HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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Facilitated by: Karen Wakelin, ACMM	Last reviewed: January 2015
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Active Management of Third Stage Policy

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Scope

- All obstetric staff employed by the Hutt Valley DHB
- All midwifery staff employed by the Hutt Valley DHB
- All Hutt Valley DHB maternity access agreement holders.
- Anaesthetic staff
- Neonatal staff

Abbreviations used in this document

LSCS	Lower segment caesarean section
PPH	Postpartum haemorrhage

Definitions

Active Management

Active management of the third stage of labour involves cord clamping (after 1 to 3 mins unless there are fetal concerns), cutting followed by administration of ecbolics and controlled cord traction of the umbilical cord.
(Rogers, Wood, McCandish, Ayers, Truesdale & Elbourne, 1998 and WHO, 2014)

Third Stage of labour

The third stage of labour occurs from after the birth of the baby until the delivery of the placenta and membranes.

Indications

For all situations deemed high risk for example;
Anaemia
Induction and/or augmentation of labour
Multiple pregnancies
Previous LSCS
Previous history of PPH
Grand multip (> 4 births)

Contraindications

Maternal refusal. This should be documented in the woman's notes.

Purpose of the policy

The purpose of this policy is to provide safe and effective care for women in the third stage of labour where physiological management is not appropriate or women choose to have active management.

Active Management of the Third Stage

For **high risk** women or maternal choice, active management of the third stage is recommended to be used. (For low risk women, refer to physiological management of third stage policy).

It is widely accepted that estimation of blood loss is often under estimated, with varying definitions of PPH from 500 mls – 1000mls (Cotter, Ness and Tolosa, 2001). Active management with the use of ergometrine (on its own or in combination with syntocinon) is associated with an increased risk of nausea vomiting and raised blood pressure, (Rogers et al, 1998; Prendiville, Elbourne, & McDonald, 2004). For this reason, consideration must be taken when administering syntometrine (syntocinon and ergometrine), and must not be used when women are hypertensive.

Procedure

- Oxytocin is administered 1-3 minutes after the birth of the baby
- The umbilical cord is clamped and cut after 1-3 minutes after the birth of the baby.
- Signs of placental separation are awaited
- Controlled cord traction is applied to the maternal end of the umbilical cord whilst the uterus is guarded.
- The placenta is delivered
- Assessment is then made of
    - Estimated blood loss
    - Location and uterine tone
    - The woman's perineum
- The placenta is checked for completeness

Drug dose and method of administration

Drug	Dose	Route of Administration
Syntocinon	5IU	IM or slow IV push
Syntocinon	10 IU	IM only
Syntometrine	1ml	IM only

Caution must be taken

- with the administration of intravenous syntocinon (give as slow push)
- With syntometrine as it contains syntocinon 5 units and ergometrine 0.5mg. **Not to be given in women with high blood pressure.**

Documentation

All drugs administered must be prescribed on the woman's medication chart.
Any adverse reaction to medication should also be noted.

Third stage management and time should be noted in the labour and birth record.

References

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World Health Organization(2014). The Prevention of post partum haemorrhage

Associated documents

Labour induction guidelines
Protocol: Syntocinon infusion for induction and augmentation of labour
Massive obstetric haemorrhage guidelines
Postpartum Haemorrhage management and treatment
Physiological management of the third stage of labour

Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).