Labour Care Guide
(LCG)

د. علا حيدر الحلي
بكلوريوس طب و جراحة عامة

Labor: is the physiological process that results in birth of baby, delivery of the placenta and signal for lactation to begin.

- **Labor** is defined as the **onset of a sequence of painful regular uterine contractions** that results in progressive effacement and dilatation of the cervix with descent of the presenting part and voluntary maternal bearing-down efforts leading to the expulsion of the products of conception through the vagina.

Symptoms and signs of labor

1-abdominal and back pain

2- increased vaginal discharge which may be bloody stained discharge or watery (show).

3- there may be nausea and vomiting due to pain

4- in advanced stage of labour (late 1st and 2nd stage) there is increased pain and urge to (push) bearing down

5- increased frequency of micturition, and urge for bowel evacuation when the baby's head press on the bladder and rectum

6- **uterine contractions** by abdominal palpation on regular intervals

7- cervical dilatation and effacement by serial vaginal exam

Stages of Labour

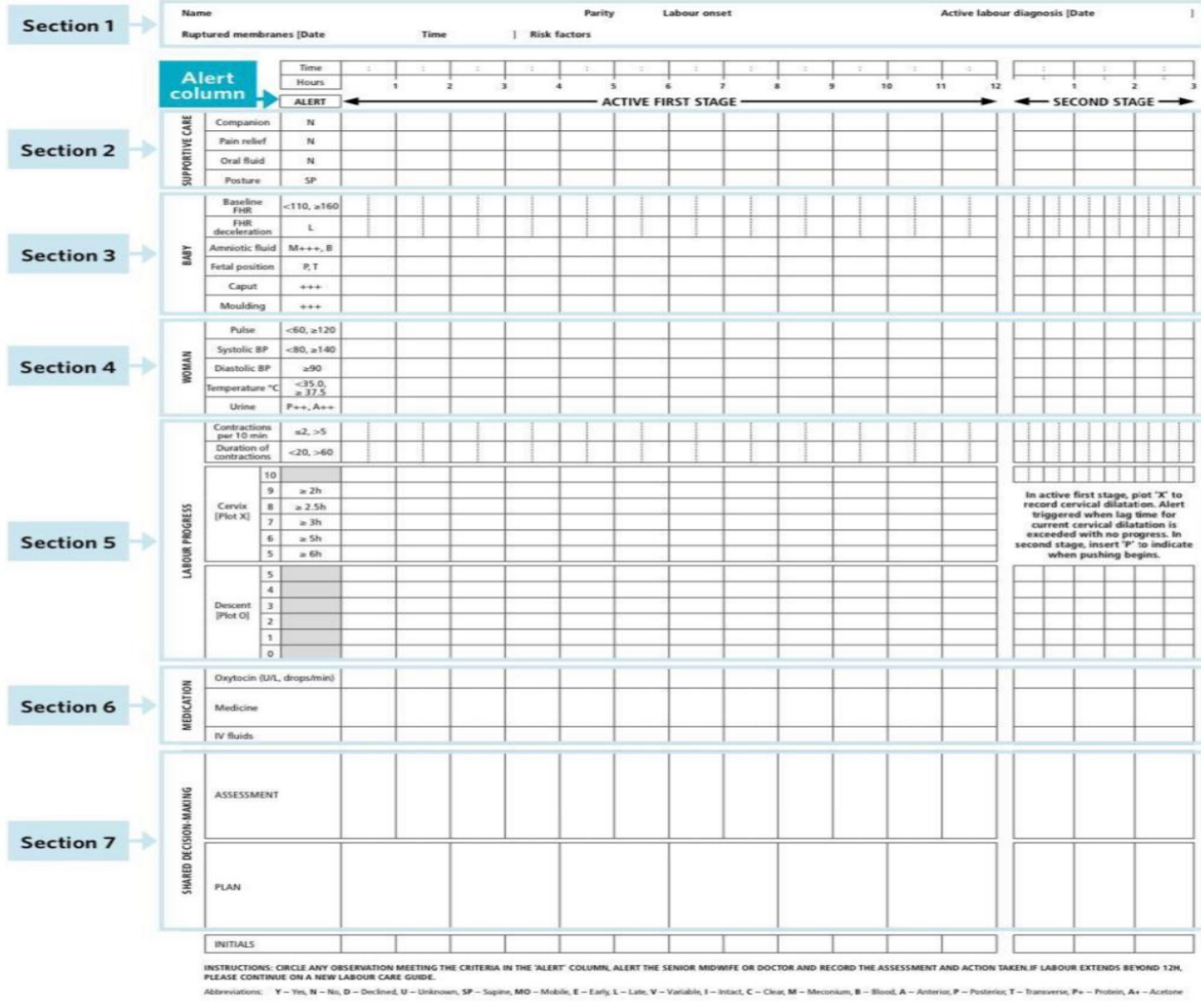
- **First stage:** from the time of the onset of labour until 10 cm cervical dilatation.

A-latent phase: from the onset of labor to 3-4cm

B-active phase:from 3-4cm up to 10cm

- **Second stage:** begins with full cervical dilatation and ends with birth of baby
- **third stage:** begins with birth of baby and ends with complete delivery of the placenta and membranes

WHO LABOUR CARE GUIDE



INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN. IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.

Abbreviations: **Y** – Yes, **N** – No, **D** – Declined, **U** – Unknown, **SP** – Supine, **MO** – Mobile, **E** – Early, **L** – Late, **V** – Variable, **I** – Intact, **C** – Clear, **M** – Meconium, **B** – Blood, **A** – Anterior, **P** – Posterior, **T** – Transverse, **P+** – Protein, **A+** – Acetone

LCG (Partograph previously)

Is a medical tool to monitor and record The condition of the mother, the condition of the fetus, and the progress of labour.

When should LCG initiated?

Documentation on the Labour Care Guide should be initiated **when the woman enters the active phase of the first stage of labour** (5cm or more cervical dilatation), regardless of her parity or membrane status.

Structure of WHO Labour Care Guide (LCG)

Has 7 sections:

Section1/identify information and labour characteristic at admission.

