Policy for the Management of the First Stage of Labour

Name of Policy author: Karen Morton, Anne Carvalho

Name of Review/Development Body: Maternity Risk Management Group (MRMG)

Ratification Body: Maternity Risk Management Group (MRMG)

Effective from: 27 April 2012

Date of Ratification: 26 April 2012

Review Date: April 2015

Reviewing Officer: Karen Morton, Anne Carvalho

Signed

Jacqui Tingle
Chair of MRMG
### Example of a Version Control Sheet

<table>
<thead>
<tr>
<th>Date</th>
<th>Review Type (please tick)</th>
<th>Version No.</th>
<th>Author of Review</th>
<th>Date Ratified</th>
<th>Ratification Body</th>
<th>Page Numbers (where amended)</th>
<th>Line Numbers (where amended)</th>
<th>Details of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2012</td>
<td>✅ Full Review</td>
<td>V1.0</td>
<td>Anne Carvalho</td>
<td>26/04/2012</td>
<td>MRMG</td>
<td></td>
<td></td>
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</tbody>
</table>

* Where there is a full review, amendment details are not required in the version control sheet.
1. Introduction
This document provides guidance on the management of the latent and first stages of labour and applies to all clinical staff.

2. Purpose
This evidence based guideline has been developed to help ensure consistency of the quality of care experienced by women during both the latent and established first stages of labour in accordance with relevant national guidance.

It is intended to enable healthcare professionals to give appropriate research-based advice to women and their families. This will enable women to make properly informed decisions during the latent and first stages of labour.

This policy supersedes the Policy for the Management of the First Stage of Labour (to include use of Oxytocin) (2008).

3. Scope
This policy applies to all clinical staff.

Definitions;
For the purposes of this guideline, the following definitions of labour are used:

Latent first stage of labour;

a period of time, not necessarily continuous, when there are painful contractions, and there is some cervical change, including cervical effacement and dilatation up to 4 cm.

Established first stage of labour;

when there are regular painful contractions, and there is progressive cervical dilatation from 4 cm.


4. Duties and Responsibilities

4.1 Managers
It is the responsibility of the managers to ensure that the midwives are aware of the guidelines and their application to practice. They will also review and update and them in line with the latest evidence as required, or at least every 3 years.
4.2 Clinical Staff
All clinical staff have a duty to be familiar with this policy and to use it to guide their practice.

4.3 Local Policy Officer
The Local Policy Officer has a duty to ensure the policy is compliant with the Trust Policy on Policies. The Local Policy Officer must ensure this policy is reviewed within the designated time period or as changes in national guidance arise. The policy should comply with the current base of evidence and best practice guidance and be current and in date.

5. Management of the latent and first stages of labour

5.1 On admission

- Establish what has been happening to the woman in the period immediately prior to admission and the reasons for her seeking advice at this stage of her pregnancy/labour.
- Complete Admission Standard (See Appendix A).
- Record blood pressure, temperature and pulse rate.
- Perform Urinalysis
- Perform abdominal palpation
- Assess contractions (length, strength and frequency)
- Auscultate the fetal heart and record average rate
- Assess vaginal loss
- Assess the woman's pain, including her wishes for coping with labour along with the range of options for pain relief.
- **DO NOT routinely offer CTG monitoring**, unless a risk factor has been identified (refer to Fetal Surveillance Policy).
- Offer vaginal Examination however be aware that for many women who may already be in pain, highly anxious and in an unfamiliar environment, vaginal examinations can be very distressing. Ensure the woman's consent, privacy, dignity and comfort, explain the reason for the examination and what will be involved, and explain the findings and their impact sensitively to the woman.

There is an assumption that, in the absence of identified risk factors, all women will be cared for in the Active Birth rooms as low risk, midwifery led cases.

