

Midwifery care in  
labour guidance for all  
women in all settings

**Information for  
Women and Families**



**THE ROYAL  
COLLEGE OF  
MIDWIVES**

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# Introduction

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This document includes information for women and those supporting them in preparing for and during labour and birth. In the UK, women give birth in different places: at home, in midwifery units and in obstetric units. These recommendations have been developed with all women in mind, whatever their medical and social needs may be. However, every woman and her family is different and this guidance is set out to be a series of points for consideration and discussion. It should be used as a tool to support communication with your maternity care team, on any issues that are important to you, not as a set of instructions.

The recommendations have been developed following detailed work that has looked at which aspects of care can make a real difference to the health and wellbeing of all women and their babies. This has included looking at scientific research published since 2000. It has also included consulting with women and other experts during the process. There is a companion midwives' version of these recommendations that includes references for the evidence used and a technical manual detailing all the scientific work which went into this guidance.

This summary and the recommendations can be used to help you gain more information about options available during labour and birth. It includes some questions that you may wish to ask your midwife to help you to consider what some of the options are for labour and birth and the ways in which you would like support for you and your family to be given. This guidance does not cover every aspect of care during labour and birth. The topics included were informed by our Expert Advisory Group and service user organisations. The facilities available in different areas may vary.

The development of these recommendations by a team at the University of Nottingham has taken place over a 14-month period from 1st September 2017- 31st October 2018. We are very grateful for the support of our Expert Advisory Group and Nottingham Maternity Research Network at all stages of this work.

The work was funded by the Royal College of Midwives (RCM). The RCM did not influence the guidance development process or individual recommendations. We recommend that this guidance is reviewed and updated in three years.

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# People you may meet

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Many women meet several different health professionals during their pregnancy and birth. It is always acceptable to ask anyone you meet who they are and what they do. In both hospital and community settings, you may also meet other staff who contribute to maternity care. They may include maternity support workers, health care assistants, operating theatre staff, domestic and administrative staff.

## Here are some of the people you may meet:

**A midwife** is a trained specialist in supporting women in pregnancy, labour and birth, the postnatal period and women's reproductive health. Midwives work both independently as your lead professional in pregnancy and birth and also as part of a multi-professional maternity care team for the NHS and for other services. In the UK, it is common to do midwifery training without having a nursing background. There are a small number of **independent midwives** (private midwives) working in the UK; they have the same qualifications and registration as midwives who work for the NHS.

A **community midwife** is someone you may meet at your GP surgery or at your home. All women who 'book' for pregnancy care will be allocated a midwife or team of midwives. They are there to support and advise you during your pregnancy and in the postnatal period. Some community midwives will also be there for your birth; we often call these **caseloading midwives**. Caseloading midwives provide care throughout the whole pregnancy until when your baby is a few weeks old. There are also **hospital midwives** who always work in birth centres and/or in an obstetric unit.

**Student midwives** are people who are training to be a midwife (typically a three-year university degree with a large element of experience in practice). They will always work with a qualified midwife.

**An Obstetrician** is a doctor who is trained in supporting women in pregnancy and childbirth and who can perform surgery such as caesarean sections. Obstetricians generally offer you care when you have medical or pregnancy related needs which may increase the likelihood of you and your baby needing some kind of treatment. Obstetricians have completed their general medical and surgical training and then years of specialist training. **Consultants** are the doctors in charge and **registrars** are still completing their specialist training, but are often very experienced. Doctors in their **foundation years** usually also work in the hospital (such as on labour ward) and they work with the registrars and the consultants.

**An Anaesthetist** is a doctor who is trained in administering **general anaesthetics** and other pain relieving medicine, such as an **epidural**. They are experts in supporting women who need emergency treatment. **Consultants** are the doctors in charge and **registrars** are still completing their specialist training, but are often very experienced. You are most likely to meet an anaesthetist if you want an epidural during labour or if you have a caesarean section operation to deliver your baby.

You will sometimes meet **nurses in maternity**. You may meet theatre nurses who support the obstetric surgeons during operations such as caesarean section. Nurses may also work with you to care for your baby, especially if your baby needs some kind of treatment after he or she is born.

# Locations for birth

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A **home birth** is typically planned with your community or caseloading midwife. When you call them when you are in labour, a midwife will come to your home. Often a second midwife will attend your home to assist the first midwife when your labour is more advanced. Gas and air (nitrous oxide and oxygen mix, sometimes called Entonox) is usually offered for pain relief at a home birth. You can arrange to have your own pool for a waterbirth. Some areas provide a pool 'rental' service or you can rent or buy one privately.