Section2/ supportive care

Section3/care of the baby

Section 4/care of the woman

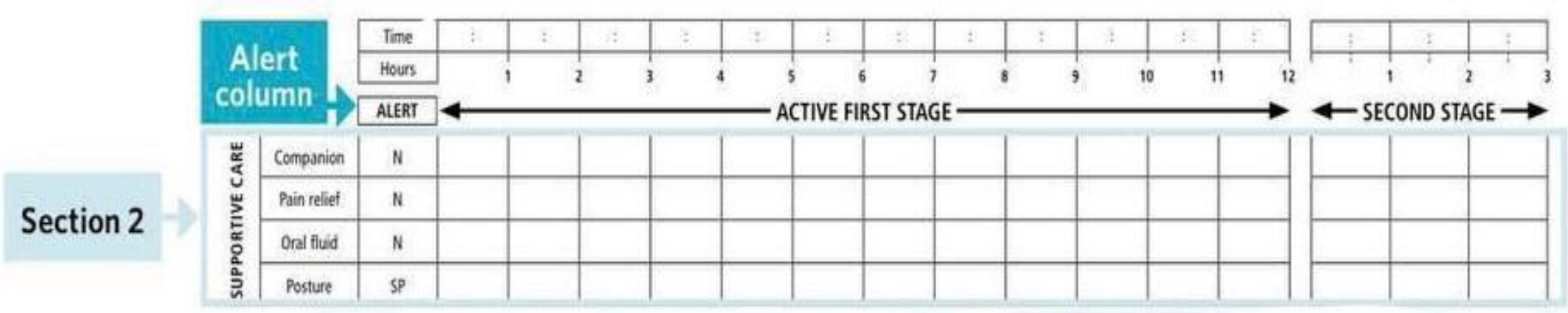
Section 5/ labour progress

Section 6/ medication

Section 7/ shared decision making

Section 1: identifying patient information and labour characteristics at admission

Section 2: Supportive care

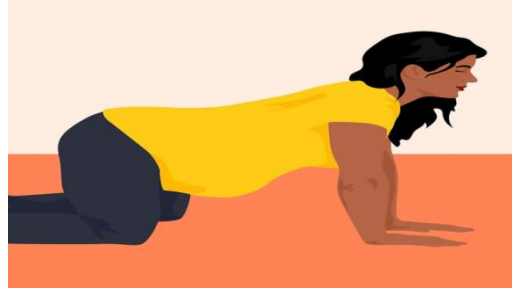


The supportive care section includes labour **companionship**, access to pharmacological and non-pharmacological **pain relief**, ensuring women are offered **oral fluid**, and techniques to improve women's comfort (such as encouraging women to be **mobile** during labour).

If you recorded “SP” supine position, encourage the woman to walk around freely during the first stage of labour.

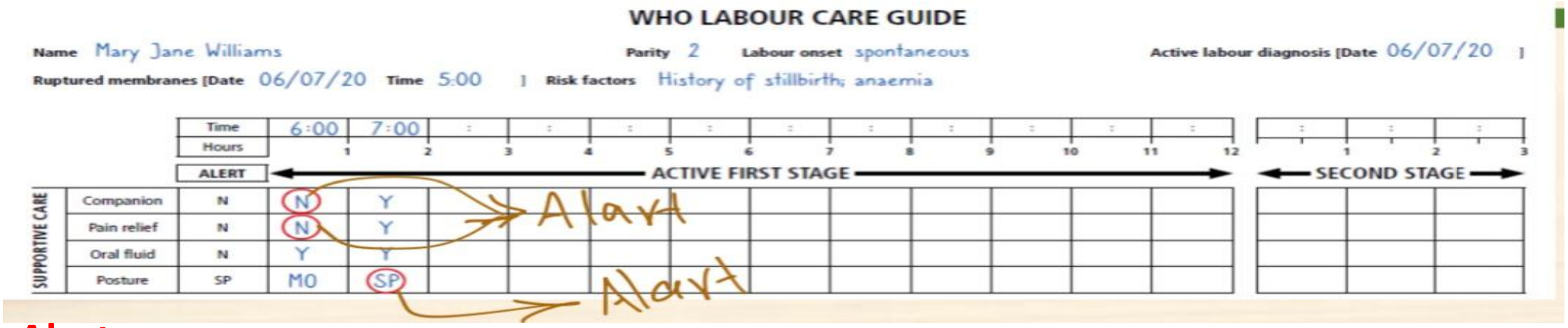
Support the woman’s choice of position (**left lateral**, **squatting**, **kneeling**, **standing supported by companion**) for each stage of labour

Squatting position



Knelling on hand and knees position

Example



WHO LABOUR CARE GUIDE

Name Mary Jane Williams Parity 2 Labour onset spontaneous Active labour diagnosis [Date 06/07/20]

Ruptured membranes [Date 06/07/20 Time 5:00] Risk factors History of stillbirth; anaemia

		Time	6:00	7:00	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
		Hours	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3		
		ALERT	← ACTIVE FIRST STAGE →												← SECOND STAGE →				
SUPPORTIVE CARE	Companion	N	(N)	Y															
	Pain relief	N	(N)	Y															
	Oral fluid	N	Y	Y															
	Posture	SP	M0	(SP)															

Alert

Alert

Alert

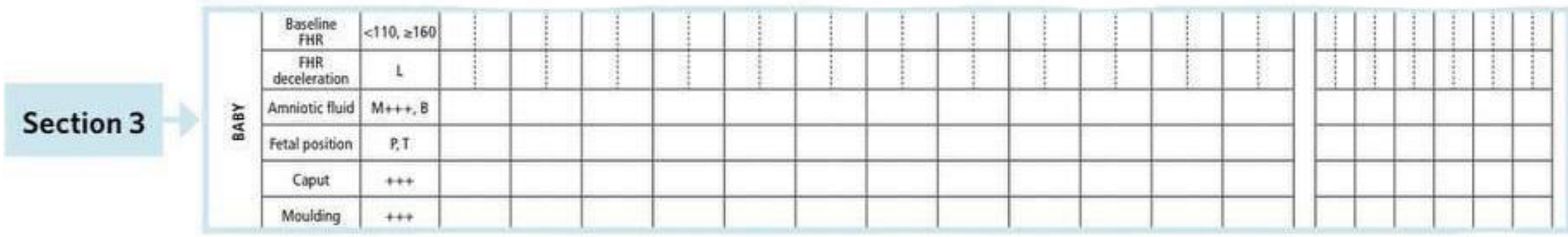
-No

-Supine position

Circled in red are those observations that meet the corresponding criterion in the “Alert” column.