Clinical Risk Assessments

This should be done on admission using the Admission Standard as a framework and should take in to consideration:

- Problems arising during the course of the current pregnancy
- Medical conditions as described in the *Policy for the Management of Routine Antenatal Care of Healthy Pregnant Women*
- Anaesthetic history
- Factors from previous pregnancies as described in the *Policy for the Management of Routine Antenatal Care of Healthy Pregnant Women*
- Lifestyle history to include smoking, weight, substance misuse
If labouring at home or in the Active Birth Unit are they suitable or does the woman require a Consultant Led delivery suite environment
Women who will decline blood or blood products.

Referral after Clinical Risk Assessment

If the level of risk increases the woman should be cared for on the delivery suite and the Obstetric Registrar informed. If the woman is cared for at home she should be transferred via ambulance to the Consultant Led Maternity Unit (see Policy for the Transfer of Women by Ambulance In-Utero, during Homebirth or in the Postnatal Period).
If the increase in level of risk is significant then the woman should be reviewed by the Obstetric Registrar.
If the Obstetric Registrar is unavailable to review then the on call Obstetric Consultant should be called to come and review if judged appropriate by the Delivery Suite Co-ordinator.
In an Obstetric Emergency the 05 team will be bleeped by the hospital switch board to attend immediately.
A management plan will be developed, discussed with the woman and her birth partner, documented and acted upon.
Any change in Lead Professional will be documented in the labour record.

Nutrition in labour

There is insufficient evidence to support the practice of starving women in labour in order to lessen the risk of gastric acid aspiration (Baker 1996; Johnson et al. 1989). Fasting may result in dehydration and acidosis which, combined with starvation and fatigue, can increase the need for active management and instrumental delivery (Broach and Newton 1988; Foulkes and Dumoulin 1985).

Where there are no risk factors suggesting the need for general anaesthesia, women who wish to eat and drink in labour should be offered a light, nutritious and easily absorbable diet (Grant 1990) e.g. fruit.

The desire to eat, however, would appear to be most common in early labour. Women do not usually wish to eat in active labour, and it is inappropriate to be encouraging them to do so against their natural instincts (Odent 1994).

5.3 Management and Care of Women in the Latent Stage of Labour
Some women have pain without cervical change. Although these women are described as not being in labour, they may well consider themselves ‘in labour’ by their own definition. Women who seek advice or attend hospital with painful contractions but who are not in established labour should be offered individualised support and occasionally analgesia, and encouraged to remain at or return home.

5.4 Management and Care of Women in the First Stage of Labour
Once in established labour women should have continuous, one to one care, especially as this has been shown to reduce the likelihood of the labour ending in a caesarean section (Maternity Care Working Party 2007). In addition they should be encouraged to
adopt upright positions and to mobilise (MIDIRS, 2005). Women who adopt a semi-recumbent position should have this recorded as a variance in their labour record.

Mobilising during the first stage of labour has been shown to reduce the need for analgesics, shorten labour and improve satisfaction with care (Walsh 2011). Mobility and upright posture have not been associated with any adverse outcomes and should therefore be positively encouraged in all women.

5.4.1 Monitoring of the Maternal Condition

The following observations should be documented on the partogram (See Appendix 2). If any deviations are noted these should be documented in the labour record along with a plan of care

- Hourly pulse (in addition the maternal pulse should be recorded when a FHR abnormality is detected to differentiate the two heart rates/ the fetal heart is auscultated intermittently
- 4 hourly blood pressure, unless otherwise indicated
- 4 hourly temperature, unless in the birthing pool (in which case refer to Policy)
- Frequency of emptying bladder documented.
- Every 30 minutes record uterine contractions, describing length, strength and frequency
- Abdominal Palpation should be performed prior to vaginal examinations every four hours and more frequently if clinically indicated.
- Vaginal examination should be offered every 4 hrs unless indicated more regularly – e.g. with concern about presenting part, position of presenting part, cervical effacement, dilatation, consistency, position, station and application to the presenting part to be documented. During active first stage position of head and dilatation of cervix should be recorded on the partogram.

