Module 4: Care During Labour

In March 2016, bump2babe sent a comprehensive survey to the 19 maternity hospitals/units and 2 midwifery-led units in Ireland. Responses were returned between March 2016 and May 2017 and can be found on the website www.bump2babe.ie.
Private Midwives completed the same survey documents in May 2017 and we have presented them here.
The information provided here is as was provided to us Private Midwives but please check with your caregiver to see if there have been any recent changes to services, polices or practices.
Blank spaces indicate no information was provided.

	County	
	Unit or hospital name	Private Midwives Ireland
Person completing the survey	Name	Liz Halliday
	Title	Deputy Head of Midwifery
	Contact details and working hours (in case we need to contact you for clarification)	liz@privatemidwives.com
Is there a 24-hour drop in support service or emergency phone number available for women in late pregnancy?	Yes/No	Yes
	Please provide details	24 hour phone number for lead midwife.
Is there a labour assessment or triage room available?	Yes/No	N/A
	Please provide details including if birth partners/supporters are welcome to stay with mother during assessment	
	Please describe the unit procedure for induction of labour	
	Please describe the routine admission procedure (specifically include the routine practice of vaginal examination, ARM and admission trace etc.)	Midwife attends the client's home. Full assessment is undertaken with consent (vital signs, urinalysis, palpation and auscultation. Vaginal examination is offered. No ARM or CTG.

	What happens when a mother declines any or all of the above admissions procedures?	The midwife will explore any reasons that the client may have for declining care and address them. Should the client continue to decline the midwife will call the Head of Midwifery to see if we can continue to provide care at home due to safety concerns. In the case of vaginal examination, unless the client has previously agreed to examination as part of her care (due to risk factors/indemnity reasons) or the midwife is concerned over a safety issue, her wishes will be respected.
	If an admission trace is still part of the unit admission procedure, what plans are there to phase it out?	
	What happens if a woman presents with contractions, but is assessed as only effacing or in very early labour?	Supported as appropriate and await events.
	Unit policy/guideline on SROM (spontaneous rupture of membranes) at term **with** contractions. **Please include what women are advised to do.**	Call the midwife immediately for individual advice
	What is the unit policy/guideline on SROM (spontaneous rupture of membranes) at term with **no** contractions? **Please include what women are advised to do.**	Call the midwife immediately for individual advice. Arrangements made for appointment. Await events.
	What are the options for women with no contractions who decline induction of labour for SROM at term?	Expectorant management with maternal and fetal monitoring for well-being.
What are the implications for labour management (including induction of labour) for:	Multiples (twins, triplets etc.)	
	Women planning a VBAC	Hourly blood pressure, 15 minutes maternal pulse, 1:1 continuous midwifery care, routine 4 hourly vaginal examination. Immediate transfer to hospital with any concerns.
	Diabetes/gestational diabetes	Women who have diet-controlled diabetes may choose to birth at home if aware of risks of same. Blood sugars checked regularly in labour.

What are the implications for labour management (including induction of labour) for:	Women who tested positive for Group B Strep during this pregnancy	If the client has made an informed decision to home birth and does not present with additional risk factors she will be supported. We cannot provide antibiotic cover at home. Vaginal examinations are avoided and close monitoring of baby is undertaken postnatally.
	Women who tested positive for Group B Strep during a previous pregnancy	Normal intrapartum care
	Assisted conception pregnancy	Normal intrapartum care
	Older mother	Normal intrapartum care
	Obese mother	Normal intrapartum care
	Baby diagnosed as small	Referral to hospital
	Baby diagnosed as big	If client has made an informed decision to birth at home, and no additional concerns are present: normal intrapartum care. Close monitoring of baby postnatally.
	Breech baby	Transfer to hospital
	OP baby	Techniques to help baby turn and to support client through labour. Normal intrapartum care
	Known fetal anomalies	Transfer to hospital
	Pre-eclampsia	Transfer to hospital
	Preterm birth	Transfer to hospital
	Stillbirth	Transfer to hospital
	Under what circumstances would a woman's care be transferred to a tertiary centre in late pregnancy or in labour?	At the hospital's discretion. Suspected sepsis always transferred to a tertiary unit.
Describe the accommodation in **early** labour (please include the number of each type of room/ward in the description, whether toilets/showers/bath are en-suite **and whether birth partners/supporters are welcome to stay with mothers 24/7)**	Home from home rooms	
	Early labour single rooms	
	Early labour twin rooms	
	Early labour 3-4 bed rooms	
	Communal labour ward, specify no of beds per ward	
	Other, please specify	Client's own home

