommendations presented in this section were derived from existing high quality systematic reviews as referenced below:**

1. Singata M, Tranmer J, Gyte GML. Restricting oral fluid and food intake during labour. Cochrane Database of Systematic Reviews 2013, Issue 8. Art. No.: CD003930. DOI: 10.1002/14651858.CD003930.pub3.
2. Malin, G.L., Bugg, G.J., Thornton, J., et al. 2016. Does oral carbohydrate supplementation improve labour outcome? A systematic review and individual patient data meta-analysis, BJOG, 123(4), 510-517.
3. Dawood F, Dowswell T, Quenby S. Intravenous fluids for reducing the duration of labour in low risk nulliparous women. Cochrane Database of Systematic Reviews 2013, Issue 6. Art. No.: CD007715. DOI: 10.1002/14651858.CD007715.pub2.

# Positions for labour and birth

## Evidence summary

There is some limited evidence to suggest that upright positions such as standing, squatting, kneeling up or using birth equipment to remain upright, are associated with a reduction in the duration of the second stage of labour<sup>1</sup>. There is low quality evidence to suggest there is no clear difference in the rates of caesarean section between upright and supine positions<sup>1</sup>. However, upright positions are associated with a significant reduction in instrumental deliveries<sup>1</sup>. More research needs to be done on women's experiences of all positions in labour and birth<sup>1,2</sup>.

There is low quality evidence that upright positions are associated with a reduction in episiotomies<sup>1,2</sup> but an increase in second degree perineal tears in some positions such as standing<sup>1</sup>. There is low quality evidence that there is no clear difference in the number of third or fourth tears between upright and supine positions during labour<sup>1</sup>. Upright positions during labour may be associated with a very small increase in the risk of postpartum haemorrhage<sup>1,2</sup>.

There is low quality evidence that upright positions are associated with fewer recorded abnormal fetal heart rate patterns when compared to supine positions but there is no clear difference in the number of babies admitted to neonatal intensive care<sup>1</sup>.

Research suggests that there is no difference in outcomes for an upright or lying position for women with an epidural in second stage<sup>3</sup>, but recent evidence may give more information on this topic.

## Recommendations for practice

There is some evidence to recommend that:

- Midwives should support women to adopt any position they choose during labour and birth and to change positions as and when they want to
- Midwives should advise women that upright positions during the second stage of labour may reduce the likelihood of interventions such as instrumental births, episiotomies and concern about fetal heart patterns

## Good Practice Points

- Medical equipment should be made to work around a woman's choice of positions
- Many women strongly dislike the lithotomy position therefore use should be limited to facilitating certain procedures such as immediately before an instrumental delivery or for fetal blood sampling and discontinued immediately afterwards
- A recent study, not yet included in the systematic reviews used, suggests that supine positions result in more spontaneous vaginal births for nulliparous women with epidural analgesia compared to upright positions (The Epidural and Position Trial Collaborative Group, BMJ 2017;359:j4471)

---

**The evidence and recommendations presented in this section were derived from existing high quality systematic reviews as referenced below:**

1. Gupta JK, Sood A, Hofmeyr GJ, Vogel JP. Position in the second stage of labour for women without epidural anaesthesia. Cochrane Database of Systematic Reviews 2017, Issue 5. Art. No.: CD002006. DOI: 10.1002/14651858.CD002006.pub4.
2. Deliktas A, Kukulcu K. (2017) A meta-analysis of the effect on maternal health of upright positions during the second stage of labour, without routine epidural analgesia. *J Adv Nurs*; 74 (02) 263-278. DOI: 10.1111/jan.13447
3. Kibuka M, Thornton JG. Position in the second stage of labour for women with epidural anaesthesia. Cochrane Database of Systematic Reviews 2017, Issue 2. Art. No.: CD008070. DOI: 10.1002/14651858.CD008070.pub3.

# Fetal heart rate assessment

## Evidence summary

There is some evidence that intermittent fetal auscultation (with a hand-held Doppler or pinard) may reduce the risk of interventions in labour<sup>1</sup>. There is some evidence that continuous cardiotocograph (CTG) is associated with reducing the rate of neonatal seizures compared with intermittent auscultation<sup>1</sup>. However, there is also low-quality evidence that continuous electronic fetal monitoring (CEFM) with a CTG increases the risk of caesarean section and instrumental deliveries in all groups of women<sup>1</sup>. There is low-quality evidence that monitoring by continuous CTG has no effect on the rate of perinatal death, cerebral palsy rates or the incidence of cord blood acidosis<sup>1</sup>.

