Normal birth

Clinical Guideline Presentation v3.0

45 minutes

Towards CPD Hours

References:

Queensland Clinical Guideline: *Normal birth* is the primary reference for this package.

Recommended citation:

Queensland Clinical Guidelines. *Normal birth* clinical guideline education presentation E17.25-1-V3-R22. Queensland Health. 2017.

Disclaimer:

This presentation is an implementation tool and should be used in conjunction with the published guideline. This information does not supersede or replace the guideline. Consult the guideline for further information and references.

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Objectives

By the end of this presentation you will be able to identify:

- The benefits of normal birth
- Care that supports normal birth
- Deviations from normal birth

Normal birth

- Refers to a labour and birth that has not been *managed* by medical intervention
- Also referred to as ‘physiological birth’ or ‘natural birth’
- Benefits include:
  - Improved outcomes for mothers and babies
  - Reduced healthcare costs
  - Less iatrogenic events related to overuse of medical interventions
  - Improved maternal psychological and physical wellbeing

Criteria for normal birth

Included

- 37+0 to 42+0 weeks
- Spontaneous onset of labour
- Normal labour progress
- Vertex position
- Spontaneous vaginal birth
- Intermittent fetal auscultation
- Third stage: modified active (delayed cord clamping) or physiological
- Nitrous oxide
- No maternal or fetal complications or risk factors

Excluded

- Induction of labour
- Augmentation
- Continuous fetal monitoring
- Other pharmacological analgesia
- Instrumental birth
- Caesarean section
- Episiotomy
- Complications
- Active management of third stage (early cord clamping)

Consultation & referral

- During the birth process, deviations from normal or concerns with the labour or birthing process may arise.
- When indicated:
  - Increase frequency of observations
  - Modify care to individual circumstances while maintaining a focus on supporting
  - Discuss, consult, refer and manage according to professional and Queensland guidelines

Wellness paradigm

Protect, promote and support normal birth

- Includes:
  - A shared philosophy of care
  - Positive professional culture and collaboration
  - Positive communication
  - Woman centred-care approach to care
  - Continuity of care and carer
  - Supportive one-to-one midwifery care
  - Avoiding intervention if woman and baby are well and labour is progressing normally
  - Private, safe and undisturbed environment

Birth preparation

- Is a continuous ongoing process
- Support and empower the woman to be an active participant in decision-making
- Inform the woman of the benefits of normal birth
- Provide psychoeducation
- Provide options for care
- Assist to develop an individualised birth plan

Vaginal examination

- There is no evidence to support or reject the use of routine VEs in labour to improve outcomes for women and babies
- Before offering VE ask:
  - Is a VE necessary?
  - Will a VE aid clinical decision making?
  - Do I have your consent?
- Aim to keep the number of VE to a minimum

First stage of labour

Latent phase

- Irregular painful contractions and some cervical effacement and dilatation less than 4 to 6 cm.
- No consensus on what is prolonged latent phase

Active phase (established labour)

- Regular painful contractions AND some cervical effacement AND dilatation of at least 4 to 6 cm
- May not progress in a linear pattern

Latent phase

Kim-Ly has had an uncomplicated pregnancy and is at term with her first baby. She telephones her local facility saying she thinks she is in labour.

What are your main aims when talking to Kim-Ly over the phone?

- Assess the need for consultation and referral
- Identify the stage of labour
- Provide practical support

What will you discuss with Kim-Ly?

- Her pregnancy so far (due date, complications, investigations, care)
- Any concerns she has
- Past health history
- Contractions: onset, frequency, strength, duration
- Fetal movements in the last 24 hours
- Vaginal loss
- Current location and access to hospital
- Coping ability, emotional state, supports
- Preferences for labour and birth
- Indications for presenting to hospital
- Agree a time for the next contact (in person or by phone)

Latent phase: home or hospital?

You advise Kim-Ly she can safely remain at home. A student asks why you don't tell Kim-Ly to come straight into hospital if she is in early labour.

How might you explain your rationale?

- Kim-Ly would like to stay at home
- She is coping well and has support people with her
- Her pregnancy has been uncomplicated and she is at term
- You have not identified any areas for concern
- In your clinical opinion, Kim-Ly is likely to be in the latent phase and can safely remain at home
- Kim-Ly has understood when she might need to come in or call back

Active phase

Kim-Ly has been in active labour for 8 hours and is now 7 cm on VE?

When would you be concerned about a delay in active first stage?

