# Eating and drinking in labour guidelines

| | |
|---|---|
| Document type: | Clinical guideline |
| Version: | 2 |
| Author (name): | Dr S Kimber Craig, Consultant Anaesthetist, Lead for Obstetric Anaesthesia |
| Validated by | Women's Quality Forum |
| Date validated | 23/04/2019 |
| Ratified by: | Clinical Governance Quality Committee |
| Date ratified: | 07/12/2016 |
| Name of responsible committee/individual: | Women's Quality Forum |
| Name of Executive Lead (for policies only) | |
| Master Document Controller: | Helen Bailey, WQF Secretary |
| Date uploaded to intranet: | 23/04/2019 |
| Key words | Oral intake; eating; drinking; labour; high risk; antacid prophylaxis |
| Review date: | March 2022 |

## Version control

| Version | Type of Change | Date | Revisions from previous issues |
|---|---|---|---|
| 1 | New document | 09/12/2016 | New document |
| 2 | Schedule review | 06/03/2019 | Updated to current document control format. Evidence for recommendations reviewed and additional reference from Uptodate added plus the need to use supplemental intravenous fluids if not eating. |
| | | | |
| | | | |

**Equality Impact**

Bolton NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of healthcare Bolton NHS FT aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed to ensure fairness and consistency for all those covered by it regardless of their individuality. The results are shown in the Equality Impact Assessment (EIA).

## Contents

# 1. Purpose and scope

1.1. Evidence shows that low risk women should be eating and drinking in labour if they wish to as there is no evidence of harm or poorer outcomes for them or their babies.[1]

1.2. Women at high risk of needing operative intervention may be more at risk of harm should they require anaesthesia if they have eaten, as there is the potential for aspiration of gastric contents and consequent pneumonitis.

1.3. This document defines those women that are high risk for operative intervention and outlines the acceptable oral intake for women in labour.

1.4. Labour refers to "established labour" – equitable to the first stage of labour where there is cervical dilatation from 4cm **and** regular painful contractions.[3]

# 2. Identifying those at high risk for surgical intervention

2.1. Women who are at an increased risk of requiring operative intervention (and who will therefore need anaesthesia) may be identified in the antenatal period or during labour.

2.2. The following list outlines the kinds of clinical conditions/obstetric situations that make surgery more likely (this list is not exhaustive):

- BMI >40 (more than double the risk of a woman with a BMI of 20-25)[2]
- Multiple pregnancy
- Significant medical conditions (e.g. known cardiac disease
- Pre-eclampsia or eclampsia
- Recurrent antepartum haemorrhage or haemorrhage in labour
- Anaemia – haemoglobin <85g/litre at onset of labour
- Previous complex/complicated deliveries (e.g. uterine rupture)
- Intrauterine death

2.3. Any woman who is due to be reassessed for progress at the next vaginal examination and will be offered a caesarean delivery should there have been no progress should also be considered high risk for operative intervention.

# 3. Oral intake

### Low risk women

3.1. Low risk women can drink freely in labour and can eat a light diet should they wish to. This includes all women who are labouring on the Birth Suite or at home (who by definition must be low risk). There is no strong evidence for the types of food that are best to eat in labour.[1]

3.2. The NICE guidelines for labour recommend that women who have received opioids during labour not eat, however on review of the evidence it is the view of this Trust that otherwise low risk women who receive opioids in labour should be allowed a light diet if they wish.[1,3]

### High risk women

3.3. Once in labour, high risk women should be limited to clear fluids only. They should be encouraged to drink water, isotonic drinks or diluted cordial.

3.4. High risk women should not eat during labour.[4] They should be told that their oral intake is restricted for safety reasons and that they will be able to eat after delivery.

3.5. Avoid dehydration by administering supplementary intravenous fluids if not tolerating oral fluid intake.

## 4. Reducing gastric acidity

4.1. High risk women should receive antacid prophylaxis to further reduce any risk of harm should they require anaesthesia.