There is no evidence comparing the benefits or risks of no fetal monitoring with continuous CTGs<sup>1</sup>.

Performing a CTG as part of a standard admission process is not required as it increases the risk of caesarean section and there is not enough evidence to determine whether this affects outcomes for babies. Therefore, there is no current justification for offering an admission CTG for women receiving midwifery led care<sup>2</sup>.

## Recommendations for practice

There is some evidence to recommend that:

- CTG should only be used when there is a clear clinical reason
- Women without clinical indication for continuous monitoring should not be offered a CTG on arrival at a birth unit as part of a standard admission process
- Intermittent fetal heart rate auscultation throughout labour, using a Doppler or a pinard, is likely to be more suitable for women without clinical indication for CTG

## Good Practice Points

- Midwives need to be aware that CTG fetal monitoring can both reassure women and promote anxiety
- Offering CEFM is currently recommended for women where pregnancy or labour complications pose a risk to the baby
- Consider how you can support women who have chosen to be continuously monitored to remain mobile in labour and to adopt different positions using birthing aids
- New methods of CTG interpretation based on contextual fetal physiology are being introduced but more research is urgently required

**The evidence and recommendations presented in this section were derived from existing high quality systematic reviews as referenced below:**

1. Alfievic Z, Devane D, Gyte GML, Cuthbert A. Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour. *Cochrane Database of Systematic Reviews* 2017, Issue 2. Art. No.: CD006066. DOI: 10.1002/14651858.CD006066.pub3.
2. Devane D, Lalor JG, Daly S, McGuire W, Cuthbert A, Smith V. Cardiotocography versus intermittent auscultation of fetal heart on admission to labour ward for assessment of fetal wellbeing. *Cochrane Database of Systematic Reviews* 2017, Issue 1. Art. No.: CD005122. DOI: 10.1002/14651858.CD005122.pub5.

# Coping and comfort in labour

## Immersion in water during labour and birth

### Evidence summary

*Labouring in water* – there is good evidence of benefit from water immersion during the first stage of labour. Results indicate that it can reduce the likelihood of requiring an epidural and qualitative studies have illustrated that women who choose to labour in water feel a high sense of control and satisfaction. There is some evidence that, for women receiving midwifery led care, water immersion during the first or second stage of labour does not affect rates of spontaneous birth, instrumental birth, or caesarean section<sup>1</sup>. There is no evidence of the effect of water immersion on blood loss or genital trauma<sup>1</sup>.

*Giving birth in water* – there is some evidence that associated maternal satisfaction with maternal pushing experience in water and no added risk of sustaining obstetric anal sphincter injury, no increase in maternal or neonatal infection or requirement for resuscitation or admission to NICU. There is some evidence that waterbirth presents no added risk for the neonate<sup>1</sup>.

There is no evidence evaluating different baths/pools, timing of entry into the pool, or third stage labour management<sup>1</sup>.

There is no evidence to suggest that using water in labour affects adverse outcomes for women and babies<sup>1</sup>.

### Recommendations for practice

There is some evidence to recommend that:

- Women should be informed that using the pool might help women to cope with labour and to feel in control
- All women who want to use water immersion should be supported to do so, provided local clinical guidelines for their individual care needs can be met
- Women are informed that there is no evidence of a difference of increased risk of adverse events for them (such as PPH) or for their baby (such as needing to be admitted to the neonatal unit) from using water immersion for labour and birth

### Good Practice Points

- The provision of water-appropriate continuous fetal monitoring equipment should be considered
- Preserving women's privacy and dignity whilst in the pool is important for both cultural and personal reasons

**The evidence and recommendations presented in this section were derived from existing high quality systematic reviews as referenced below:**

1. Cluett ER, Burns E, Cuthbert A. Immersion in water during labour and birth. Cochrane Database of Systematic Reviews 2018, Issue 5. Art. No.: CD000111. DOI: 10.1002/14651858.CD000111.pub4

## Women's decision making and experience of epidural

### Evidence summary

Women expect to be actively involved in the epidural analgesia decision-making process and to receive support and advice from their midwife. Some women have made birth plans, considering epidural analgesia depending on their experience when in labour. Some women feel pressured or persuaded by healthcare professionals (HCPs) to have an epidural. Access to epidural may influence women's choice of birthplace.

There is some evidence that overall birth satisfaction is lower for women who used epidural analgesia compared with no pain relief or other analgesia methods. However, most women who had an epidural were satisfied with the effectiveness of their labour analgesia. Continuity of carer and the support and presence of a midwife are key factors associated with positive experiences of epidural analgesia. After an epidural takes effect many women will want and value the presence of the midwife and to discuss the plans for the remaining part of labour.