**Midwifery unit:** A suite of rooms, sometimes joined onto the obstetric unit and sometimes in a building of its own, to which women and their families can go to give birth. These rooms are staffed by midwives, who are experts in pregnancy and birth. They are usually a more 'homely' environment and the rooms look less like a hospital environment. An **alongside midwifery unit** is a birth unit which is next to or near an obstetric unit (labour ward) in a hospital. A **freestanding midwifery unit** is a centre which is in its own building, away from the hospital. Some freestanding midwifery units are relatively close to the hospital, but some (especially rural units) may be at quite a distance. The majority of midwifery units will offer most forms of pain relief (such as gas and air and opioids) except epidurals.

**Obstetric unit:** A ward or a set of wards in a hospital which offer care for women with complex needs in pregnancy. These needs might be illnesses which are caused by the pregnancy, babies who might need extra care, or other health issues which women had before they were pregnant. On these wards you will be looked after by a midwife and obstetricians will be available if you require them. All forms of pain relief including epidurals should be available to you if you are in an obstetric unit.

# Discussions about birth with your community midwife

## Choosing your place of birth

Giving birth in the UK is generally very safe for women and their babies. If this is your first baby and you do not need to have a doctor involved in your care during labour then an **alongside or freestanding midwifery unit** is likely to be the most beneficial place for you and your baby. Research suggests that you will have the best chance of having a straightforward birth at these midwifery units and that women feel more satisfied with their birth experiences there.

Research suggests that having a **home birth** for your first baby is just as beneficial for you as being in a midwifery unit, but there is a slightly higher likelihood of serious outcomes for your baby.

If it is not your first baby and you do not need a doctor then an **alongside or freestanding midwifery unit AND home** are the most beneficial places to labour and birth in, for you and your baby too.

Some women start their labour in a birth centre or at home then move to the hospital or over to the obstetric unit. Research suggests that women who start their labours at home or in a midwifery unit but then move to an obstetric unit due to their additional needs still have a greater likelihood of having a straightforward birth. You have the choice to move to an obstetric unit during labour (for instance, if you wanted an epidural). Some women prefer to delay their choice of place of birth till they are near or in labour.

Most birth centres and obstetric units will offer 'tours' of the facilities for pregnant women and their families. Your midwife will be able to advise you on what is available locally and give you information about visiting units, to help you make a decision on where you want to give birth. Some of these tours will be in person, others may be available on line. Research suggests that feeling relaxed and secure is very important to the process of labour and birth. Everyone is different and different women will find different places more reassuring, it is what is right for you that matters.

### Some questions you might like to ask your midwife:

- If I want to, is there an alongside or freestanding midwifery unit that I can use?
- What things about me and my baby would you suggest when planning where I give birth?
- If I want to, how do I plan a homebirth?
- If I want to, can I make the decision on where I give birth late in my pregnancy or when labour starts?
- If I want to, can I see the birth centre and/or the obstetric labour ward before I go into labour?

## Discussing having a baby after you have had a caesarean birth

If you had a previous child by caesarean then your midwife will offer to talk to you about your options for this birth. In many areas, you will also be offered an appointment with an obstetrician to discuss your birth. Your team should provide you with clear information to help you and your family make choices that are right for you. The risks and benefits of each option will be different for each woman and a personal plan should be developed with you.

Some women prefer to go into labour and plan for vaginal birth for many reasons, sometimes because they want to experience giving birth in that way or because recovery from a vaginal birth is usually shorter than from a caesarean birth. Other women prefer to plan another caesarean section (a caesarean birth planned in advance of labour is often called an 'elective' caesarean birth). This might be because they feel more in control by planning the operation or because they feel that this option is more familiar. It is wise to consider your future childbearing plans when deciding on this birth and discuss these with your midwife and doctor too.

#### Some questions you might like to ask your midwife:

- What options for birth are available to me after my previous caesarean section?
- If I want to, can I plan to have another caesarean birth?
- How will this decision affect my future pregnancies, if I want to get pregnant again?
- What are the risks and benefits of each option for me and my baby?
- What is the likelihood that I will need an emergency caesarean if I plan to have a vaginal birth?
- What information is available to me to help me make this decision?

## Early labour

Early labour is the period after contractions start but before you are in established labour. Early labour can be very short, or can sometimes go on for some time. It is common for early labour to be longer if it is your first baby, but every woman is different.