5.4.2 Monitoring of the Fetal Condition

The following observations should be documented on the partogram If any deviations are noted these should be documented in the labour record along with a plan of care

- Fetal Heart listened to every 15 mins after a contraction for 1 minute or via Continuous CTG if indicated (refer to Fetal Surveillance Policy) and average rate on the partogram.
- Intermittent auscultation of the fetal heart after a contraction should occur for a minimum of 1 minute, at least every 15 minutes, and the rate should be recorded as an average. The maternal pulse should be palpated if a FHR abnormality is detected to differentiate the two heart rates.

5.5 Monitoring the Progress of Labour

It is the midwife’s responsibility to ensure that progress in labour is satisfactory and that failure to progress is detected and acted upon without delay.

Vaginal examinations remain the most accepted method of measuring progress in labour (Enkin et al. 2000). These examinations, however, should not be routine or prescriptive, but carried out only where there is clinical necessity and after discussion with the woman.
Vaginal examinations are an imprecise measure of the progress of labour when performed by different examiners (Clement 1994; Robson 1991), where possible therefore, they should be carried out by the same staff member.

5.5.1 Progress

- Cervical dilation — in the first stage of labour 0.5cm per hour is adequate progress.
- Strength, length and frequency of contractions are assessed manually. As labour progresses contractions should increase in strength and frequency to effect adequate cervical dilation.
- Descent of the presenting part — failure of the head to descend during the first stage of labour may indicate cephalo-pelvic disproportion (CPD). Excess moulding and caput together with other signs of poor progress (i.e. cervical dilation less than 0.5cm per hour) are strong indicators of CPD and the duty registrar should be notified of women who exhibit these signs.

5.5.2 Delay in Progress in the First Stage of Labour

5.5.2.1 The diagnosis of delay in the first stage of labour needs to take into account all aspects of progress including:

- Cervical dilation of less than 2 cms in 4 hours (or a slowing in rate of dilation in a second or subsequent labour)
- Decent and position of the fetal head
- Changes in strength, duration and frequency of uterine contractions

5.5.2.2 Where delay in the first stage is suspected the following should be considered:

- parity
- cervical dilation and rate of change
- uterine contractions
- station and position of presenting part
- the woman’s emotional state
- referral to the appropriate healthcare professional.

5.5.2.3 Where woman’s labour appears to have slowed the following causes should be considered:

- Lack of continuity of care
- Lack of one to one care
- Shift change

Where possible a woman in established labour should be cared for by the same midwife exclusively. This has been shown to lead to a decrease in labour length and an increase in satisfaction.

- Lack of mobility and use of upright positions
- Malposition of the presenting part

Mobilising during labour, the use of upright positions and optimal fetal positioning are all of proven value in shortening labour, decreasing the need for analgesics and improving women’s experience

- Maternal Exhaustion
Women should be offered nutrition, hydration and emotional support to overcome periods of tiredness and exhaustion.

- Labour ‘plateau’

Walsh has written widely on the concept of a physiological pause in labour, which has no adverse outcomes. It is stressed that during such a pause contractions stop, along with cervical dilation, as opposed to lack of cervical progress in the presence of regular, painful contractions. It is proposed that in low risk labour, in the absence of abnormal observations, a plateau or pause in labour will not lead to a diagnosis of delay and non interventionist approaches to addressing causes for delay given in this section (5.5.2.3) should be utilized. Where abnormal observations are noted alongside a pause/plateau, obstetric review should be initiated.

The above causes of a perceived slowing in labour progress should be considered at the outset. Once these have been addressed the following intervention should be considered;

Artificial Rupture of Membranes/Amniotomy (with woman’s consent)

Amniotomy is not part of normal physiological labour (RCM 1997, All Wales Pathway for Normal labour, 2003) and should be reserved for women with confirmed delay in labour progress (Fraser et al. 2004).