Companion	Y= Yes
	N=No
	D=Woman declines
Pain relief	Y= Yes
	N=No
	D=Woman declines
Oral fluid	Y= Yes
	N=No
	D=Woman declines
Posture	SP= Supine
	MO=Mobile

Section 3: care of the baby (The fetal wellbeing)



The well-being of the baby is monitored by regular observation of **baseline fetal heart rate**(FHR) and **decelerations** in FHR, and of **amniotic fluid**, **fetal position**, **molding** of the fetal head, and development of **caput succedaneum**

Fetal Heart Rate

-Listen to the FHR for a **minimum of 1 minute**.

-Auscultate **during a uterine contraction** and continue for at least **30 seconds after** the contraction.

-**Intermittent** auscultation of the FHR with either a Doppler ultrasound device or a Pinard fetal stethoscope is recommended for **healthy** pregnant women in labour.

-If FHR ranges between **110 and 160**, continue to assess FHR **every 30 minutes** during the **first stage** and every **15 minutes** during the **second stage** of labour

Alert: if <110, and ≥160 turn the patient to her left side and inform senior

FHR decelertion

Record the presence of decelerations using:

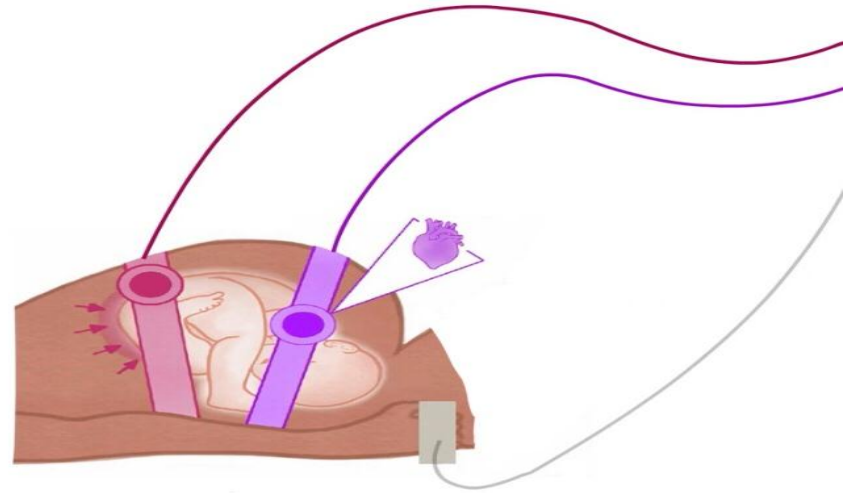
N = No

E = Early

L = Late

V = Variable

Alert: L = Late

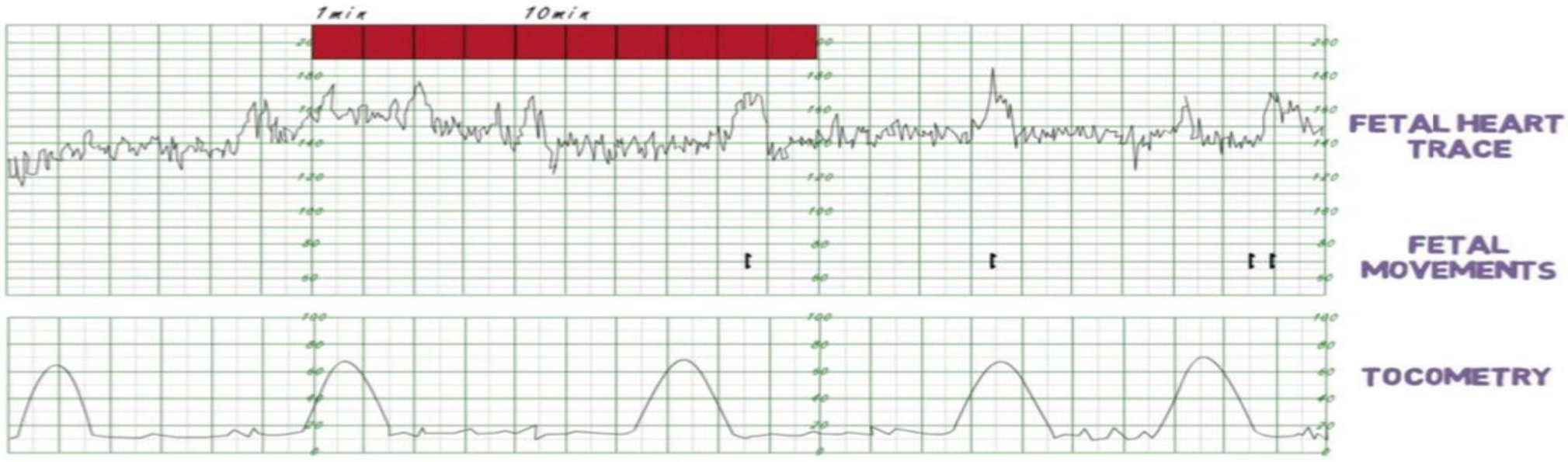


Types of Deceleration:

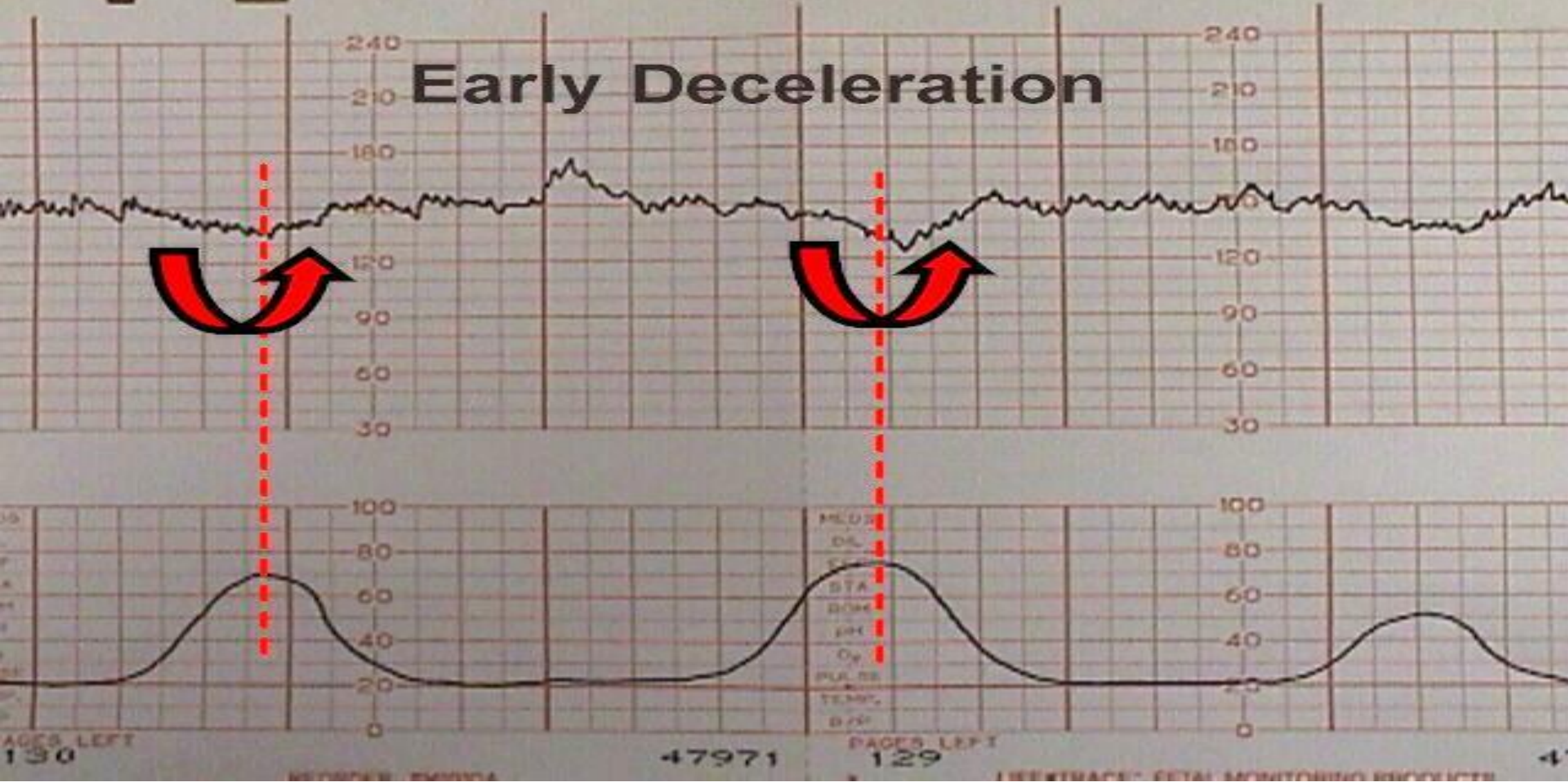
1-Early deceleration: Trough of deceleration concides with peak of contraction

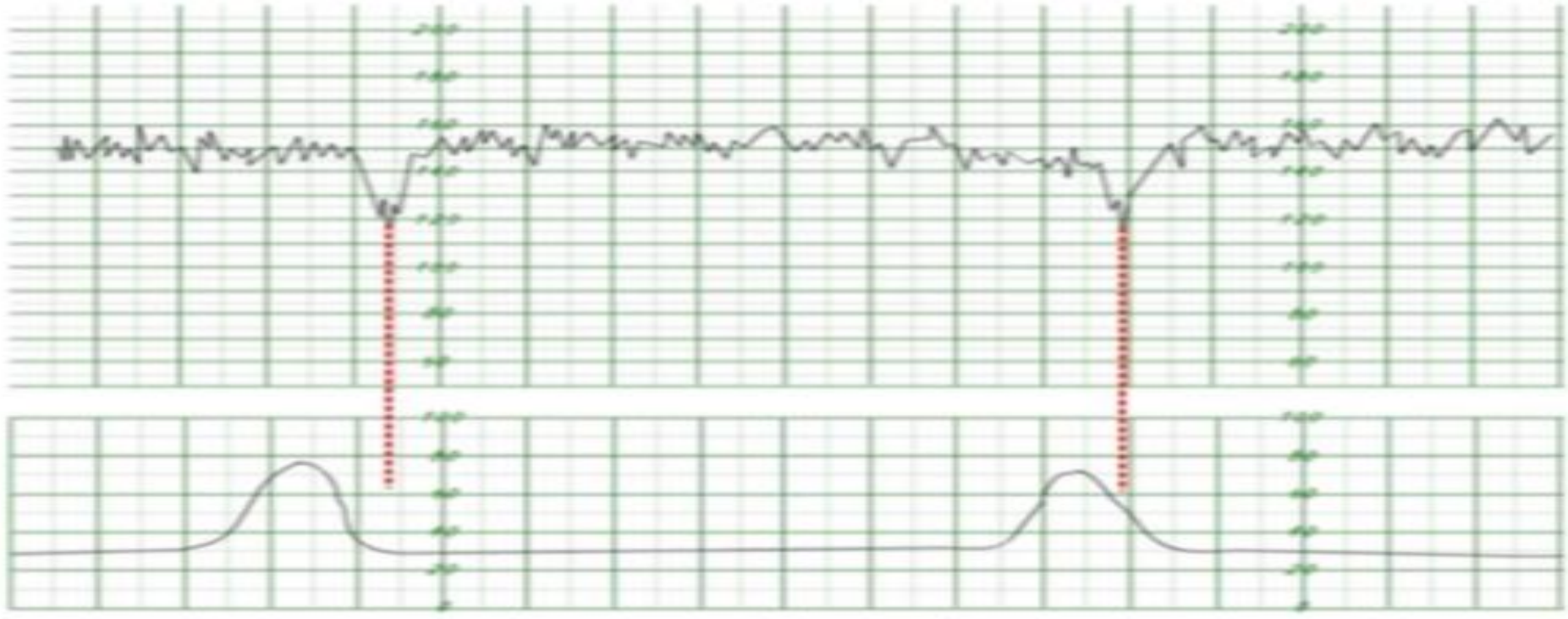
2- Late deceleration: deceleration starts after the contraction begins and persists after the contraction ends

3- Variable deceleration: vary in shape,form and timing in relation to contractions.