A midwife will be able to discuss with you and your family how to tell if labour is established, the best time for you to go to the maternity unit or for a midwife to visit you at home or why you may wish to stay at home for longer. If you are feeling pain, they can also offer you information on coping. Sometimes midwives at a maternity unit or the hospital will give you advice over the phone and your community midwife will let you know the telephone number to call. Sometimes you will be offered an assessment during the early stages of labour, either at home, the Midwifery Unit or where you plan to give birth.

Making the decision to travel to the maternity unit is an important one for women and those supporting them at this time. It is fine to ask for information or advice more than once when you feel that your labour is starting. If you receive advice that you are unsure about, ask the person giving you advice to explain that to you. Planning your journey into your place of birth, if you are not having a homebirth, is important. If you are concerned about the cost or practicalities of getting to a unit then you can discuss this with your community midwife or with the midwife at the maternity unit on the telephone.

#### Some questions you might like to ask your midwife:

- How can I tell when my labour is established? At what point is it most beneficial for me to go into a midwifery unit or the hospital?
- Can you suggest some strategies which may help me in early labour?
- I am planning a homebirth, at what point will a midwife come to my home?
- Can we discuss travel to the unit? Is public transport an option for me? Is there parking available at the unit? Is there a charge for that?
- Who can be with me in early labour in a Midwifery or Obstetric Unit?
- What are my choices if I am not considered to be in early labour?

# Discussions with your labour and birth midwife

## Birth environment

Research suggests that women often feel more relaxed and secure in places which have a 'homely' feel. A positive, comfortable and calming environment is very important to many women giving birth. Many birth centres are designed to look more like a home but it is more likely that an obstetric ward will look like a hospital. Many birth centres and hospitals have equipment that you can use during your labour, such as exercise balls to sit or lean on, bean bags and floor mats and other furniture to support a range of positions for labour and birth. If you want to, you can also ask to dim the lighting during labour. This option should be available in most birth settings, including in the hospital on an obstetric labour ward. You can bring items from home that you may find helpful during labour (such as pillows or your own birth aids).

During your labour, in any birth setting, you can ask to be consulted about who comes into the room and you can ask that other staff and visitors knock and wait before they enter. You can ask for privacy if you would like to take time alone or with your birth companions.

If you need emergency care, for example if you start to bleed heavily after birth, then it is likely that more staff will come in to the room very quickly to provide a quick response to the situation. It can sometimes be difficult to know what is happening in these more urgent situations. A member of staff should be there to discuss emergency treatment with you and your chosen birth companions in such events.

### Some questions you might like to ask your midwife:

- If I want to use them, what aids and equipment are likely to be available in my chosen place of birth to help me change position and is there room to move around during labour?
- If I want them to, can people please ask permission to enter my room?
- Is there space to safely store my own and my companions' belongings safely?
- If I/we want a few moments alone, how do we ask for this and how do we call the midwife back if we need them?

## Eating and drinking in labour

Research suggests that women who are unlikely to need the care of a doctor during labour should eat and drink as they wish.

Women in labour may not want to eat a large meal so having small snacks may be better, but whatever you want to eat is fine.

Some women may be more likely to need a general anaesthetic. Eating before a general anaesthetic increases the risks of an extremely rare but very serious illness (acid aspiration syndrome). If you are more likely to need a general anaesthetic then you can talk to your midwife and anaesthetist about the best plan for you.

If you are not planning a homebirth, then you could think about the food and drink you may want in labour. Not all hospitals or birth centres have places to buy food, particularly out-of-hours, so packing some snacks in your birth bag can save time and money.

Some birth centres may provide some kinds of food and drink and some may have fridges to store your food in or even a small kitchen that families can use, but others may not. Your midwife will be able to tell you what is available locally. Your companions will also need to bring some snacks.

#### Some questions you might like to ask your midwife:

- Am I more likely to need a general anaesthetic and if so can we discuss an eating and drinking plan for my labour?
- If I want to, is there anywhere that I can store my food and drinks at my place of birth?
- What food and drink is available for free on the ward/birth unit?
- If I want to, is there anywhere I can buy drinks and snacks locally?

## Positions for labour and birth

Research suggests that using upright positions, particularly when pushing may shorten your labour. Many women also find that changing positions helps them cope with any pain. Some research suggests that being upright also improves blood flow to the baby, but more research is needed on this. More research is needed on what positions are best for women who have an epidural.