Policy/guideline on eating and drinking in **early** labour (please enter Yes for all that apply)	Mother's choice	Yes
	Light diet	
	Fluids only	
	Ice	
	Nil by Mouth	
	IV fluids for hydration	
	Criteria / comments	
Midwife:women ratio	In early labour	1:1 if client wishes
	In established labour	1:1 sometimes 2:1
	At birth	2:1 planned
	Please indicate differences that might occur at weekends or on nights.	None
Unit policy/guideline on the number of birth partners/supporters for each woman	In early labour	
	In established labour	
	At birth	
	Unit procedure on maternal request for more birth partners/supporters than the unit policy/guideline states	Supported in choice
	Unit procedure on maternal request for different birth partners/supporters at different times	Supported in choice
	Unit policy/guideline on birth plans	We respect birth plans; any changes are made with full consent
	Criteria used when allocating birthing rooms to mothers	
Is a midwife or student midwife assigned to each woman in established labour to give one to one care?	Yes/No	Yes
	Additional comment	
Continuity of carer in the midwifery-led unit **(alongside)**	N/A	N/A
	Mothers are attended by the same person they saw antenatally	
	Mothers are attended by one of team (8 people or less) that they saw antenatally	
	Mothers are attended by a midwife they may not have met before	

	Additional comment	
Continuity of carer with community midwives - **antenatal and postnatal care provided in woman's home or at outreach clinic with option for home birth or birth in hospital attended by a Community Midwife.**	N/A	
	Mothers are attended by the same person they saw antenatally	Yes
	Mothers are attended by one of team (8 people or less) that they saw antenatally	
	Mothers are attended by a midwife they may not have met before	
	Additional comment	Clients may not have met the second midwife
Continuity of carer with DOMINO midwives - **antenatal and postnatal care provided in woman's home or at outreach clinic with birth in unit not necessarily attended by DOMINO team midwife.**	N/A	
	Mothers are attended by the same person they saw antenatally	Yes
	Mothers are attended by one of team (8 people or less) that they saw antenatally	
	Mothers are attended by a midwife they may not have met before	
	Additional comment	
Continuity of carer with mothers who attended the public midwives clinic - **antenatal care provided by midwives only**	N/A	
	Mothers are attended by the same person they saw antenatally	
	Mothers are attended by one of team (8 people or less) that they saw antenatally	
	Mothers are attended by a midwife they may not have met before	
	Additional comment	
Continuity of carer in other midwifery-led services specified by you in the Questionnaire: Module 2 - Antenatal Care	N/A	
	Mothers are attended by the same person they saw antenatally	Yes
	Mothers are attended by one of team (8 people or less) that they saw antenatally	
	Mothers are attended by a midwife they may not have met before	
	Additional comment	

Continuity of carer for mothers who attended the public clinic	N/A	N/A
	Mothers are attended by the same person they saw antenatally	
	Mothers are attended by one of team (8 people or less) that they saw antenatally	
	Mothers are attended by a midwife they may not have met before	
	Additional comment	
Continuity of carer for mothers who attended the semi-private clinic	N/A	N/A
	Mothers are attended by the same person they saw antenatally	
	Mothers are attended by one of team (8 people or less) that they saw antenatally	
	Mothers are attended by a midwife they may not have met before	
	Additional comment	
Continuity of carer for women who attended the private clinic	N/A	N/A
	Mothers are attended by the same person they saw antenatally	
	Mothers are attended by one of team (8 people or less) that they saw antenatally	
	Mothers are attended by a midwife they may not have met before	
	Additional comment	
Continuity of carer in other obstetric-led services specified by you in the Questionnaire: Module 2 - Antenatal Care	N/A	N/A
	Mothers are attended by the same person they saw antenatally	
	Mothers are attended by one of team (8 people or less) that they saw antenatally	
	Mothers are attended by a midwife they may not have met before	
	Additional comment	