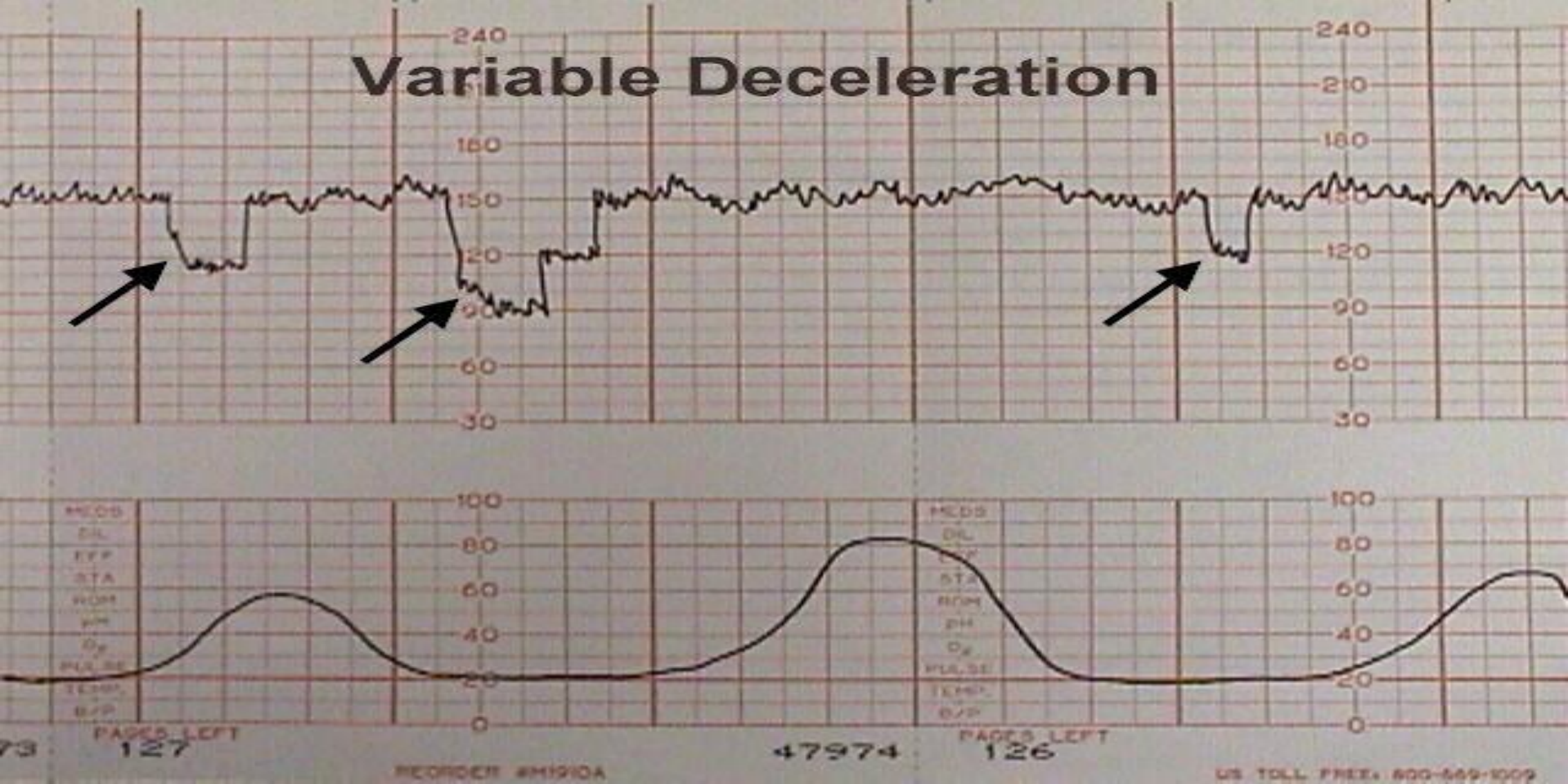
No deceleration


Early Deceleration
240
210
180
120
90
60
30
100
80
60
40
20
0
PACES LEFT
130
47971
PACES LEFT
129



Late deceleration

Variable Deceleration



Amniotic fluid& membranes

If membranes are rupture or leaking liqour look at fluid colour

I = Intact membranes, reassess after 4 hr

C = Membranes ruptured, clear fluid, reassess after 4 h

M = Membranes ruptured, meconium stained fluid: use **+**, **++** and **+++** to represent non-significant, medium and thick meconium, respectively

B = Membranes ruptured, blood-stained fluid

Alert:

-M+++ (thick meconium)

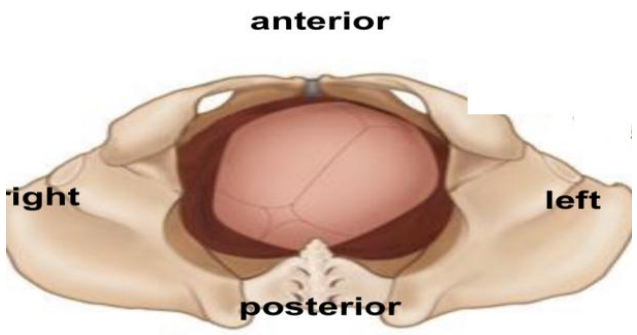
-B = Blood

Fertal Position

A = Occiput anterior position

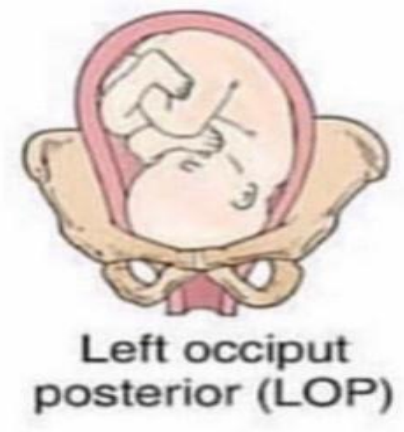
P = Occiput posterior position

T = Occiput transverse position



Left occipito-anterior

Left occipto-transverse



Alert: Occiput posterior or **Occiput transverse** position is detected

Failure of a fetal occiput transverse or posterior position to rotate to an occiput anterior position should be managed as **abnormal** fetal position

Note: **PV** exam every **4h**

Caput

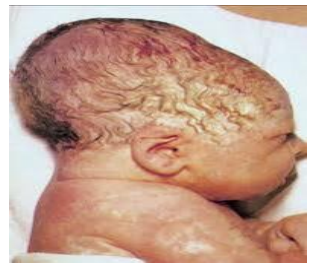
Is **swelling** of scalp of the new born because of the compression of fetal head

The presence of caput succedaneum can also be felt as a soft, boggy swelling, which may make it difficult to identify the presenting part of the fetal head clearly. With severe caput the sutures may be impossible to feel.