Adopting a position you feel comfortable with and changing positions as you wish is the most important thing in labour. All women are different and positions that are comfortable for a while may change as labour progresses. You can use birth aids or your partner or birth companions to help you move, sit, stand or lie as you feel the need to.

#### Some questions you might like to ask your midwife:

- If I want to, what is available at my place of birth to help me to get into different positions and to give birth?
- If I want to, is there space to move around at my place of birth?
- Are there any reasons (such as an epidural or a monitor for the baby's heartrate) which may make it difficult for me to get into different positions? What can we do to help me use different positions if I want to, if this is the case?

## My baby's wellbeing during labour – listening to my baby's heart

Listening to your baby's heartbeat is one of the main ways a midwife will offer to check that baby is well during the labour. There are two main ways in which a midwife will offer to listen to your baby's heart rate in labour. One is when the midwife will offer to listen every fifteen minutes (every five minutes when you are pushing) usually with a small Doppler device or with a pinard (a small stethoscope that looks like a cone). This is called 'intermittent auscultation (or "listening in)'. The other is when your baby's heart rate is measured constantly with a cardiotocograph (CTG). This is a machine which has small devices which are placed on your bump, and prints out your baby's heartrate on a long sheet of paper (a 'trace'). The second method is often offered if there are any concerns about you or your baby or if you have an epidural.

Research suggests that for healthy women who are progressing well in labour, listening in or monitoring with a CTG result in no difference in babies' wellbeing at birth. Having continuous CTG monitoring may increase the chance of having birth interventions such as a forceps birth or caesarean section. A CTG can sometimes restrict your movements as you will be connected to a machine throughout the labour.

There is good research to suggest that having a CTG when you arrive at a unit as part of a routine assessment (an 'admission trace') has no benefit and increases the likelihood of interventions for you and your baby.

The types of listening to the baby's heartrate is your choice. You can change your mind during the labour if you wish to. If the midwife or doctor has concerns about your baby, they may offer you a CTG and this can be started at any time during labour. If monitoring is suggested, you can ask your midwife or doctor the reasons for this.

#### Some questions you might like to ask your midwife:

- What options for checking on my baby's wellbeing during labour are available for me and my baby?
- What are the reasons I am being offered a CTG?

## Coping with pain and comfort in labour

Some women find that they do not need help to cope with pain during labour and birth and some women do. Further, not all women feel pain in labour. Every labour is different and what is important is that you feel able to make the decisions that are right for you and your family.

### Water

Many women find that being in water (such as using a birth pool or a bath) helps them cope with labour pain and research suggests that being in water for labour and birth is just as beneficial for you and your baby as being on dry land. You can use water at any stage of your labour and of course can get in and out as you wish. There may be some circumstances where midwives or obstetricians advise against using a birth pool for labour and birth and you can ask to discuss the concerns with them.

### Drugs

Gas and air (nitrous oxide and oxygen mix) is usually available in all birth settings, including at home. Many units can offer opioid drugs (such as morphine) in labour. You can discuss what is locally available with your midwife and what might be helpful for you.

### Epidurals

Some women will want to use an epidural, which is a drug injected into your lower back. An epidural may make it difficult to walk whilst it is working and sometimes it temporarily makes you lose the feeling in your legs. Research suggests that the likelihood of any serious long-lasting illness from using an epidural is very low. Epidurals are usually only available in a hospital obstetric unit and an anaesthetist will discuss any possible problems with you before you have an epidural put in. We do not know if using epidurals increases women's sense of satisfaction with their births and with their care. There may be some circumstances where your midwife or anaesthetist advise for or against an epidural; they will explain that to you.

## Other methods and therapies

Many women use other kinds of 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. Research suggests that the methods and therapies below are not harmful to women and babies. More research is needed on other forms of alternative therapies. Whilst these methods do not seem to change the length or other aspects of labour and birth, they can be a very helpful coping tool for women and are often highly valued.

- Hypnosis (or hypnobirthing)
- Relaxation techniques
- Massage, reflexology and other manual methods
- Aromatherapy
- TENS (Transcutaneous electrical nerve stimulation)

Caution is advised with methods that pierce the skin (such as subcutaneous sterile water injections or acupuncture) as any incision carries a risk of infection. You should also be aware that maternity units will not usually allow naked flames (for example a candle in an aromatherapy oil burner) as there are flammable medical gases present. You can buy flame free aromatherapy diffusers. A few units, especially midwifery units, may offer some types of therapies so do ask your midwife what might be available at your chosen place of birth. Bear in mind that a midwife will not always be trained to provide details and advise you further on methods and administration of alternative therapies.

