NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Intrapartum care

Draft for consultation, March 2025

This guideline covers the care of women and their babies during labour and immediately after birth. It focuses on women who give birth between 37 and 42 weeks of pregnancy (‘term’). The guideline helps women to make informed choices about where to have their baby and about their care in labour. It also aims to reduce variation in aspects of care.

Using inclusive language in healthcare is important for safety, and to promote equity, respect and effective communication with everyone. This guideline does not use inclusive language in whole or in part because:

- the evidence has not been reviewed, and it is not certain from expert opinion which groups the advice covers, or
- the evidence has been reviewed, but the information available for some groups was too limited to make specific recommendations, or
- only a very limited number of recommendations have been updated in direct response to new evidence or to reflect a change in practice.

Healthcare professionals should use their clinical judgement when implementing recommendations, taking into account the individual's circumstances, needs and preferences, and ensuring all people are treated with dignity and respect throughout their care.

This guideline will update NICE guideline NG235 (published September 2023).

Who is it for?

- Healthcare professionals
- Commissioners and providers

- Healthy women who have had a straightforward pregnancy and give birth between 37 and 42 weeks of pregnancy

What does it include?

- new and updated recommendations on fluid balance, bladder care and hyponatraemia during labour
- the rationale and impact section that explains why we made the 2025 recommendations and how they might affect services.

Information about how the guideline was developed is on the guideline's webpage. This includes the supporting document for why the recommendations were made.

New and updated recommendations

We have made new and updated recommendations on fluid balance, bladder care and hyponatraemia during labour. You are invited to comment on the new and updated recommendations. These are marked as **[2007, amended 2025]**, **[2023, amended 2025]** or **[2025]**.

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.8 First stage of labour

Eating and drinking

1.8.17 Explain to the woman or pregnant person that they should drink during labour when they are thirsty, and that isotonic drinks may be more

beneficial than water. Also explain that there is no benefit to drinking any more than normal, and overconsumption may be harmful (see sections on fluid intake and output and confirmed peripartum hyponatraemia. **[2007, amended 2025]**

1.8.18 Inform the woman that she can eat a light diet in established labour unless she has received opioids or she develops risk factors that make a caesarean birth more likely. **[2007, amended 2023]**

Bladder care

1.8.25 Review bladder care for women and pregnant people at least every 4 hours to prevent an overdistension injury to the bladder. This should include:

- encouraging regular emptying of the bladder (at least once every 4 hours)
- monitoring frequency of passing urine
- asking the woman or pregnant person to inform their midwife as soon as possible if they have any concerns about passing urine
- offering to insert a catheter if there are any ongoing concerns about the ability to pass urine.

Note that women and pregnant people with an epidural in situ do not routinely need a catheter. However, because of the effects of the epidural on bladder sensation, catheterisation is more common in this group. **[2023, amended 2025]**

For a short explanation of why the committee made the 2023 recommendation see the rationale and impact section on bladder care.

Fluid intake and output

1.8.26 Discuss with the woman or pregnant person:

- it is important to drink during labour when thirsty (see recommendation 1.8.17)

- excessive intake of fluids may be harmful as this can cause hyponatraemia (a sodium level of <130 mmol/L in a pregnant woman or person) and lead to maternal and neonatal seizures or death
- fluid balance monitoring may be needed during labour to reduce the risk of hyponatraemia or dehydration. **[2025]**

1.8.27 Do not routinely administer intravenous fluids for the treatment of ketosis in non-diabetic women. **[2025]**

1.8.28 Monitor fluid balance, if:

- there are any concerns about fluid intake or output, for example there is concern that the woman or pregnant person is drinking too much
- the woman or pregnant person is receiving intravenous fluids
- the woman or pregnant person is receiving an oxytocin infusion
- there is an inability to pass urine
- there is nausea or vomiting
- there are certain medical conditions, such as pre-eclampsia (also see NICE guideline on hypertension in pregnancy). **[2025]**

1.8.29 If there is a positive fluid balance of 1500 ml or more:

- explain to the woman or pregnant person that it is possible they are developing or have developed hyponatraemia
- offer a blood test to check their sodium level (this may need transfer to a hospital setting for testing and subsequent care). **[2025]**

Confirmed peripartum hyponatraemia

1.8.30 If the woman or pregnant person has peripartum hyponatraemia, follow local protocols for the management of hyponatraemia. **[2025]**

1.8.31 If the pregnant woman or person is hyponatraemic inform the following as care staff soon as possible, or immediately if the woman or person is symptomatic or their sodium level is <125 mmol/L:

- the consultant obstetrician

- the consultant anaesthetist
- the neonatal team
- the delivery suite coordinator. **[2025]**

For a short explanation of why the committee made the 2025 recommendations see the rationale and impact section on fluid balance and hyponatraemia.

Full details about the committee's discussion are in the supporting document for the recommendations on fluid balance and peripartum hyponatraemia.

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline. For other definitions see the NICE glossary and the Think Local, Act Personal Care and Support Jargon Buster.