Policy/guideline on eating and drinking in **established** labour (please enter Yes for all that apply)	Mother's choice	Yes
	Light diet	
	Fluids	
	Ice	
	Nil by Mouth	
	IV fluids for hydration	
	Criteria / comments	
	Number of labour / birthing rooms in the unit	
How many of the birthing rooms in the unit have en-suite facilities?	Toilet only	
	Shower only	
	Bath only	
	Toilet and shower/bath	
	No en suite facilities	
	Other	
For the rooms without en suites, how accessible are the facilities (**proximity/how many**)?	Toilet	
	Shower	
	Bath	
Are birthing pools available to women?	Yes, for labouring	Yes
	Yes, for giving birth	Yes
	No	
	If no, are women facilitated to bring their own	Yes
	Birthing aids available	
Bath	Yes/No	
	Additional comment	If available in client's home
Shower	Yes/No	
	Additional comment	If available in client's home
Chairs to straddle	Yes/No	
	Additional comment	If available in client's home
Chairs for rocking/reclining	Yes/No	
	Additional comment	If available in client's home
Birth ball	Yes/No	Yes
	Additional comment	
Floor mats	Yes/No	Yes
	Additional comment	
Beanbags	Yes/No	
	Additional comment	If available in client's home
Pillows	Yes/No	Yes
	Additional comment	
Peanut ball	Yes/No	Yes
	Additional comment	
Birthing stool	Yes/No	
	Additional comment	Depending on midwife attending

Adjustable lighting	Yes/No	Yes
	Additional comment	
Privacy (**doors closed, knock & wait before entering**)	Yes/No	Yes
	Additional comment	
Music system	Yes/No	Yes
	Additional comment	
Aromatherapy vaporiser	Yes/No	
	Additional comment	If available in client's home
	Other birthing aids, please specify	
	Facilitation of non-pharmacological pain relief or coping methods (please add comments where necessary)	
TENS	Yes/No	
	Additional comment	If available in client's home
Doula **as the main birth supporter or as second birth supporter**	Yes/No	
	Additional comment	If booked by client
Acupuncture / Acupressure	Yes/No	Yes (acupressure)
	Additional comment	Client may self-treat or employ an acupuncturist to attend
Hypnobirthing or **Gentlebirthing**	Yes/No	Yes
	Additional comment	
Psychoprophylaxsis (breathing and relaxation)	Yes/No	Yes
	Additional comment	
Homoeopathy	Yes/No	Yes
	Additional comment	Women may self-treat or employ a homeopath
Aromatherapy	Yes/No	Yes
	Additional comment	Women may self-treat or employ an aromatherapist
Hot or cold packs	Yes/No	Yes
	Additional comment	
Hot towels	Yes/No	Yes
	Additional comment	
Massage	Yes/No	Yes
	Additional comment	
	Other non-pharmacological coping methods - please specify	Rebozo. active labour, balls, colouring, gaming, mazes... Whatever the client has planned.

For non-pharmacological strategies that require a practitioner, does the unit facilitate the practitioner to be present in addition to birth partners/supporters?	Yes/No	Yes
	Additional comment	
	Is there a comfortable chair or bed for birth partners/supporters to rest in?	If available in client's home
Location of toilets for birth partners/supporters (please enter Yes for all that apply)	En-suite	
	Toilet on labour ward	
	Public toilets off labour ward	
	Additional comment	
	Availability of pharmacological pain relief methods or anaesthesia at various stages of labour and birth (please enter Yes to all that apply)	
Nitrous Oxide and Oxygen (Entonox)	Early labour	Yes
	1st stage	Yes
	2nd stage	Yes
	3rd stage	Yes
	After birth	Yes
	Additional information	
	Indications for use	
Mobile epidural	Early labour	
	1st stage	
	2nd stage	
	3rd stage	
	After birth	
	Additional information including any differences for first-time mothers versus 2nd- and subsequent-time mothers, use of continuous infusion versus single dose plus top ups, OR plans to introduce a mobile epidural	N/A
	Indications for use	