### Some questions you might like to ask your midwife:

- If I want to use one, is there a pool available at my chosen place of birth and is it likely to be available when I get to the unit?
- If I want to use an epidural, what effects may having an epidural have on me and on my labour and birth? What are the possible side effects and risks of an epidural for me?
- If I want to use them, are there any therapies available at my chosen place of birth?

## My partner, birth companions and family

All families are different and it is often useful to have a discussion with your midwife about who people are and what they would like to be called.

Many women are accompanied in labour by members of their family and friends. Often their partner or co-parent is there to support the mother in labour, sometimes a woman's own mother or other people are part of the birth. Some women prefer to birth alone or with a trained birth supporter (a doula). In a birth centre, partners who are the other parent are often able to stay overnight after the birth, if a stay is necessary. In obstetric units, this is often not the case and partners are likely to be asked to leave a few hours after the birth if it is not visiting hours. There is research that suggests that homebirths are often felt to be a positive experience by partners, as they have more to do and are more in control of their surroundings.

Birth can be a very emotional experience for everyone, and supporting partners and companions is important so that the mother can relax and concentrate on the labour and birth. Many partners find that they feel more able to engage and to cope with labour if they can help, such as supporting the mother in different positions, playing music or helping with the mother's snacks and drinks.

Partners also often feel reassured and able to support the mother if they feel welcome to ask questions and to get information from the midwife and other staff. During your pregnancy, it may be helpful for you and your partner or birth companions to discuss how you would like them to be involved and what they feel they would like to do.

#### Some questions you might like to ask your midwife:

- Is there room for my partner to stay if I want them to?
- What facilities are there for my partner, such as bathrooms and food outlets?
- What things is it a good idea for my partner to bring with them, to my chosen place of birth?
- How could my partner or companions help me during the labour and birth?

## Preventing genital tears in birth

There are different options available to try to prevent tears at birth. These kinds of tears require repair which is often offered immediately after birth. The more serious forms of tears (involving the anal structures) are usually repaired in an operating theatre.

There is good research to suggest that using warm compresses on your perineum during labour helps to reduce genital tears.

There is some research to suggest that a midwife (or doctor) holding your baby's head as it is born may reduce the likelihood of tears. There is no evidence to suggest that there is any benefit or harm to the baby from any of these methods.

#### Some questions you might like to ask your midwife:

- What can I do that may reduce the likelihood of having a serious tear?
- If I want you to, what can you do at birth that may reduce the likelihood of me having a serious tear?

## After my baby is born: the cord and the placenta

There is very good research to suggest that when your baby is born, it is of great benefit to your baby if the cord is not cut for at least two minutes. This gives your baby the chance to receive all of their own blood back out of the placenta. Even if you have a caesarean section, it is still recommended that there is a two minute delay before cutting the cord. If you chose to give birth to the placenta by yourself (see below) then the cord will often not be cut until the placenta is out of your body.

There are two options to give birth to your placenta after the baby is born. One is to wait until the placenta comes out by itself, which usually involves a little more pushing. The other is to accept drugs which help the placenta to separate from the womb and the midwife (or doctor) will then gently guide it out of your vagina (controlled cord traction). If you do have drugs to birth the placenta then the time between the birth of the baby and the placenta is usually shorter.

For women who are more likely to bleed heavily (a postpartum haemorrhage), for example those who have twins or who have blood clotting problems, research suggests that using drugs can reduce the likelihood of a serious bleed. For most women who are not likely to bleed, there is little difference in

the chance of serious effects from bleeding between the two options (using drugs or waiting) but the drugs do sometimes have unpleasant side effects.

One drug available syntocinon (oxytocin) is just as good at preventing heavy bleeding but without some of the side effects of other drugs. Drugs containing ergots (such as syntometrine) increase the risk of the placenta being retained (getting stuck in the womb) and also of you feeling unwell, such as being sick or having a headache.

#### Some questions you might like to ask your midwife:

- If I want to, can we wait for a while before we cut our baby's cord?
- If we want to, can I, my partner or my chosen birth companion cut the baby's cord when we are ready?
- Are there any situations where baby's cord may need to be cut immediately or where cutting the cord may need to be delayed more than a few minutes?
- What are the options for delivering my placenta? What are the benefits for me of each option?
- If I chose to have drugs to deliver the placenta, what are the benefits for me of the different drugs that can be used?





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