Grade caput from 0 (none) to +, ++ or +++ (marked).

If the presenting part has large caput succedaneum, this (along with other abnormal observations) could be a **sign of obstruction**

Alert: +++ inform a senior one



Moulding

Moulding is the **overlapping of the fetal skull bones** at the saggital suture which may occur during labour due to the head being compressed as it passes through the pelvis of the mother

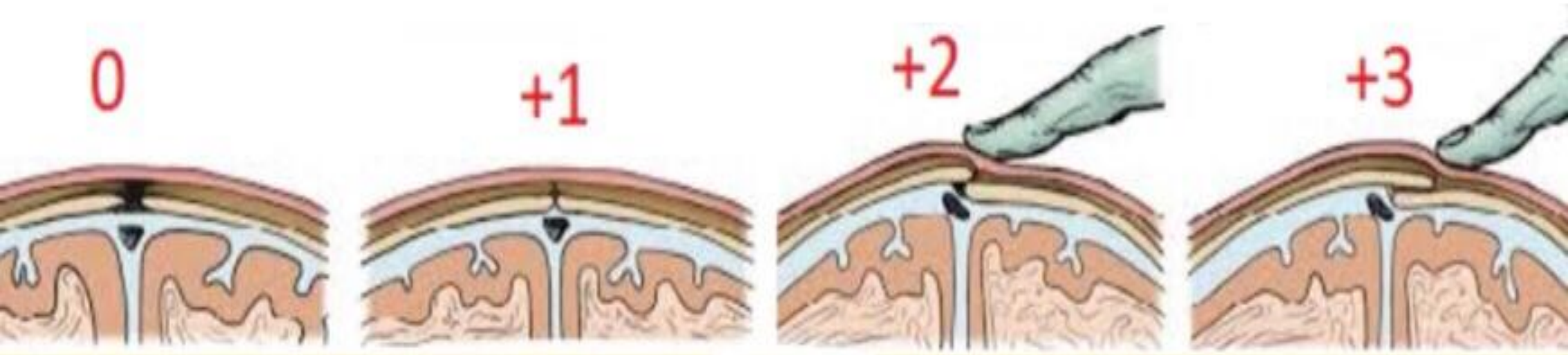
The degree of moulding is assessed according to the following scale:

0 = Normal separation of the bones with open sutures.

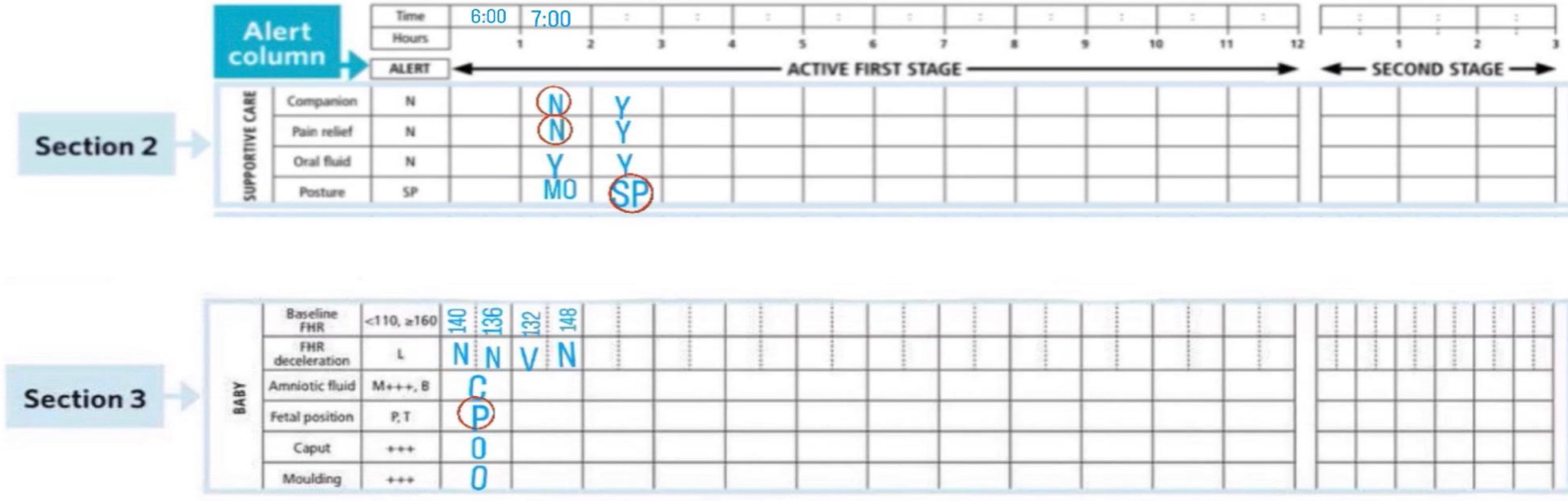
1+ = Bones touching each other.

2+ = Bones overlapping, but can be separated with gentle digital pressure.

3+ = Bones **overlapping**, but cannot be separated with gentle digital pressure. (3+ is regarded as severe moulding.)

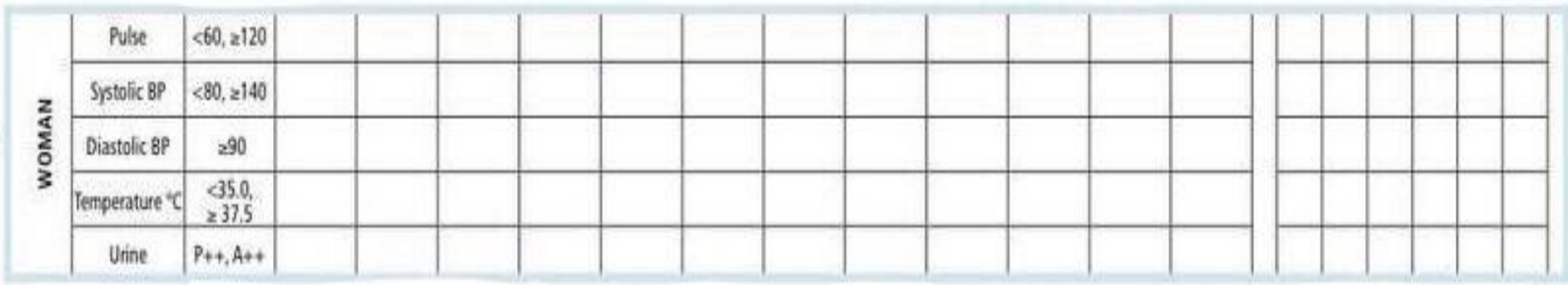

0
+1
+2
+3

Example


Alert column
Section 2
Section 3
Time
Hours
ALERT
6:00
7:00
ACTIVE FIRST STAGE
SECOND STAGE
SUPPORTIVE CARE
Companion
Pain relief
Oral fluid
Posture
N
SP
MO
BABY
Baseline FHR
<110, ≥160
FHR deceleration
Amniotic fluid
Fetal position
Caput
Moulding
140
136
132
148
V
C
P
O