Epidural	Early labour	
	1st stage	
	2nd stage	
	3rd stage	
	After birth	
	Additional information including any differences for first-time mothers versus 2nd- and subsequent-time mothers, and use of continuous infusion versus single dose plus top ups	Requires hospital transfer
	Indications for use	
Spinal	Early labour	
	1st stage	
	2nd stage	
	3rd stage	
	After birth	
	Additional information	
	Indications for use in labour	Requires hospital transfer
Combined spinal/epidural	Early labour	
	1st stage	
	2nd stage	
	3rd stage	
	After birth	
	Additional information including any differences for first-time mothers versus 2nd- and subsequent-time mothers, and use of continuous infusion versus single dose plus top ups	Requires hospital transfer
	Indications for use	
Pethidine	Early labour	
	1st stage	
	2nd stage	
	3rd stage	
	After birth	
	Additional information including any precautions	Requires hospital transfer
	Indications for use	

Diamorphine	Early labour	
	1st stage	
	2nd stage	
	3rd stage	
	After birth	
	Additional information including any precautions	Requires hospital transfer
	Indications for use	
	Other pharmacological pain relief available (please specify type and stage administered)	
	Positions facilitated during labour (please enter Yes to all that apply)	
Recumbent	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	
Semi-recumbent	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	
Left/right lateral	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	
Upright: all fours - **on** bed	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	
Upright: all fours - **off** bed	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	
Upright: kneeling leaning forward - **on** bed	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	
Upright: kneeling leaning forward - **off** bed	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	
Walking	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	
Standing	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	
Sitting upright on stool or chair	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	

High squat	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	
Supported squat	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	
Low squat	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	Advised against in late second stage
Knee - chest	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	
Pelvic rocking	During 1st stage	Yes
	During 2nd stage	Yes
	Other, please specify	
	Other positions facilitated (please describe)	Any position that feels comfortable
	Are positions used in 1st and 2nd stage of labour documented in the woman's notes?	Yes
	What supports are given to a labouring woman who is hoping to avoid using an epidural?	Non-pharmaceutical coping strategies, nitrous oxide
	What is the unit practice to ensure that the mother and birth partners / supporters receive evidence-based information on the benefits, risks and alternatives (including expectant care or 'watch & wait' approach) of routine and non-routine procedures, in order to obtain informed consent / refusal?	Every option is fully discussed with the clients, evidence is presented along with our guidelines, RCOG and NICE Guidelines and the decision lies with the clients unless immediate safety is an issue. Most options will have been discussed antenatally, including obstetric emergencies and transfers.
When discussing routine and non-routine procedures with mother and birth partners / supporters, is the likelihood of possible further interventions made clear?	Always	Yes
	Mostly	
	Sometimes	
	Never	
	Additional comment	

	Unit policy / procedure if a mother requests a second opinion during labour	Clients may speak to another midwife, or anyone outside of Private Midwives Ireland if they wish to
	Monitoring of fetal well-being	
Pinard stethoscope	Used with low-risk women (yes/no)	Yes
	Indication for use (low-risk women)	To auscultate fetal heart
	Used with high-risk women (yes/no)	Yes
	Indication for use (high-risk women)	To auscultate fetal heart
Hand-held Doppler	Used with low-risk women (yes/no)	Yes
	Indication for use (low-risk women)	To auscultate fetal heart
	Used with high-risk women (yes/no)	Yes
	Indication for use (high-risk women)	To auscultate fetal heart
Cardiotocograph (CTG)	Used with low-risk women (yes/no)	No
	Indication for use (low-risk women)	
	Used with high-risk women (yes/no)	No
	Indication for use (high-risk women)	
Wireless CTG	Used with low-risk women (yes/no)	No
	Indication for use (low-risk women)	
	Used with high-risk women (yes/no)	No
	Indication for use (high-risk women)	
Fetal scalp electrode	Used with low-risk women (yes/no)	No
	Indication for use (low-risk women)	
	Used with high-risk women (yes/no)	No
	Indication for use (high-risk women)	
Fetal blood sampling	Available in the unit? Yes/No	
	Used with low-risk women (yes/no)	No
	Indication for use (low-risk women)	
	Used with high-risk	No

