Normal Birth

Clinical Guideline Presentation v4

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 E22.25-1-V4-R27. Queensland Health. 2022.

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:

- Benefits of normal birth
- Care that supports normal birth
- Deviations from normal birth

Normal birth

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

Criteria for normal birth

Included

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

Excluded

- Induction of labour
- Augmentation
- Continuous fetal monitoring
- Epidural or spinal anaesthetic
- Opioid administration
- 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 normal birth
  - 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 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 women to make informed decisions
- Inform the woman of the benefits of normal birth
- Provide psychoeducation
- Provide options for care
- Assist the woman to develop an individualised birth plan

Vaginal examination

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

First stage of labour

Latent phase (early labour)

- 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

Amanda 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 Amanda over the phone?

- Assess the need for consultation and referral
- Assess the stage of labour
- Provide practical support, encouragement and reassurance

What will you discuss with Amanda?

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

Latent phase: home or hospital?

You advise Amanda she can safely remain at home. A student midwife asks why you don't tell her to come straight into hospital if she is in labour.

How might you explain your rationale?

- Amanda would like to stay at home
- She is managing 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
- Your clinical assessment is that Amanda is likely to be in the latent phase and remaining at home is a safe option
- Amanda has understood when she might need to come in to hospital or call back

Active phase

Amanda presents to hospital after being in active labour for 8 hours. Upon VE she is now 7 cm dilated.

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

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

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

When do you advise Amanda to start pushing?

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

Active second stage

Amanda 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?

- Amanda is a nulliparous woman, therefore if progress is slow after one hour of active second stage
- If Amanda 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 Amanda'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 postpartum haemorrhage (PPH)—oxytocin, timing of cord clamping or controlled cord traction

Active versus modified active

Amanda 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 minute 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 third stage 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 outcomes

Uterotonics

Amanda has heard that most women should have oxytocin in the third stage.

Do you recommend a uterotonic to Amanda?

- Yes. Administration of oxytocin 10 IU intramuscular in the third stage of labour is recommended
- Provide information on the risks and benefits
- Support individual choice

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

Amanda has a friend that recently had a lotus birth and asks you about it.

What do you tell Amanda 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.

Amanda asks if it is safe. What can you advise her?

- 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 material bag as required
  - Avoid strain on the umbilical cord

Physiological management

Amanda has chosen physiological management for the third stage.

How will you assess if this is a safe option?

Physiological care is generally suitable for women who:

- Have had 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 her choice?

- Withhold uterotonic
- Wait for cord pulsation to cease or placenta birthed before clamping cord unless neonatal resuscitation required
- 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

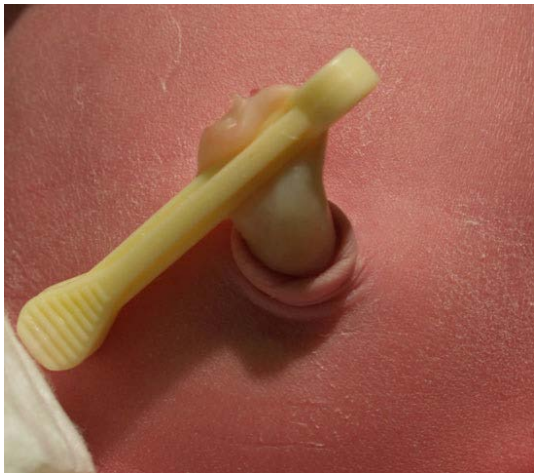
Immediately after the birth of Amanda's baby Joseph, his heart beat is 58 beats per minute

What do you do?

- Clamp and cut the cord and commence resuscitation
- Ideally, you have already discussed and agreed with Amanda 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 and the type of management



Controlled cord traction (CCT)

Amanda 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 clamped and cut

What do you tell her 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, globular and ballotable
- 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 Amanda's placenta and membranes.

What do you look for?

Placenta

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

Membranes

- 1 amnion and 1 chorion
- Whether complete or ragged

Cord

- 2 arteries, 1 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

Amanda 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 for at least 1 hour, where possible
- 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

Amanda 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
- Discuss safer infant sleeping
- 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