Miscommunication and lack of empathy from HCPs, late initiation of and/or ineffective analgesia all contribute to negative birth experiences. Studies have reported that women are fearful of adverse side effects and find it difficult to access good quality information about epidural analgesia.

Intrapartum informed consent is often undertaken by the anaesthetist who the woman has not met before. Women would prefer to be informed about epidurals by their midwife or obstetrician during the antenatal period, ideally during the second or third trimester of pregnancy.

There is some evidence that written and audio-visual information can improve women's knowledge of pain relief options and support decision-making. Printed material should support discussions with HCPs. Other suggested information formats include leaflets, trustworthy websites, 'question and answer' resources, other women's experiences and a video demonstrating epidural placement.

### Recommendations for practice

There is some evidence to recommend that:

- Key information for epidural analgesia should include benefits and potential side-effects. Information should be supported by written or audio-visual materials
- Midwives should be mindful that women can feel pressured to have or not to have an epidural
- The midwife should remain with a woman after an epidural is sited as the woman may wish to discuss plans for the remaining part of labour

### Good Practice points

- Consider the woman's feelings, values, concerns, sense of control, self-esteem and satisfaction before, during and after epidural
- Midwives discuss coping strategies or pain relief with women and their birth companions during antenatal visits

**The evidence and recommendations presented in this section were derived from a new systematic review developed for these guidelines. This is awaiting publication:**

Phoebe Pallotti, Helen Spiby, Jeanette Eldridge, Catrin Evans, Sara Borrelli, Kerry Evans, Mandy Forrester, Lia Brigante. Women's decision making and experiences on the use of epidural analgesia in labour: a systematic review of quantitative and qualitative evidence. PROSPERO 2018 CRD42018094905 Available from: [http://www.crd.york.ac.uk/PROSPERO/display\\_record.php?ID=CRD42018094905](http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42018094905)

## Other methods and therapies for coping in labour

### Evidence summary

Many women use various methods and therapies to support them during labour and birth. This may be particularly in the context of a focus on exploring ways of coping with the experience rather than attempting to eliminate pain.

There is some evidence to suggest that the methods and therapies listed below are not harmful to women and babies<sup>1,2,3,4,5,6,7</sup>. There is some low-quality evidence to suggest that hypnosis and acupuncture / acupressure may help to reduce the use of pharmacological pain relief<sup>2,6</sup>. Whilst there is some evidence that these methods do not seem to change the length of labour or any other outcomes from birth they can be a very helpful coping tool for women and there is some low-quality evidence that the methods and therapies listed may increase women's satisfaction<sup>2,3,4,6,7</sup>. More research is needed on other forms of alternative therapies.

### Recommendations for practice

There is some evidence to recommend that:

- Midwives advise that women may find some therapies beneficial for wellbeing but there is no clear evidence to support the efficacy of other therapies for pain relief in labour

### Good Practice Points

- Midwives should support women's choices regarding other therapies
- Consider safety issues and discuss these with the woman
- Advise that anything requiring a naked flame cannot be used where medical gases are available (including at a home birth, if Entonox is supplied)
- Advise that any method which pierces the skin (acupuncture, sterile water injections) carries a risk of infection

---

**The evidence and recommendations presented in this section were derived from existing high quality systematic reviews as referenced below:**

1. Derry S, Straube S, Moore RA, Hancock H, Collins SL. Intracutaneous or subcutaneous sterile water injection compared with blinded controls for pain management in labour. *Cochrane Database of Systematic Reviews* 2012, Issue 1. Art. No.: CD009107. DOI: 10.1002/14651858.CD009107.pub2.
2. Madden K, Middleton P, Cyna AM, Matthewson M, Jones L. Hypnosis for pain management during labour and childbirth. *Cochrane Database of Systematic Reviews* 2016, Issue 5. Art. No.: CD009356. DOI: 10.1002/14651858.CD009356.pub3.
3. Smith CA, Levett KM, Collins CT, Armour M, Dahlen HG, Sukanuma M. Relaxation techniques for pain management in labour. *Cochrane Database of Systematic Reviews* 2018, Issue 3. Art. No.: CD009514. DOI: 10.1002/14651858.CD009514.pub2.
4. Smith CA, Levett KM, Collin CT, Dahlen HG, Ee CC, Sukanuma M. Massage, reflexology and other manual methods for pain management in labour. *Cochrane Database of Systematic Reviews* 2018, Issue 3. Art. No.: CD009290. DOI: 10.1002/14651858.CD009290.pub3.
5. Smith CA, Collins CT, Crowther CA. Aromatherapy for pain management in labour. *Cochrane Database of Systematic Reviews* 2011, Issue 7. Art. No.: CD009215. DOI: 10.1002/14651858.CD009215.
6. Smith CA, Collins CT, Crowther CA, Levett KM. Acupuncture or acupressure for pain management in labour. *Cochrane Database of Systematic Reviews* 2011, Issue 7. Art. No.: CD009232. DOI: 10.1002/14651858.CD009232.
7. Dowswell T, Bedwell C, Lavender T, Neilson JP. Transcutaneous electrical nerve stimulation (TENS) for pain management in labour. *Cochrane Database of Systematic Reviews* 2009, Issue 2. Art. No.: CD007214. DOI: 10.1002/14651858.CD007214.pub2.