	women (yes/no)	
	Indication for use (high-risk women)	
Are the increased risks of instrumental or surgical birth with continuous electronic fetal monitoring explained?	Yes, to low risk women	Yes
	Yes, to high risk women	Yes
	Only when asked	
	No	
	Additional comment	
	Assessment of progress in labour	
Policy/guideline on frequency of abdominal palpation	First-time mothers	4 hourly or sooner if indicated
	2nd- & subsequent-time mothers	4 hourly or sooner if indicated
Policy/guideline on frequency of vaginal examination	First-time mothers	4 hourly or as indicated
	2nd- & subsequent-time mothers	4 hourly or as indicated
How is progress assessed using maternal indicators? (Please list as many as possible including emotional, physical, psychological and behavioural indicators.)	First-time mothers	Strength, length and frequency of contraction, maternal behaviour, verbalisation, palpation, rhombus of michaelis, purple line, vaginal examination, visualisation of descent
	2nd- & subsequent-time mothers	Strength, length and frequency of contraction, maternal behaviour, verbalisation, palpation, rhombus of michaelis, purple line, vaginal examination, visualisation of descent
	Unit policy/guideline (if any) on length of first stage of labour. (**Please give details of when (established) labour is deemed to have started, use of partogram and action lines etc.)**	No policy on same – providing maternal and fetal well-being and progress is occurring
	Indications for use of antibiotics in labour	Transferred with signs of infection
Indications for artificial rupture of membranes	First-time mothers	Post birth if en caul
	2nd- & subsequent-time mothers	Post birth if en caul
	What else can a woman or her caregiver do first or instead?	
Indications for use of Syntocinon	First-time mothers	At hospital discretion if transferred
	2nd- & subsequent-time mothers	At hospital discretion if transferred
	What else can a woman or her caregiver do first or instead?	Dim lights, active labour, nipple stimulation

Indications for unplanned / emergency caesarean section in the first stage of labour	First-time mothers	At hospital discretion if transferred
	2nd- & subsequent-time mothers	At hospital discretion if transferred
	What else can a woman or her caregiver do first or instead?	
	Unit policy/guideline (if any) on length of second stage of labour for first-time mothers who are **not** using epidural anaesthesia.	No policy on same – providing maternal and fetal well-being and progress is occurring
	Unit policy/guideline (if any) on length of second stage of labour for first-time mothers who are using epidural anaesthesia	N/A
	Unit policy/guideline (if any) on length of second stage of labour for second- or subsequent-time mothers who are **not** using epidural anaesthesia	No policy on same – providing maternal and fetal well-being and progress is occurring
	Unit policy/guideline (if any) on length of second stage of labour for second- or subsequent-time mothers who are using epidural anaesthesia	N/A
In the second stage	Self-directed pushing is practiced	Yes
	Caregiver-directed pushing and breath-holding is practiced	
	Combination, depending on circumstances	Rarely, if indicated
	Additional comment	
Indications for episiotomy	First-time mothers	Fetal distress, presenting part on perineum
	2nd- & subsequent-time mothers	Fetal distress, presenting part on perineum
	What else can a woman or her caregiver do first or instead?	
	Describe measures in place to minimise the use of episiotomies	Perineal massage, birth pool. We use warm compresses and lubricant if client is happy for same 0% episiotomy rate

Indications for use of forceps (please indicate type usually used)	First-time mothers	At hospital discretion if transferred
	2nd- & subsequent-time mothers	At hospital discretion if transferred
	What else can a woman or her caregiver do first or instead?	At hospital discretion if transferred
Indications for use of ventouse (please indicate type of vacuum extractor usually used)	First-time mothers	At hospital discretion if transferred
	2nd- & subsequent-time mothers	At hospital discretion if transferred
	What else can a woman or her caregiver do first or instead?	At hospital discretion if transferred
Indications for unplanned / emergency caesarean section in the second stage of labour	First-time mothers	At hospital discretion if transferred
	2nd- & subsequent-time mothers	At hospital discretion if transferred
	What else can a woman or her caregiver do first or instead?	At hospital discretion if transferred
Is a physiological (natural) third stage practiced?	Always	
	Mostly	Yes
	Sometimes	
	Never	
	At maternal request	
	Additional comment	In some cases, active management may have been pre-agreed due to risk factors or maternal choice
Is the third stage routinely actively managed? (Please provide indications for use **and dosages**)	Yes, with Syntocinon	
	Yes, with Syntometrine	
	No	No
	Additional comment	In some cases, active management may have been pre-agreed due to risk factors or maternal choice
	Unit policy/guideline on delayed (optimal) cord clamping	Minimum of 5 minutes unless otherwise indicated
	Unit policy/guideline in relation to cord cutting (including timing and by whom)	Clamped and cut at a time convenient to client by whomever the client wishes to cut cord
	Under what circumstances must the cord be clamped and cut immediately?	Neonatal resuscitation required if mother cannot move to facilitate intact cord
	Are beside Resuscitaires available so that babies can be resuscitated with the cord intact and pulsating?	Resuscitation equipment is usually brought to mother