Section 4: care of the woman

Section 4



WOMAN																							
	Pulse	<60, ≥120																					
	Systolic BP	<80, ≥140																					
	Diastolic BP	≥90																					
	Temperature °C	<35.0, ≥ 37.5																					
	Urine	P++, A++																					

The woman's health and well-being are monitored on the Labour Care Guide by regular observation of the **pulse**, **blood pressure**,**temperature** and **urine**..

If normal findings so repeat every 4hr

P= Protein
A= acetone

WHO LABOUR CARE GUIDE

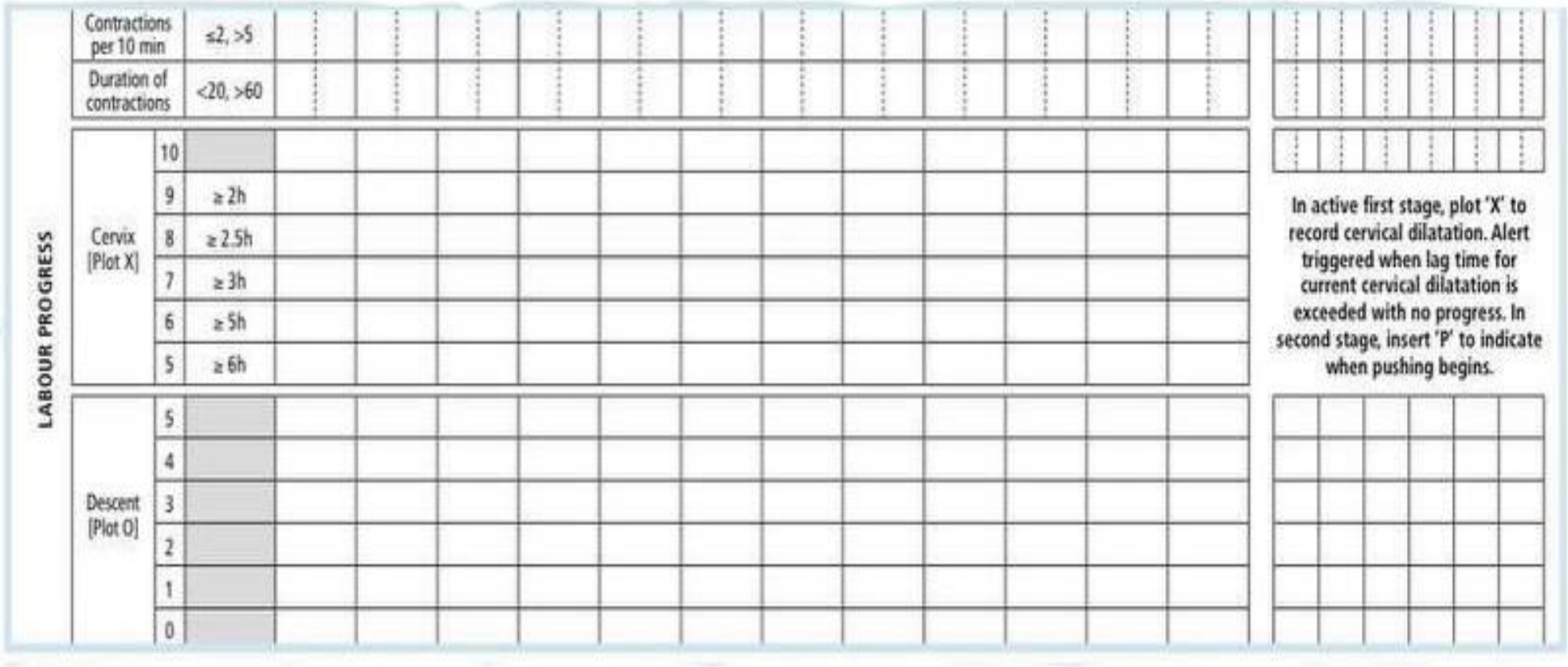
Name Mary Jane Williams **Parity** 2 **Labour onset** spontaneous **Active labour diagnosis [Date** 06/07/20 **]**

Ruptured membranes [Date 06/07/20 **Time** 5:00 **] Risk factors** History of stillbirth; anaemia

	Time	6:00	7:00	8:00	9:00	10:00	:	:	:	:	:	:	:	:	:	:
	Hours	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
	ALERT	ACTIVE FIRST STAGE												SECOND STAGE		
SUPPORTIVE CARE	Companion N	N	Y	Y	Y	N										
	Pain relief N	N	Y	Y	Y	N										
	Oral fluid N	Y	Y	Y	D	Y										
	Posture SP	MO	SP	MO	MO	SP										
BABY	Baseline FHR <110, ≥160	140 / 136	132 / 148	133 / 145	138 / 128	151 / 133										
	FHR deceleration L	N / N	V / N	N / N	N / N	V / N										
	Amniotic fluid M+++, B	C				+										
	Fetal position P, T	P				T										
	Caput +++	0				+										
	Moulding +++	0				+										
WOMAN	Pulse <60, ≥120	88				96										
	Systolic BP <80, ≥140	120				128										
	Diastolic BP ≥90	80				84										
	Temperature °C <35.0, ≥ 37.5	36.5				36.9										
	Urine P++, A++	-/-				-/-										

Section 5: progress of labour

Section 5



Labour progress is recorded on the Labour Care Guide by regular observation of the **frequency** and **duration of contractions**, **cervical dilatation** and **descent** of the baby's head

Uterine contraction should be checked **every 30 min in 1st stage** and **15 min in 2nd stage**

Duration of each contraction normally between **20-60 seconds**

Normal **frequency** of contractions **3-5/10 min**

Cervical dilatation

In the **active first stage** of labour, plot **"X"** in the cell that matches the time and the cervical dilatation each time you perform a vaginal examination.