The intervention can cause an increase in pain which makes labour unmanageable (Fraser 1993; NCT 1989; Inch 1985). Amniotomy is associated with a reduction in labour duration of between 60 and 120 minutes, more commonly in nulliparous women (Johnson et al. 1997).

However a more recent literature review published in the Cochrane Database by Smyth et al 2008, challenged the conventional belief that amniotomy shortens labour and concluded that amniotomy does not shorten labour, even in nulliparous women, and may lead to an increased likelihood of caesarean section.

In the event of a decision being made for amniotomy, labour must be established, the fetal head engaged and cervical dilation should be 4 cms or more. Following amniotomy a vaginal examination should be carried out 2 hours later to assess progress. If cervical dilation is less than 1cm 2 hours following amniotomy an oxytocin infusion should be considered.

The woman should be referred to the Obstetric Registrar if delay in the first stage is suspected, an amniotomy performed and subsequent progress less than 1cm in 2 hours, as above. A full obstetric review should be undertaken prior to the administration of oxytocin.

See Delay in the first stage pathway (Appendix B)

Oxytocin (Syntocinon®) Regime

Prior to commencing oxytocin a full assessment of the woman should occur to include abdominal palpation (to include assessment of strength, length and regularity of contractions), vaginal examination, fetal wellbeing assessment. This should be documented on the ‘Commencing IV Oxytocin to Induce/Augment Labour’ pro forma (refer to Appendix C)
Midwifery staff can initiate the use of oxytocin Primigravida. In the case of a Multigravid woman, the Registrar should examine the patient prior to the use oxytocin.

Oxytocin (Syntocinon®) will be administered using a syringe pump with a non-return valve, using the following regimes.

Continuous electronic fetal monitoring should be used when oxytocin is being administered and one to one midwifery care provided.

**OXYTOCIN REGIME**

**Make up Oxytocin infusion as follows:** 1 iu (international unit = 1000 milliunits)
- Oxytocin solution (Syntocinon® 6iu in 100ml of Sodium Chloride 0.9% solution
- Draw up 50 ml syringe and attach to administration set with correct label.
- Commence infusion at \(1\text{ml/hr} = 1\text{milliunit oxytocin/min} \) – see chart below.
- Infusion increased at 30minute intervals for both primigravida and multigravida.
- Aim for 4-5 contractions in 10 minutes.

**Table 1: Oxytocin (Syntocinon®) Regime (in the presence of ruptured membranes)**

<table>
<thead>
<tr>
<th>Time after Starting (mins)</th>
<th>Oxytocin Dose delivery (milliunits/minute)</th>
<th>Volume (ml/hr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>30</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>60 (1hour)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>90</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>120 (2hours)</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>150</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>180 (3hours)</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

If regular contractions of 4/5:10 do not occur after one hour of 20 milliunits/min, the duty registrar should be consulted.

**Maximum licensed dose is 20 milliunits/minute. Maximum licensed dose is 20 milliunits/minute. Administration at a higher rate than 20 milliunits/min must only be undertaken following discussion with the Consultant on call.**

Vaginal Examination should be performed 4 hours after starting oxytocin.

If there is more than 2cm progress after 4 hours of oxytocin, vaginal examinations should continue 4 hourly

**If however if there is less than 2 cm progress in 4 hours the Obstetric Registrar should review the woman to consider caesarean section**

**6. Training**
There is no specific training required for the implementation of this policy. All maternity staff attend mandatory training which will cover any essential aspects of care addressed within the policy.
7. Implementation
The implementation of this policy will be monitored as below.