- If there is less than 2 cm cervical dilation in the last four hours
- At or after 6 cm cervical dilatation, and with ruptured membranes, there has been no change after four hours of adequate contractions

Water immersion

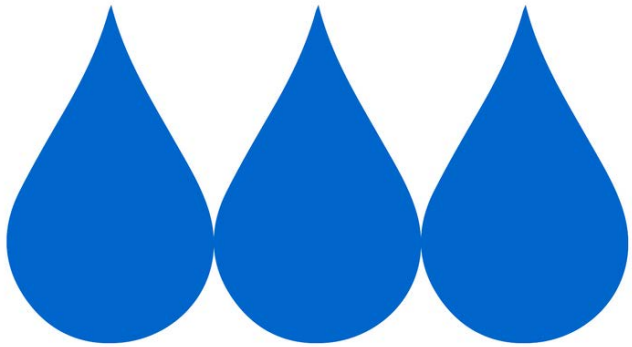
Kim-Ly asks you if she can try water immersion. You assess that this is safe and appropriate for Kim-Ly and help her enter the water.

What clinical care will you ensure during water immersion?

- Baseline maternal and fetal parameters prior to entering water
- Continuous support from caregivers skilled in water immersion
- Have a second caregiver immediately available in case of unintended water birth
- Advise Kim-Ly that narcotic analgesia is not recommended while in the water
- Keep water temperature 36–37 ^{0}C and maintain water quality
- Encourage fluid intake to maintain hydration

What conditions might prompt you to advise Kim-Ly to exit the water?

- Slow progress of labour
- Fetal heart rate abnormalities
- Meconium or blood stained liquor
- Elevated maternal temperature
- Intrapartum risk factors develop



Second stage of labour

From full cervical dilatation until birth of the baby.

Progress includes flexion, rotation and descent of the fetal head

Passive second stage

- Full cervical dilatation before or in the absence of involuntary expulsive contractions

Active second stage

- Full cervical dilatation and expulsive contractions or the baby is visible

Passive second stage

Kim-Ly is now fully dilated with no urge to push. There are no concerns about maternal or fetal wellbeing.

When do you advise Kim-Ly to start pushing?

- Delay pushing (in the absence of clinical concern) if the woman has no urge to push
- If after one hour Kim-Ly has no urge to push, or there is no evidence of progress, reassess and consult with an obstetrician

Active second stage

Kim-Ly has been pushing for 40 minutes in active second stage. There has been no real progress. There are no maternal or fetal concerns.

When would you consult and refer to an obstetrician?

- Kim-Ly is a nulliparous woman, therefore if progress is slow after one hour of active second stage
- If Kim-Ly were a multiparous woman, then if progress is slow after 30 minutes
- If clinical concerns develop

When would you diagnose delay?

- If the birth of Kim-Ly's baby is not imminent after two hours of active second stage (after one hour if she were multiparous)

Third stage of labour

- From the birth of the baby until the birth of the placenta and membranes
- Management is classified according to whether specific elements of care are routinely included
- It is unclear which element of third stage management has the greatest effect on reducing PPH (oxytocin, timing of cord clamping or controlled cord traction)

Active versus modified active

Lucy, pregnant at term asks about the difference between ‘active’ and ‘modified active’ management of the third stage

What do you tell her?

The main difference is in the timing of the clamping of the cord

Modified active: waiting at least one to three minutes after the birth of the baby or the cord ceases to pulsate

Active: Clamping of the cord within 60 seconds of the birth of the baby

Both include:

- Administration of a uterotonic
- Controlled cord traction after birth of baby
- Prolonged if not complete within 30 minutes of the birth of baby

Why is modified active preferentially recommended?

Delayed cord clamping allows a physiological transfer of placental blood to the baby.

Results in increased:

- Birth weight
- Haemoglobin at 24–48 hours
- Improved iron stores at 3-6 months
- Improved maternal and infant health and nutritional outcomes

- Also increases jaundice requiring phototherapy

Uterotonics

Lucy's has heard that most women should have oxytocin in the third stage.

Do you recommend a uterotonic to Lucy?

- Yes. The guideline recommends administration of oxytocin 10 IU in the third stage of labour
- Provide information on the risks and benefits
- Support women who choose a normal birth

When is the best time to administer a uterotonic?

- Can be administered before or after the cord is clamped and cut
- No difference in incidence of PPH when given before or after birth of placenta
- Usually administered shortly after birth of the baby
- May be administered with the birth of the anterior shoulder

Lotus birth

A pregnant friend of Lucy's wants a lotus birth. Lucy asks you what this is?

What do you tell Lucy about lotus birth?

The baby remains attached to the placenta until the cord separates naturally. The placenta is dried, salted and wrapped in breathable material.

Lucy asks if it is safe. What can you advise Lucy?

- There is limited evidence about the safety of lotus birth
- There are case reports of infection occurring in the newborn baby

How should you care for a woman who chooses a Lotus birth?

