REF: CTMObs 106

Management of the Third Stage of Labour including Retained Placenta

Initiated By	Cwm Taf Morgannwg University Health Board Obstetrics and Gynaecology Directorate
Approval Group	Labour Ward and Guideline Forums
Distribution	Midwifery and Obstetric staff within Cwm Taf Morgannwg University Health Board (via email)
Archiving	Directorate secretary will be responsible for archiving all versions
Document Location	WISDOM and Health Board intranet Hard copy in Management file /Guidelines on fileshare
Freedom of Information	Open

CHANGE HISTORY

Version	Date	Author Job Title	Reasoning
2.0	August 22	Kath Greaves	Revised / no change

AUTHORSHIP, RESPONSIBILITY AND REVIEW

Author	DawnApsee/Catrin Rees	Ratification Date	August 2022
Job Title	Intrapartum Lead Midwife	Review Date	August 2025

CONTENTS

1. Introduction

The third stage of labour is the time immediately from the birth of the baby to the expulsion of the placenta and membranes. This is time is when the woman and her birth companions are getting to know the baby and any care provided should be sensitive to this and minimise separation and disruption.
Management of the third stage of labour should be discussed with the women in the antenatal period and the associated benefits and risks of each method considered. Women should be informed that active management of the third stage reduces the risk of maternal haemorrhage and shortens the length of the third stage but can increase the risk of vomiting after birth.

2. Definitions

Active management of the third stage involves a package of care which comprises of the following components:

- Use of uterotonic drugs
- Clamping and cutting of the cord
- Controlled cord traction

Physiological management of the third stage involves a package of care which comprises of the following components:

- NO routine use of uterotonic drugs
- NO clamping and cutting of the cord until pulsation ceases
- Placenta delivered with maternal effort – management should never involve pulling the cord or palpating the uterus.

3. Active management

For active management, administer 10 IU of oxytocin by intramuscular injection with the birth of the anterior shoulder or immediately after the birth of the baby and before the cord is clamped and cut. Use oxytocin as it is associated with fewer side effects than oxytocin plus ergometrine (RCOG 2014). Although for women at risk of PPH the use of oxytocin and ergometrine should be considered,
After administering oxytocin, clamp and cut the cord.

- Do not clamp the cord earlier than 1 minute from the birth of the baby unless there is concern about the integrity of the cord or the baby has a heart rate below 60 beats/minute that is not getting faster.
- Clamp the cord before 5 minutes in order to perform controlled cord traction as part of active management.

- If the woman requests that the cord is clamped and cut later than 5 minutes, support her in her choice. (NICE 2014)
- After cutting the cord use controlled cord traction. This should only be performed after the administration of oxytocin and signs of placental separation.
- If placenta is not delivered within 30 minutes please refer to management of retained placenta
- Consideration should be given to the use of Syntometrine if the woman is at higher risk of PPH

4. Physiological management

Changing from physiological management to active management of the third stage is indicated in the case of:

- Haemorrhage
- Failure to deliver the placenta within 60 minutes
- The woman's desire to artificially shorten the third stage

5. Management of retained placenta

The third stage of labour is diagnosed as prolonged if not completed within 30 minutes of the birth of the baby with active management and 60 minutes with physiological management.

If the woman is not already in an obstetric unit then an urgent transfer should be arranged from AMU/FMU or home environment.

- Intravenous access should always be secured in women who have a retained placenta and bloods taken for FBC and group and save
- Intravenous infusion of oxytocin should **NOT** be used to assist the delivery of the placenta
- Give intravenous oxytocic agents if the placenta is retained and the woman is bleeding excessively**.** (NICE 2014)
- Do not use umbilical vein agents if the placenta is retained

If the placenta is retained and there is concern about the woman's condition:

- Offer a vaginal examination to assess the need to undertake manual removal of the placenta

- Explain that this assessment can be painful and advise her to have analgesia. (NICE 2014)

- If a women reports inadequate pain relief during the assessment, immediately stop the examination and address this need.

- Do not carry out uterine exploration or manual removal of the placenta without an anaesthetic

6. Care following Manual Removal of Placenta

- Ensure Oxytocin infusion is commenced (40IU of oxytocin in 500ml of Hartman's at 125ml/hour.)
- Observe closely for Post Partum Haemorrhage.
- Record observations on MEOW's chart

7. Risk factors for retained placenta

- Previous retained placenta
- Morbidly adherent placenta – placenta accrete/increta/percreta
- Preterm gestation/preterm labour
- Uterine abnormalities or uterine scars
- Uterine atony
- Full bladder
- Inappropriate management of third stage.
- Velomentous cord insertion.

8. References

- **NICE Intrapartum care for healthy women and babies**
Clinical guideline [CG190] Published date: 03 December 2014 Last updated: 21 February 2017

- **Weeks A (2018)** Retained Placenta. UpToDate content https://www.uptodate.com/contents/retained-placenta-after-vaginal-birth?csi=56168e51-81eb-4de4-a190-76f7153fade7&source=contentShare

THIRD STAGE OF LABOUR: RETAINED PLACENTA

Active Management

Physiological/Expectant Management

Timing to intervention period ONLY applies if the mother is not bleeding and is haemodynamically stable

Placenta NOT expelled <30 mins in 3rd trimester stage

Placenta NOT expelled <60 mins in 3rd trimester stage

Administer oxytocic drug & revert to active management

Placenta retained in the Absence of Haemorrhage/Maternal collapse

- **AMU – transfer to LW**
- **FMU/homebirth – call 999 ambulance & inform LW**

- **Inform Obstetrician**
- **Empty the bladder**
- **Secure IV access**

Attempt to deliver the placenta
Always with sufficient analgesia and consent

Placenta Trapped in Cervix

- **Attempt CCT again**
- **Apply CCT with traction on the cord until the placenta is delivered**

Do not carry out uterine exploration or MROP without an anaesthetic

Placenta Adherent

- **Expectant management for a maximum of 120 60 minutes following the birth of the baby (in the absence of bleeding)**
- **Transfer to theatre for MROP**

Do not carry out uterine exploration or MROP without an anaesthetic

Haemorrhage/Maternal Collapse

- **Follow OBSCYMRU PPH Pathway**
- **Transfer to Theatre**