8. Monitoring compliance and effectiveness of the document

<table>
<thead>
<tr>
<th>Audit criteria</th>
<th>Tool</th>
<th>Audit Lead</th>
<th>Frequency of audit</th>
<th>Responsible committee</th>
<th>How changes will be implemented</th>
<th>Responsibility for Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Observations in first stage</td>
<td>Audit</td>
<td>Audit MW</td>
<td>Annual</td>
<td>MRMG</td>
<td>PD team, one to one teaching, CG Newsletter, policy review</td>
<td>As identified in action plan from audit results</td>
</tr>
<tr>
<td>-Management of delay</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Risk assessment in labour and referral</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Review, Approval/Ratification and Archiving
Previous versions of this policy can be found in the Maternity Archive on the shared drive. This policy will be reviewed prior to its third anniversary in accordance with the Maternity Policy Development and Ratification Policy January 2009.

10. Dissemination and Publication
- Circulated to all Matrons and Consultants via email
- Circulated to the Local Policy officer for publishing the document on the Department policy library on the shared drive.
- Circulated to the Central Policy officer for publishing the document on the Trust’s Central Library (intranet).

11. A statement in relation to its Equality Impact Assessment
See Appendix D

12. Details of any associated documents –
WAC058 (DS 3 0 Care of Women in Labour
WACO64 Clinical Risk Assessment (Antenatal)
WACO61 Clinical Risk Assessment in Labour

13. References
NICE (2007) Intrapartum care: Care of healthy women and their babies during childbirth
London, NICE. Available at www.nice.org.uk

London: RCOG Press. Available at www.rcog.org.uk

Simkin,ANCHETA (2011)

Walsh, D (2012)
14. Appendices

Appendix A; Admission Standard

Appendix B; Delay in the First Stage of Labour Pathway

Appendix C; Commencing Oxytocin to Induce/Augment Labour Pro Forma

Appendix D; Equality Impact Assessment
ADMISSION DOCUMENTATION STANDARD

**Situation**
- Date and time of admission and where admitted to and from
- Gestation and reason for admission

**Background**
- History of pregnancy to date
- Relevant obstetric history
- Relevant medical history
- Any allergies
- Medication in pregnancy
- Blood group

**Assessment**
- Baseline observations – temp, pulse, BP and urinalysis
- Abdominal palpation noting lie, presentation and position of fetus
- Describe what is happening now, fetal movements and the fetal heart rate including whether CTG commenced

**Recommendation**
- Make a plan of care including referral to doctor if risk factors identified, information given to woman and when you will review again

ALL ABOVE TO BE DOCUMENTED CLEARLY IN THE RECORDS, SIGNED AND NAME PRINTED

**Example**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.01.08</td>
<td>Admitted to Delivery Suite from home at 39+2 wks gestation with</td>
</tr>
<tr>
<td>0850hrs</td>
<td>history of onset of regular contractions at 0400hrs becoming</td>
</tr>
<tr>
<td></td>
<td>stronger and more regular since. No history of SROM</td>
</tr>
<tr>
<td></td>
<td>PREGNANCY TO DATE – Uneventful pregnancy, no raised BP,</td>
</tr>
<tr>
<td></td>
<td>proteinuria, pv bleeding or UTI’s</td>
</tr>
<tr>
<td></td>
<td>OBSTETRIC HISTORY - Primigravida</td>
</tr>
<tr>
<td></td>
<td>MEDICAL HISTORY – Nil of note</td>
</tr>
<tr>
<td></td>
<td>ALLERGIES – None known</td>
</tr>
<tr>
<td></td>
<td>DRUGS – Pregaday in early pregnancy</td>
</tr>
<tr>
<td></td>
<td>BLOOD GROUP – O rh negative</td>
</tr>
<tr>
<td></td>
<td>O/A – Temp 36.3, Pulse 84, BP 130/82</td>
</tr>
<tr>
<td></td>
<td>Urinalysis – NAD</td>
</tr>
<tr>
<td></td>
<td>O/P Longitudinal lie, cephalic presentation, head 2/5ths palpable,</td>
</tr>
<tr>
<td></td>
<td>LOA position</td>
</tr>
<tr>
<td></td>
<td>Contracing 3:10 moderate on palpation, no show or liquor</td>
</tr>
<tr>
<td></td>
<td>Draining. Coping well</td>
</tr>
<tr>
<td></td>
<td>FHH&amp;R with pinnards and sonicaid at 136bpm, no decelerations</td>
</tr>
<tr>
<td></td>
<td>Heard before during or following contraction.</td>
</tr>
<tr>
<td></td>
<td>PLAN – For VE to assess progress in labour</td>
</tr>
</tbody>
</table>

Name - Signed & Printed
Appendix B: Delay in the First Stage of Labour Pathway.