- Support the woman's choice
- Advise her to supply all materials needed for care of the placenta
- Provide information about signs of infection in the newborn
- Advise to:
  - Change the placental bag as required
  - Avoid strain on the umbilical cord

Physiological management

Lucy has chosen physiological management for the third stage..

How will you assess if this is a safe option for Lucy?

Physiological care is generally suitable for women who:

- Have a healthy pregnancy
- Have had a normal first and second stage
- Have no risk factors for excessive bleeding
- Have made an informed choice after discussion of risks and benefits

What will you do to support Lucy's choice?

- Not give a uterotonic
- Wait for cord pulsation to cease or placenta birthed before clamping cord
- If cord is cut, leave maternal end unclamped
- Allow placenta to birth spontaneously by maternal effort
- Unobtrusively wait and observe for signs of separation and remain 'hands off'
- Diagnose delay if not completed within 60 minutes

Clamping of the cord

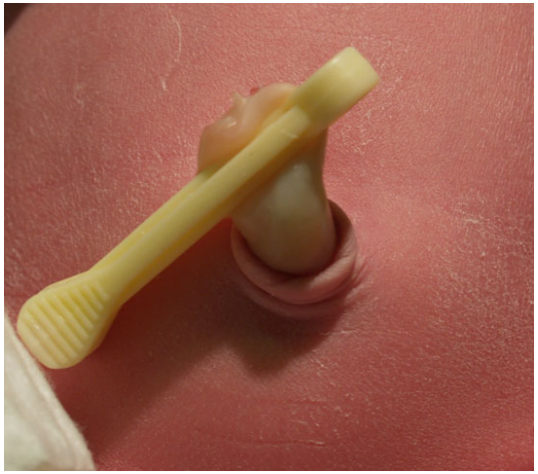
Immediately after the birth of Lucy's baby Joseph, his heart beat is 58 beats per minute

What do you do?

- If there are concerns with cord integrity or the heart rate of the baby is below 60 beats per minutes, clamp and cut the cord and commence resuscitation as required
- Ideally, you have already discussed and agreed with Lucy the potential circumstances that might require alternative management and what this will be

What do you document about the type of third stage management?

- Document the time the cord is clamped rather than the type of management



Controlled cord traction (CCT)

Lucy decides she wants to shorten third stage so she can focus on her new baby. You administer oxytocin and prepare for CCT.

What will you check before performing CCT?

- Uterus is well contracted
- Placenta has separated
- Cord has been cut

What do you tell Lucy about the risks and benefits of CCT?

Is associated with:

- Reduced incidence of manual removal and PPH (but not severe PPH)
- Shortened duration of third stage
- Rare but serious complication is uterine inversion

How will you know placental separation has occurred?

- Uterus rises in the abdomen
- Uterus becomes firmer and globular
- Trickle or gush of blood from the vagina
- Umbilical cord lengthens
- Cord does not retract with suprapubic pressure
- Woman may feel urge to bear down
- Placenta may become visible in the vagina

Placenta and membranes

Third stage is complete and you are checking Lucy's placenta and membranes.

What do you look for?

Placenta

- General shape and appearance
- Evidence of abruption, calcifications or infarctions
- Absence of cotyledons
- Presence of succenturiate lobe

Membranes

- one amnion and one chorion
- Whether complete or ragged

Cord

- two arteries, one vein
- Insertion site
- Velamentous insertion

What will you do if you find the following?

Placenta appears incomplete

- Observe vaginal loss and fundal height, advise the woman to report increase in loss, or if passing clots

Offensive odour

- Collect swab from maternal and fetal surface

Abnormality detected

- Consider histopathology

Comprehensively document all findings in the health record

Fourth stage

Lucy is exhausted but keen to spend time with her partner and new baby Joseph.

What is the fourth stage?

Defined in the guideline as the first six hours immediately following the birth. Fourth stage is aimed at supporting physiological adaptation and mother-infant bonding

How will you support mother infant bonding?

- Facilitate uninterrupted skin to skin contact
- Avoid unnecessary interruptions
- Ensure calm, supportive environment
- Assess mother-infant interactions
- Offer emotional support
- Maintain newborn warmth
- Assist with breast/infant feeding if required

Fourth stage

Lucy breastfeeds baby Joseph but is feeling quite tired.

How will you support safe physiological adaptation?

- Continuous care for first two hours
- Regular maternal and newborn observations
- Explain importance of positioning baby to maintain patent airway
- Respond to requests for pain management
- Offer food and drink

Can you alter the frequency of observations?

- The recommended **minimum** observations following *normal labour and birth* are outlined in the guideline
- Increase the frequency of observations if there are risk factors, deviations from normal or clinical concerns
- Use standardised documentation and forms to record observations
- Escalate concerns as needed