Hyponatraemia

Peripartum hyponatraemia occurs during labour and birth when the sodium concentration in the blood drops below 130 mmol/L and can have life-threatening consequences. Women or pregnant people in labour are predisposed to developing hyponatraemia because of lower baseline sodium level during pregnancy, lowered ability to excrete water in the third trimester and exposure to the anti-diuretic effect of oxytocin (both natural and synthetic). Maternal hyponatraemia also impacts the unborn baby because water crosses the placenta freely, which can lead to hyponatraemia in the newborn.

Early symptoms and signs include headache, loss of appetite, nausea and lethargy, while more advanced symptoms and signs include agitation, confusion, seizures, depressed reflexes and coma.

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice.

Bladder care

Recommendation 1.8.25

Why the committee made the recommendation

As part of the editorial updates planned for this guideline in 2023 (see supplement 3) the committee were asked to update recommendations on general good practice advice on bladder care. The committee therefore added this new recommendation as this aspect of care was not previously covered in the guideline. This recommendation was amended in 2025, based on committee consensus, as part of the guideline update related to recommendations on fluid intake and output and hyponatraemia.

How the recommendation might affect practice

This recommendation reinforces best practice and is unlikely to have any resource impact.

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Fluid balance and hyponatraemia

Recommendations 1.8.26 to 1.8.31

Why the committee made the recommendations

Based on a Prevention of Future Deaths report and other concerns about peripartum hyponatraemia being under-recognised in practice and sometimes leading to maternal or neonatal severe morbidity or death, the committee were asked to make recommendations on fluid balance and hyponatraemia. No new evidence was reviewed, so the committee made new recommendations and amended existing advice based on their expertise and experience. The committee acknowledged that clinical consensus and practice around this issue has been influenced by a former guideline which has been archived and no longer maintained: the Guidelines and Audit Implementation Network (GAIN) / Regulation and Quality Improvement Authority (RQIA) guideline for the prevention, diagnosis and management of hyponatraemia in labour and the immediate postpartum period.

Natural changes in water and sodium balance in the body during pregnancy mean that normal sodium levels in the blood during pregnancy (130 to 140 mmol/L) are slightly lower than the level in the general population (135 to 145 mmol/L). Women and people in labour are at higher risk of hyponatraemia (sodium less than 130 mmol/L) because of physiological changes in pregnancy and in labour, including a lower blood osmolality, a lower sodium level and the antidiuretic effect of both endogenous and exogenous oxytocin in labour. The liberal use of intravenous fluids and excessive oral intake further increases the risk. Maternal hyponatraemia impacts the unborn baby because water crosses the placenta freely, which can lead to hyponatraemia in the newborn. Mild hyponatraemia can be asymptomatic, but more severe hyponatraemia can cause maternal or neonatal neurological morbidity, including seizures, coma and death.

The committee agreed that administering intravenous fluids to treat ketosis in non-diabetic women and people in labour was common practice, but often unnecessary and potentially harmful because of the increased risk of hyponatraemia.

The best way to prevent hyponatraemia is to monitor fluid balance by recording the volume of fluid intake (oral and intravenous) and output (primarily urine) in a chart. Fluid balance monitoring may also be important for other clinical reasons, including to prevent dehydration if the person is vomiting, for example. Based on their expertise, the committee recommended indications for fluid balance monitoring during labour. The committee agreed that if healthcare professionals (particularly midwives) have any concerns about the person’s fluid intake or output, fluid balance monitoring should be carried out.

The committee agreed that a positive fluid balance of 1500 ml is a reasonable cut-off for prompting a blood test to check for sodium levels. In some cases, this will mean transferring to a hospital setting from a low-risk setting.

The committee did not make recommendations about how to manage hyponatraemia and instead advised the use of local protocols. However, they emphasised the importance of informing the consultant obstetrician, consultant anaesthetist and the neonatal team so that appropriate oversight and care plans are

in place. The urgency of this depends on severity of hyponatraemia demonstrated by symptoms or blood sodium level.

How the recommendations might affect practice

The recommendations will improve awareness of the risk of excessive fluid intake in labour, and the subsequent risk of hyponatraemia. This will in some cases lead to a change in practice with the increased use of fluid balance monitoring in labour. Increased use of fluid balance monitoring will have a small impact on midwife's time and there may be a small increase in need for blood tests or hospital transfers, but the benefits of preventing adverse outcomes from hyponatraemia should outweigh this. The recommendations are unlikely to have any significant resource impact.

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Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic page on fertility, pregnancy and childbirth.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

Update information

March 2025: We have updated and made new recommendations on fluid balance, bladder care and hyponatraemia during labour. These new and updated recommendations were made based on committee consensus. These recommendations are marked **[2007, amended 2025]**, **[2023, amended 2025]** and **[2025]**.

September 2023: We have reviewed the evidence and made new recommendations on pain relief, regional analgesia, prelabour rupture of membranes, care in all stages

of labour and postpartum care. We have also made new recommendations based on committee consensus. These recommendations are marked **[2023]**.

We have also made some changes without an evidence review throughout the guideline. These recommendations are based on committee consensus and marked **[2007, 2014 or 2017, amended 2023]**.

Recommendations marked **[2007, 2014 or 2017]** last had an evidence review in 2007, 2014 or 2017, respectively. In some cases, minor changes have been made to the wording to bring the language and style up to date, without changing the meaning.

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