HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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| Facilitated by: Lucy Griffiths, Midwife | Last reviewed: May 2017 |
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# Physiological Management of the Third Stage of Labour 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 medical and midwifery staff employed by Hutt Valley DHB
All Hutt Valley DHB maternity access agreement holders

## Purpose of the policy

The purpose of this policy is to provide safe and effective care for women having a physiological third stage of labour.

Research undertaken in New Zealand with a sample size of over 33,000 women over five years from 2004 – 2008 has shown that taking a physiological approach to the third stage of labour led to a reduced average amount of blood loss when compared with actively managing the third stage using an uterotonic drug (Dixon et al, 2006). While there is evidence to suggest that using uterotonic drugs to actively manage the third stage of labour has resulted in reduced mean blood loss and postpartum haemorrhage (Rogers, et al, 1998; POPPHI, 2009; Silverman & Bornstein, 2010), many of the initiatives stem from preventing postpartum haemorrhage and maternal mortality in developing countries where women have poorer nutrition, anaemia and health in general (Begley et al, 2010; Cotter, 2010; POPPHI, 2009).

Physiological management has been shown to increase the length of time for third stage of labour (Rogers et al, 1998; Dixon et al, 2006) so careful observation of the woman for postpartum haemorrhage must be taken.

Postpartum haemorrhage remains a leading cause of obstetric maternal death, and therefore an uterotonic drug should always be readily available in case it is needed.

## Abbreviations used in this document

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| LSCS | Lower segment caesarean section |
| PPH | Postpartum haemorrhage |

## Definitions

### Physiological Management

The physiological third stage involves supporting the woman's physiology during the third stage. This is delivery of the placenta without intervention. No oxytocic drug, no cord clamping, unless it has stopped pulsating, no controlled cord traction, no palpation of the uterus. The placenta is delivered by maternal effort, assisted by

gravity and the baby suckling at the breast. Signs of separation and descent are seen (Baddock & Dixon, 2006).Providing that fresh blood loss is not excessive, the mother's condition remains stable and her pulse rate normal, there need be no anxiety. This spontaneous process can take from 20 minutes to an hour. Eighty nine percent of women having physiological management of the third stage birthed their placenta within 40 minutes of birth (Dixon et al, 2006).

**Third Stage of Labour**
From the time of the birth of the baby to the time the placenta is delivered.

**Indications**
Maternal request
Women who have a normal vaginal birth with a spontaneous onset of labour after 37 weeks and cephalic presentation

**Contraindications**

**Any intervention that deviates the course of labour from normal.**
Anaemia
Prolonged labour
Induction and/or augmentation of labour
Epidural use
Multiple pregnancies
Grand multiparity
Previous LSCS
Placenta praevia
Operative vaginal delivery
Previous history of PPH
Clotting disorders
Malpresentation
Intrauterine death
Inability to give informed consent i.e. language barriers

**Procedure**
"Recognise that the time immediately after the birth is when the woman and her birth companion(s) are meeting and getting to know the baby. Ensure that any care or interventions are sensitive to this and minimise separation or disruption of the mother and baby." (NICE, 2016).

Following the birth of the baby the midwife unobtrusively:

1. Facilitates undisturbed maternal baby interaction, encourages skin to skin contact; keeps mother and baby warm.
2. The infant is encouraged to suckle to induce uterine contractions.
3. Encourages the woman to adopt a comfortable position for her – preferably upright to aid descent of the placenta and observation of blood loss.

- Following a physiological labour and birth the midwife does not administer an uterotonic.
- Controlled cord traction is not used.
- Do not clamp the cord, as interventions such as this can interrupt the normal mechanism of third stage. The cord is left alone until either it stops pulsating, or

preferably, the placenta is born so the baby receives an optimal blood supply to start extra uterine life, the cord may then be clamped/tied and cut. The decision to clamp and cut the cord should be on a case by case basis and in accordance with the woman's wishes. This may include keeping the cord intact for those choosing a lotus birth.

- Observe the woman's condition and pulse rate for signs of deterioration
- The midwife may unobtrusively observe for signs of placental separation. These are:
  1. The woman may become uncomfortable, experience contractions or feel that she wants to change her position. She may also indicate heaviness in the vagina and a desire to bear down.
  2. There may be some blood loss from separation bleeding, and lengthening of the cord.
  3. The uterus may be observed to become smaller, rounder and the fundus may rise in the abdomen and become more mobile.

**IMPORTANT:**

**Do not palpate or 'rub up' the uterus** unless blood loss becomes excessive- in which case you are changing to Active Management- refer to policy.

- Once there are signs of placental separation or if the woman is uncomfortable:
  1. The mother's position may be changed (support upright positions) to aid the descent of the placenta (e.g. kneeling or squatting position).
  2. Encourage maternal effort to expel the placenta.
  3. If the placenta is in the vagina, only then can gentle traction on the cord be used to guide the placenta out.
  4. A relaxed atmosphere, privacy and emptying the bladder may help to facilitate placental birth.
  5. Once separated the placenta may be caught in a container. The midwife can assist slow membranes to be born complete, by holding the placenta in two hands and gently turning until the membranes are twisted, then exert gentle tension to complete the birth. Or by asking the woman to cough.
- After the placenta is delivered assessment is then made of:
  1. Estimated blood loss
  2. Palpate the uterus for tone and fundal height Woman's condition, including pulse and blood pressure
  3. Perineal check
  4. The placenta and membranes are checked for completeness

**Practice notes:**

1. Cord blood may be collected from the large vessels on the surface of the placenta.

2. If the baby requires resuscitation there are some indications that it may be beneficial to leave the cord intact for resuscitation efforts, as long as resuscitation can be managed optimally

**IMPORTANT:**

- Physiological management of the third stage is very much a 'hands off' technique. It is vital that:
  1. Controlled cord traction is **NOT** applied to the umbilical cord
  2. The uterus is **NOT** palpated (unless blood loss becomes excessive- in which case you are changing to Active Management, refer to policy)

3. The practitioner managing the third stage does not mix management between physiological and active management

**If the woman starts to bleed significantly and the placenta has not been delivered then active management of the third stage must be instigated** (refer to the active management of third stage policy).

If the placenta has not delivered after 60 minutes then consultation with the obstetric team should occur and refer to retained placenta policy. Consultation should occur earlier if there are signs of maternal deterioration.

**Prolonged third stage**

The third stage of labour is diagnosed as prolonged after 60 minutes of the birth of the baby in physiological management. (NICE, 2016).

**For women birthing at home**

Depending on location of birth, if after 40 minutes the placenta has not delivered, preparations for transfer to hospital should be considered (or earlier, if maternal deterioration). The midwife is to ring delivery suite on emergency number 5709562, if condition warrants it, with details of the birth and reason for transfer so that a consultation with the on-call obstetrician can be arranged on arrival. Midwives should follow the process for emergency transport as per *Guidelines for consultation with Obstetric and related Medical Services (Referral Guidelines).* It is recommended the midwife travel with the woman in the ambulance during the transfer and the woman have an IV insitu.

**Documentation**

All events in the third stage must be documented including notation on the state of the placenta and membranes.

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

**Placental pathway to be clearly documented i.e. if family wishes to keep the placenta or hospital disposal (in which case it should be double bagged and clearly dated and labelled). Also note if it is sent for histology, then please weigh the placenta first.**

**Associated Documents**

Active management of the third stage of labour
Massive obstetric haemorrhage
Primary postpartum Haemorrhage management and treatment (Draft October 2005)
Placenta Pathway

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**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).