4.2. Ranitidine 150 milligrams should be prescribed and given orally every 6 hours while in labour.

## 5. Monitoring Compliance

5.1. This table outlines the auditing schedule for this document:

| Area to be monitored | methodology | Who | Reported to | frequency |
|---|---|---|---|---|
| Restriction of oral intake in high risk women in labour | Retrospective casenote review using K2 | CDS MDT | Labour Care Forum | Every 3 years |
| Administration of ranitidine to high risk women | Retrospective casenote review using K2 | CDS MDT | Labour Care Forum | Every 3 years |

## 6. References


[1] Singata M, Tranmer J, Gyte GML. Restrciting oral fluid and food intake during labour. *Cochrane Database of Systematic Reviews* 2013, Issue 9. Art No: CD003930. DOI: 10.1002/14651858.CD003930.pub3.

[2] Denison FC, Price J, Graham C, Wild S, Liston WA. Maternal obesity. Length of gestation, risk of post-dates pregnancy and spontaneous onset of labour at term. *British Journal Obstetrics Gynaecology.* 2008;115(6):720-5.

[3] National Institute for Health and Care Excellence (2014). Intrapartum care: care of healthy women and their babies during childbirth (CG190). Available at: https://www.nice.org.uk/guidance/cg190/chapter/1-Recommendations#care-in-established-labour [Accessed 2 August 2016].

[4] Funai, EF, Norwitz, ER. Management of normal labor and delivery . UpToDate. [Internet]. Waltham (MA): UpToDate Inc; 2019. [updated: 27 February 2019; cited: 6 March 2019]. Available from: https://www.uptodate.com/contents/management-of-normal-labor-and-delivery?search=labor%20eating&sectionRank=1&usage_type=default&anchor=H11&source=machineLearning&selectedTitle=1~150&display_rank=1#H11

# 7. Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

| | | Yes/No | Comments |
|---|---|---|---|
| **1.** | **Does the document/guidance affect one group less or more favourably than another on the basis of:** | | |
| | • Race | No | |
| | • Ethnic origins (including gypsies and travellers) | No | |
| | • Nationality | No | |
| | • Gender (including gender reassignment) | Yes | Only relevant to patients in labour |
| | • Culture | No | |
| | • Religion or belief | No | |
| | • Sexual orientation | No | |
| | • Age | No | |
| | • Disability - learning disabilities, physical disability, sensory impairment and mental health problems | No | |
| **2.** | **Is there any evidence that some groups are affected differently?** | N/A | |
| **3.** | **If you have identified potential discrimination, are there any valid exceptions, legal and/or justifiable?** | No | |
| **4.** | **Is the impact of the document/guidance likely to be negative?** | No | |
| **5.** | **If so, can the impact be avoided?** | N/A | |
| **6.** | **What alternative is there to achieving the document/guidance without the impact?** | N/A | |
| **7.** | **Can we reduce the impact by taking different action?** | N/A | |

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Co-ordinator together with any suggestions as to the action required to avoid/reduce this impact.

## 8. Document Development Checklist

| | |
|---|---|
| Type of document | Clinical guideline |
| Lead author: | Dr S Kimber Craig (Consultant Anaesthetist) |
| Is this new or does it replace an existing document? | 2nd version |
| What is the rationale/ Primary purpose for the document | To define those women who may be at increased risk should they eat during labour |
| What evidence/standard is the document based on? | NICE guidelines, Cochrane meta-analysis |
| Is this document being used anywhere else, locally or nationally? | Similar policies are in use across the region and country |
| Who will use the document? | Central Delivery Suite staff |
| Is a pilot run of the document required? (optional) | No |
| Has an evaluation taken place? What are the results? (optional) | No |
| What is the implementation and dissemination plan? (How will this be shared?) | Shared via Qpulse and intranet with email notification of its ratification to staff |
| How will the document be reviewed? (When, how and who will be responsible?) | 3 yearly by the author or delegated staff member |
| Are there any service implications? (How will any change to services be met? Resource implications?) | No |
| Staff/stakeholders consulted | Members of Labour Care Forum (minuted discussions available); Anaesthetists via Obstetric Anaesthetic Consultants Group. |
| Any document that gives an instruction to prescribe or administer a medicine should have that instruction reviewed by the senior divisional pharmacist before it goes for ratification. | Signature of pharmacist:<br><br>Rebecca Walker<br><br>Date: 27/10/2016<br>(no changes to medications since last ratification) |
| Signed and dated<br><br>By Chair of Validating Committee or Group | <br><br>…B. Williams……23/04/2019…… |
| Signed and dated<br><br>By Chair of Ratifying Committee | <br>… T. Armstrong-Child..08/12/2016……<br>….(no changes to document since last ratification) |