Consider delay in light of the following:
- Cervical dilation of less than 2 cms in 4 hours (or a slowing in rate of dilation in a second or subsequent labour)
- Decent and position of the presenting part
- Changes in strength, duration and frequency of uterine contractions

Emotional, psychological effects of environment, mobilise, use of positions
Consider physiological plateau
Provide support, information, hydration and appropriate and effective pain relief

If delay is still suspected undertake:
- Amniotomy plus VE 2 hours later
- Explain amniotomy will shorten labour by about 60 minutes and may make contractions stronger and more painful

Diagnose delay if:
- Progress <1cm 2 hours following amniotomy or <2cm in 4 hours with SROM
- Seek obstetric advice
- Offer effective pain relief
- Offer continuous electronic fetal monitoring

Explain that oxytocin will bring forward time of birth but not influence mode of birth, will increase frequency and strength of contractions and continuous EFM will be necessary.
Consider epidural before commencing

Primips:
- Discuss with obstetrician prior to commencing oxytocin infusion
- Use as per unit regime
- Commence continuous EFM

Multips:
- Full obstetric review prior to commencing oxytocin infusion
- Use as per unit regime
- Commence continuous EFM

Vaginal examination 4 hours after starting oxytocin in established labour.
- Progress > 2 cm or more: vaginal exam 4-hourly.
- Progress < 2 cm: further obstetric review to consider caesarean section.
### APPENDIX C

#### COMMENCING IV OXYTOCIN TO INDUCE/AUGMENT LABOUR

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indication :</td>
<td>Maternal Assessment</td>
</tr>
<tr>
<td>Parity:</td>
<td>Gestation : /40</td>
</tr>
<tr>
<td>Contractions:</td>
<td>:10, lasting secs, mild moderate strong</td>
</tr>
<tr>
<td>Abdominal palpation:</td>
<td>/ 5ths palpable</td>
</tr>
<tr>
<td>Time of last VE:</td>
<td>Dilatation:</td>
</tr>
<tr>
<td>SROM / ARM</td>
<td>Station:</td>
</tr>
<tr>
<td>Dilatation:</td>
<td>Position:</td>
</tr>
<tr>
<td>Date:</td>
<td>Time:</td>
</tr>
<tr>
<td>Fetal Assessment</td>
<td>CTG: Normal □ Suspicious □ Pathological □</td>
</tr>
<tr>
<td>FBS:</td>
<td>Yes □ No □ Result: pH SBE:</td>
</tr>
<tr>
<td>Risk Factors (e.g. VBAC, IUGR, meconium, multiparity)</td>
<td></td>
</tr>
</tbody>
</table>

(Must be reviewed by an obstetrician if multiparous or if risk factors present)

- **1st stage**: -Initial rate at 1ml/h., increasing every 30 minutes according to policy until contracting 4-5 in 10 minutes. Maximum rate: 20 ml/h., then registrar/consultant review.
- **2nd Stage**: -Initial rate at 4ml/h., increasing every 20-30 minutes until contracting strongly 4-5 in 10 minutes. Maximum rate:16 ml/h.