Does the unit facilitate the harvesting of cord blood?	Yes/No	N/A
	Additional comment **including under what circumstances this is facilitated**	Currently there is no option in Ireland for cord blood collection, but we will facilitate once the option is available. All our midwives are trained in collection
	If parents wish to take the placenta home, what do they need to do?	Tell us and provide storage bag/box
	How is skin-to-skin with mother encouraged?	Babies are given straight to mother and we encourage a minimum of 1 hour skin to skin with no interference
	In what circumstances is skin-to-skin with mother replaced by skin-to-skin with father/birth partner and how is this facilitated?	If mother is unwell and unable to hold baby. If mother does not wish to hold baby. Birth partner encouraged to provide skin to skin contact.
	Circumstances under which the baby is cleaned and wrapped	Client request
Are mothers encouraged and facilitated to breastfeed their baby when the baby shows signs of readiness (usually within the first hour)?	Always	Yes
	Mostly	
	Sometimes	
	Rarely	
	Never	
	Additional comment	
Is it the unit policy that babies have their first feed before they leave the birthing room?	Yes, for breastfed babies	N/A
	Yes, for formula fed babies	N/A
	No	
	Additional comment	The midwife will not leave postnatally until baby has fed
	What tests and checks are performed on the baby soon after birth? (Please indicate which can be done whilst the baby is in the mother's arms / on the mother's chest)	Apgar scores are assessed while baby is with mother. Vitamin K can be given whilst held by mother/birth partner. Examination of newborn and weight check performed at convenient time after uninterrupted skin to skin
	Unit policy/guideline on the mode of birth for women who have had **one** previous caesarean birth (please include details of any policies/guidelines on induction of labour, **monitoring** and the length of labour for this group)	VBAC at home is facilitated with informed consent and after obstetric review. Intrapartum care is altered by the following: Hourly BP 4 hourly routine vaginal examination 4 hourly urinalysis Immediate transfer with any concerns

	Given the nationwide rise in caesarean births over the past decade, what strategies are in place to reduce the numbers of caesarean births in the unit? **How successful have these strategies been?**	N/A
Unit percentage planned VBAC (Vaginal Birth After Caesarean) rate for 2014 and 2015	2014	
	2015	
	How is the rate calculated?	
	Unit policy/guideline on the mode of birth for women who have had **two** previous caesarean births (please include details of any policies/guidelines on induction of labour, **monitoring** and the length of labour for this group)	Elective LSCS (Lower Segment Caesarean Section)
Number of planned VBA2C (Vaginal Birth After 2 Caesareans) births for 2014 and 2015	2014	0
	2015	0
	Are any of the following available to women who wish to have a more 'natural' caesarean birth: lowered or see-through drapes, slow emergence of the baby, baby lifted out by mother, optimal cord clamping, parents discovering the baby's sex etc.?	N/A
	How is skin-to-skin with mother encouraged after a caesarean birth?	N/A
	In what circumstances is skin-to-skin with mother replaced by skin-to-skin with father/birth partner after a caesarean birth and how is this facilitated?	N/A
	Under what circumstances is the cord left to stop pulsating before clamping after a caesarean birth?	N/A

	What methods does the unit support for the mother to seed her baby's microbiome after a caesarean birth?	N/A
	Circumstances under which the baby is cleaned and wrapped after a caesarean birth	N/A
	Unit policy/guideline on women having their babies with them in the recovery room after a caesarean birth	N/A
	How are mothers who have had a caesarean birth assisted when giving their baby their first feed?	N/A
	Description of the training that staff in the labour ward undergo to promote, support and protect breastfeeding **(please list topics, course duration, frequency of updates and specify staff who undergo this training (midwives, obstetricians, anaesthetists, nurses, care assistants etc.)**	20hr breastfeeding course and yearly CPD, topics of the midwives' choice
Percentage of labour ward staff who have been trained this way	Midwives	100%
	Obstetricians	
	Anaesthetists	
	Nurses	
	Care assistants	
	Others	