In the **second stage**, insert **"P"** to indicate when pushing begins.

Descent

Plot **"O"** in the cell that matches the time and the level of descent. Descent is assessed by abdominal palpation (role of 5 fifths)

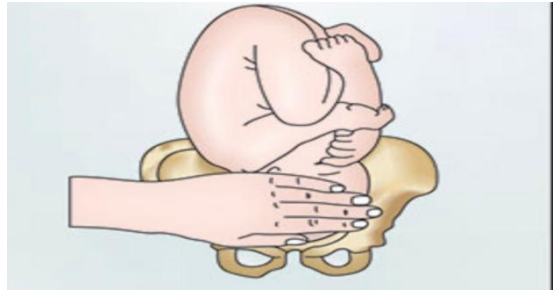
.

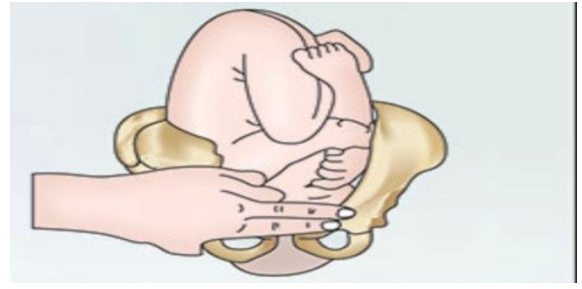
Rule of Fifth

How can you assess the descent ?

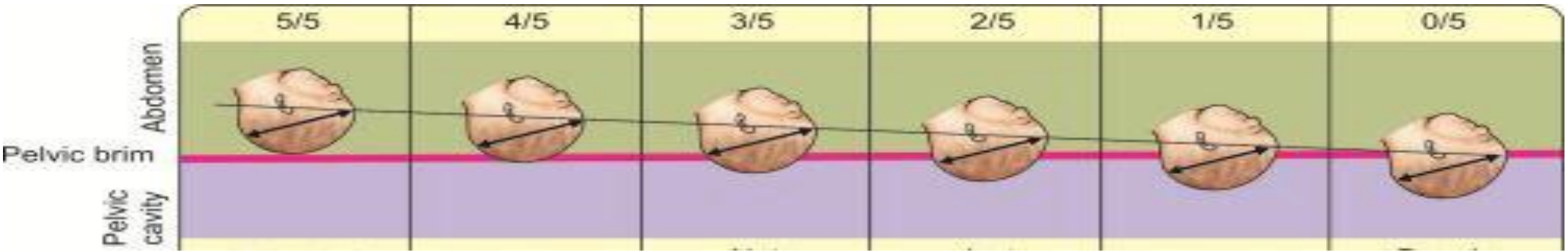
By placing arm 5 fingers above the symphysis pubis

By abdominal palpation we have to find out how many fingers are palpable above the symphysis pubis





More head descent → **less fingers palpable**


5/5
4/5
3/5
2/5
1/5
0/5
Abdomen
Pelvic brim
Pelvic cavity

Contractions per 10 min	≤2, >5	3	3	3	3	3	3	3	3	3	3	3	4	3	3	3									
Duration of contractions	<20, >60	40	40	40	40	40	45	40	45	50	50	50	40	50	50	50									

LABOUR PROGRESS

Cervix [Plot X]	10									X				
	9	≥ 2h												
	8	≥ 2.5h					X							
	7	≥ 3h												
	6	≥ 5h												
	5	≥ 6h	X											
Descent [Plot O]	5													
	4		O											
	3						O							
	2									O				
	1													
	0													

3	4	4									
50	50	50									
P	P	P									

In active first stage plot x to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage insert “P” to indicate when pushing begins

O	O				

Section 6: medications

MEDICATION													
	Oxytocin (U/L, drops/min)												
	Medicine												
	IV fluids												

aims

to facilitate consistent recording of **all types of medication** used during labour,by describing whether the woman is receiving **oxytocin**, and its dose, and whether **other medications** or **IV fluids** are being administered

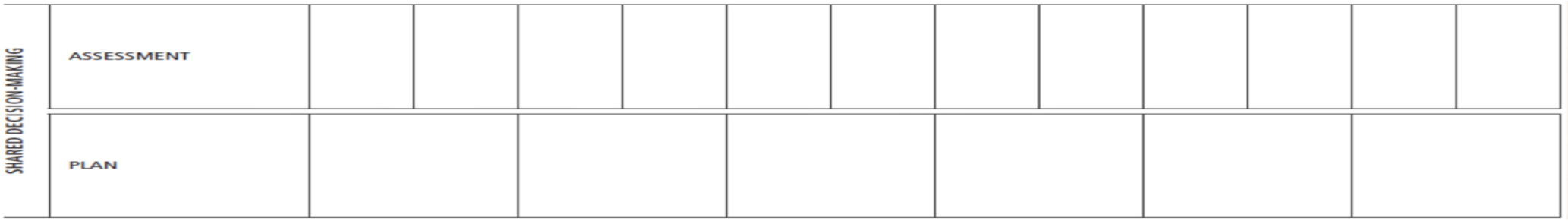
If **oxytocin** is being administered, record the amount of oxytocin in **units per litre** (U/L) and **drops per minute** (drops/min).

The routine administration of **IV fluids** for all women in labour is **not recommended**, given that it reduces women's mobility.

Low-risk women should be encouraged to drink oral fluids, and they should receive IV fluids **only if indicated**

MEDICATION	Oxytocin (U/L, drops/min)	N	N	N	N	N	N	N	N					N		
	Medicine	N	N	N	N	N	N	N	N					N		
	IV fluids	N	N	N	N	N	N	N	N					N		

Section 7: Shared Decision making



aims

to facilitate continuous **communication** with the woman and her companion, and the consistent **recording of all assessments and plans** agreed.

Clear explanations of procedures and their purpose should always be provided to each woman. The findings of physical examinations should be explained to the woman and her companion, and the subsequent course of action made clear to **enable shared decision-making**

Section 7

Record the plan following assessment **For example**:

-augmentation of labour with oxytocin infusion

-procedures such as artificial rupture of membrane

-cesarean section

<table>
<tr><td rowspan="2">SHARED DECISION-MAKING</td><td>ASSESSMENT</td><td colspan="2">Normal progress</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>PLAN</td><td colspan="3">Continuous monitoring</td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="2"></td></tr>
</table>


THANK YOU