# Birth companions

---

## Evidence summary

This evidence summary focuses on companions from women's family and friends. Women's and birth companions' satisfaction with birth is increased when companions are able to support the mother and feel supported themselves. Companions are often co-parents and evidence shows that their satisfaction with care is increased if this is acknowledged and they are valued as a parent of the child.

Giving information to companions in a friendly and inclusive way is vital. Midwives' facilitation of birth companions can maximise their potential as a positive support to women in labour. Feeling well informed increases companion's satisfaction with care and with their experience of childbirth. This is even more important during emergencies when companions can feel anxious and poorly-informed about the wellbeing of the woman and baby.

Some women and their companions make plans about ways to provide support in labour. However, many companions welcome guidance from midwives (such as ways to help physically support a mother whilst using birth aids). This helps companions feel included and having a task to focus on may allay their anxieties about a new situation in an unfamiliar environment.

When speaking generally about *groups* of parents it is important not to use the word 'fathers' as this excludes lesbian couples and families with other parenting arrangements. Individually, women and their companions should be consulted on how they want to be addressed and on what support the companion wishes to offer in labour.

## Recommendations for practice

There is good evidence to recommend that:

- Birth companions should be welcomed and orientated to facilities such as bathrooms, food outlets and other amenities
- Midwives should ask whether companions would like to receive suggestions on the ways they can provide support
- Midwives should answer questions in a friendly and timely manner. If an emergency arises, ensure that a member of staff is tasked with providing information and support to the birth companion and with supporting their needs
- Midwives should ensure all birth companions are valued for their contribution to the birth but are also recognised and supported as parents of the baby where this is the case

---

## Good Practice Points

- Not all companions need to be directed to ways to physically support the birthing mother
- Emotional support, closeness and 'being there' can help women remain focused and feel reassured
- Midwives should ask women (and their families), who will be attending the birth and how they would like to be addressed
- Lesbian couples' experiences in labour and childbirth are affected by the attitudes of health care providers. Midwives should provide inclusive and sensitive care tailored to individual needs
- Women may choose to be accompanied by doulas who should be welcomed as part of the women's birth support network

**The evidence and recommendations presented in this section were derived from a new systematic review developed for these guidelines. This is awaiting publication:**

Jeanette Eldridge, Phoebe Pallotti, Helen Spiby, Catrin Evans, Kerry Evans, Mandie Forrester, Lia Brigante. Birth companions for women in labour: experiences, views, outcomes and support for birth companions. PROSPERO 2018 CRD42018092544 Available from: [http://www.crd.york.ac.uk/PROSPERO/display\\_record.php?ID=CRD42018092544](http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42018092544)

# Preventing severe genital trauma

## Evidence summary

There is good evidence that using a warm compress on the perineum, and some evidence that perineal massage during birth may help to reduce the rates of third and fourth degree tears<sup>1</sup>.

There is low-quality evidence that hands-off (or poised) compared to hands-on techniques has no effect on the rate of third and fourth degree tears but may result in fewer women requiring episiotomy<sup>1</sup>.

There is insufficient evidence to show whether Ritgen's manoeuvre or other perineal techniques could improve outcomes<sup>1</sup>. More research is needed.

There is low-quality evidence that selective episiotomy for unassisted vaginal births, results in fewer women experiencing severe perineal / vaginal trauma than policies of routine episiotomy<sup>2</sup>. There is low-quality evidence that selective episiotomy policies do not result in harm to women or babies<sup>2</sup>. There is no evidence about the effect of selective or routine episiotomy policies for instrumental births<sup>2</sup>.