### General Management Plan
- Continuous CTG
- CTG review hourly; inform registrar if any concerns or deviations from normal.
- Monitor uterine contractions (frequency, strength, length) ½ hourly.
- Monitor amniotic fluid hourly.
- Maternal observations: hourly pulse, 4-hourly BP & temperature.
- Inform registrar if any concerns or deviations from normal.
- Time of Next VE:
- **Stop Syntocinon if CTG pathological**
- **Reduce Syntocinon if contracting 5:10 or CTG suspicious**
- Other:

*Signature/name/title:*
Appendix D

Form A

Equality and Diversity Screening Checklist

<table>
<thead>
<tr>
<th>Care Group/ Department</th>
<th>Obstetrics and Gynaecology Service Business Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Person Auditing Policy/Service</td>
<td>Anne Carvalho, Clinical Governance midwife</td>
</tr>
<tr>
<td>Policy Title/Service</td>
<td>Policy for the Management of the First Stage of Labour</td>
</tr>
<tr>
<td>Policy/Service Purpose</td>
<td>The purpose of the policy is to provide evidence based guidance for all staff on the First Stage of Labour</td>
</tr>
</tbody>
</table>

The checklist below will help you to see any strengths and/or highlight improvements required to ensure that the policy/service is compliant.

<table>
<thead>
<tr>
<th>Check for discrimination</th>
<th>DIRECT discrimination against any minority group of SERVICE USERS or EMPLOYEES</th>
<th>INDIRECT discrimination against any minority groups of SERVICE USERS or EMPLOYEES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Response (Yes/No)</td>
<td>Action Required? (Yes/No)</td>
</tr>
<tr>
<td>Age?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Gender? (Female, Male, Transsexual)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Disability?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Race or ethnicity?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Religion/Faith/Spiritual belief?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Sexual Orientation?</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

All policies will be placed on the intranet/internet to ensure flexibility of access under the Freedom of Information Act 2000. Efforts will be made to make policies and information available in alternative mediums or by alternative means to meet individual needs on request to departments or via the PALs Department (ext 2059).
Level of Impact:

<table>
<thead>
<tr>
<th>Total number of items answered ‘yes’ indicating discrimination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score: High/Medium/Low</td>
</tr>
</tbody>
</table>

| High | Medium | Low |

1. **Is this a new or revised policy / function?**
   - Revised policy

2. **What is the main purpose of the policy / function?**
   - See above for purpose of the policy

3. **How will it be put into practice?**
   - Through the management of the first stage of labour by all clinical staff at RSCH

4. **Who will be the main stakeholders/users?**
   - Pregnant women and maternity staff

5. **What are the expected benefits/outcomes of the policy/function?**
   - Evidence based care for all women

6. **Have you already consulted with people about this work? If yes, briefly describe what you did and with whom.**
   - Maternity unit staff have been consulted.

7. **What data is available about the impact the policy/function has or could have on equality groups?**
   - No evidence is available.

**Age**

**Gender (male/female/transgender)**

**Sexual Orientation**

**Disability**

**Race**

**Deprivation**

**Religion**
The following supplementary questions are to be answered for an impact assessment of employee policies/patient services – if there is a negative response to any of the questions a full impact assessment should be completed.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any access issues for disabled people eg physically, entry criteria, complexity of access</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Are there any recorded complaints relating to equality issues in the last three months?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Has a patient/staff survey highlighted any issues?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Does analysis of the take up of services raise any issues when studied against local statistics? / Does analysis of the application of policies raise any issues when studied against the employee statistics for the whole Trust?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Do outcome statistics compromise any group?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Is there a non attendance issue in any particular group?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Is the service/policy focused on any particular group and is that ‘justified’?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Are any special services/policy available or in place to accommodate specific groups? Is there a need for them?</td>
<td>No/No</td>
<td>Privacy is guaranteed during certain parts of the care pathway but cannot be guaranteed at all times (e.g. if admitted may be on a 6 bedded ward)</td>
</tr>
<tr>
<td>Is privacy available if requested? (services only)</td>
<td>Possibly</td>
<td></td>
</tr>
</tbody>
</table>

Signatures of authors/auditors:

Name of author/auditors:

Anne Carvalho

Date of signing: