ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOUR

AIM
Appropriate and effective active management of the third stage.

DEFINITION
The third stage of labour commences with the completed birth of the baby and ends with the completed birth of the placenta and its attached membranes.

BACKGROUND
Active management of the third stage of labour should be recommended to all pregnant women as this reduces the risk of postpartum haemorrhage and the need for blood transfusion.\(^1\)

Active management of the third stage of labour involves

- The administration of an oxytocic drug to the mother via an intramuscular injection immediately following the birth of the anterior shoulder of the baby will be delayed if client birthing in water and/or requesting delayed cord clamping.

- Early clamping and cutting of the cord

- Controlled cord traction

Discussions and the provision of the CMP pamphlet ‘The birth or delivery of your placenta’ about third stage management should occur in the antenatal period. The client must sign the informed choice agreement form in the Pregnancy Health Records prior to the onset of labour. This discussion should be re-visited during labour if risk factors develop (as listed below).

For unexpected breech births, ensure the administration of the oxytocic occurs after the birth of the baby is complete.

For unexpected multiple births, ensure that administration occurs after the birth of all babies.

Increased risk factors for PPH in clients eligible for the CMP (refer to CMP guideline Inclusion criteria for the Community Midwifery Program)

- Previous history of a postpartum haemorrhage
- History of a known thrombolytic condition
- History of unresolved maternal anaemia in the current pregnancy
- Suspected fetal macrosomia (weight > 4500g)
- Prolonged first and/or second stage
- South east Asian ethnicity\(^2\)
- Pyrexia in labour
- Rapid or inco-ordinate labour
PROCEDURE

- Inform the woman about the situation and what is occurring.
- Clamp and cut the umbilical cord within 2-3 minutes of the birth.
- Maintain undisturbed skin-to-skin contact between the mother and the infant to encourage breastfeeding.³
- Administer an oxytocic to the woman following clamping and cutting the cord. Syntocinon 10iu is the recommended first line management for low risk women.
- In cases of increased risk of postpartum haemorrhage, administer 1 ampoule of Syntometrine IMI (contra indicated in women with hypertension and known cardiac conditions).
- Do NOT palpate or ‘rub up’ the fundus.
- Observe for signs of separation (small gush of blood, lengthening of the cord and contraction of the uterus).
- Place a hand on the abdomen to detect uterine contraction and placental separation.
- Once placental separation is confirmed commence controlled cord traction.
  - Stabilise the uterus by placing the hand just above the symphysis pubis and apply counter pressure during controlled cord traction
  - Gently pull downward on the cord to deliver the placenta with the uterine contraction.  
  - Discontinue controlled cord traction if the placenta does not descend after 30-40 seconds
  - Gently hold the cord and wait until the uterus is contracted again
  - With the next contraction repeat controlled cord traction with counter pressure

**Note:** Never apply cord traction without applying counter pressure above the symphysis pubis and without a well-contracted uterus. Traction should be eased or discontinued if there is any suggestion of tearing of the cord, or if the uterus relaxes.

  - When the placenta is viewed at the introitus, apply upward traction on the cord
  - Remove the hand from above the symphysis pubis when the placenta is mostly visible and delivered.
  - Use both hands to support the placenta and membranes to complete the delivery.
  - Gently palpate the fundus to confirm it is well contracted.
  - Examine the placenta and membranes for completeness and the presence of
- 1 amnion and 1 chorion
- blood vessels
- succenturiate lobes
- 2 arteries and 1 vein
- insertion site
- anomalies (knots etc.)

- Estimate and record the total blood loss.
- Perform maternal observations – in the event of no deviations from the norm, observations should be performed as often as determined by the woman’s clinical status, but at a minimum of hourly after birth for 2 hours.
- In the event of unexpected blood loss (not requiring transfer to hospital), observations should occur at a minimum of:
  - Assess and document the tone and position of the fundus and the amount of lochia every 15 minutes for the first hour after birth then hourly for the second hour, then prior to leaving the woman’s home.
  - Measure and document the woman’s pulse, respiration rate, temperature, blood pressure and check the perineum every 30 minutes for the first hour after birth then hourly for 1-2 hours (unless the clinical condition of the woman determines more frequent observations are required).

Management of Delay in the Third Stage of Labour

1. If actively bleeding at any point implement PPH protocol (CMP guideline PPH management).
2. Inform the woman about the situation and what is occurring.
3. If the placenta remains in situ with no signs of bleeding or separation after 30 minutes of active management, assist the woman to mobilise and attempt to void.
4. If the woman is unable to void, perform bladder catheterisation. Record the volume and concentration of the urine drained.
5. If the placenta fails to birth, implement retained placenta protocol (CMP guideline Management of a Retained Placenta).
REFERENCES / STANDARDS


National Standards – 1- Care Provided by the Clinical Workforce is Guided by Current Best Practice

12 Provision of Care

Legislation - Nil

Related Guidelines / Policies –KEMH Labour (Third Stage) Active Management

Other related documents – Midwifery care when a Client Makes a Decision that Is Incompatible with the CMP Midwifery Standard of Practice

RESPONSIBILITY

Policy Sponsor Nursing & Midwifery Director OGCCU

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Do not keep printed versions of guidelines as currency of information cannot be guaranteed. Access the current version from the WNHS website.

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