## Recommendations for practice

There is good evidence to recommend that:

- Midwives should ask women if they would like a warm compress to be used on the perineum to help reduce the risk of serious tears

There is some evidence to recommend that:

- Perineal massage may help to reduce serious tears; midwives should discuss techniques for this during the antenatal period
- A policy of routine episiotomy may result in more women experiencing severe perineal trauma

**The evidence and recommendations presented in this section were derived from existing high quality systematic reviews as referenced below:**

1. Aasheim V, Nilsen ABV, Reinar LM, Lukasse M. Perineal techniques during the second stage of labour for reducing perineal trauma. Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD006672. DOI: 10.1002/14651858.CD006672.pub3
2. Jiang H, Qian X, Carroli G, Garner P. Selective versus routine use of episiotomy for vaginal birth. Cochrane Database of Systematic Reviews 2017, Issue 2. Art. No.: CD000081. DOI: 10.1002/14651858.CD000081.pub3.

# Third stage of labour

## Evidence summary

There is some evidence that active management of the third stage of labour reduces the risk of severe bleeding and anaemia for all women<sup>1</sup>. However active management may increase the risks of adverse effects such as increasing mother's blood pressure, vomiting, after-pains and the need to return to hospital with bleeding<sup>1</sup>. For women with no risk factors for post-partum haemorrhage (PPH), there is low-quality evidence that active management has no effect on risk of postpartum maternal hemoglobin less than 9g/dL compared to expectant management. If women choose active management, there is good evidence in favour of using prophylactic oxytocin only (syntocinon) after birth as it can reduce blood loss in women with fewer side effects than ergometrine/syntometrine<sup>2</sup>. Active management is a package of care; one component of which is Controlled Cord Traction. When controlled cord traction (CCT) is used as part of active management, it may result in a small reduction of blood loss and reduces the risk of manual removal of the placenta<sup>3</sup>.

There is good evidence that delayed cord clamping (between one and three minutes after birth) can have positive effects on neonatal outcomes such as higher birthweight, early haemoglobin concentration, and increased iron reserves up to six months after birth<sup>4</sup>.

## Recommendations for practice

There is good evidence to recommend that:

- Delayed cord clamping is advised for optimal neonatal outcomes
- Prophylactic oxytocin can reduce blood loss with fewer side effects than drugs containing ergot
- When active management is chosen, CCT is strongly recommended to reduce the risk of a retained placenta

## Good Practice Points

- Give women information about the benefits and potential adverse effects of active and expectant management to support informed choice
- Discuss with women that active management may reduce the time between birth of their baby and delivery of the placenta
- Discuss with women their preferences for cutting the cord, including who will cut the cord
- Discuss with the woman her options for delayed cord clamping in situations other than a vaginal birth (instrumental, caesarean)

**The evidence and recommendations presented in this section were derived from existing high quality systematic reviews as referenced below:**

1. Begley CM, Gyte GML, Devane D, McGuire W, Weeks A. Active versus expectant management for women in the third stage of labour. Cochrane Database of Systematic Reviews 2015, Issue 3. Art. No.: CD007412. DOI: 10.1002/14651858.CD007412.pub4.
2. Westhoff G, Cotter AM, Tolosa JE. Prophylactic oxytocin for the third stage of labour to prevent postpartum haemorrhage. Cochrane Database of Systematic Reviews 2013, Issue 10. Art. No.: CD001808. DOI: 10.1002/14651858.CD001808.pub2.
3. Hofmeyr GJ, Mshweshwe NT, Gülmezoglu AM. Controlled cord traction for the third stage of labour. Cochrane Database of Systematic Reviews 2015, Issue 1. Art. No.: CD008020. DOI: 10.1002/14651858.CD008020.pub2.
4. McDonald SJ, Middleton P, Dowswell T, Morris PS. Effect of timing of umbilical cord clamping of term infants on maternal and neonatal outcomes. Cochrane Database of Systematic Reviews 2013, Issue 7. Art. No.: CD004074. DOI: 10.1002/14651858.CD004074.pub3.





THE ROYAL  
COLLEGE OF  
MIDWIVES

Promoting • Supporting • Influencing

**The Royal College of Midwives**  
15 Mansfield Street • London W1G 9NH

0300 303 0444  
info@rcm.org.uk  
[www.rcm.org.uk](http://www.rcm.org.uk)

 @MidwivesRCM  [www.facebook.com/MidwivesRCM](http://www.facebook.com/MidwivesRCM)  [www.instagram.com/midwives\\_rcm](http://www.instagram.com/midwives_rcm)