Shoulder Dystocia Guideline

Guideline information

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Summary of document:
The aim of this guideline is to reduce fetal mortality/morbidity by ensuring early recognition and correct management of Shoulder Dystocia utilising PROMPT guidance.

Scope:
This guideline is for all health care professionals caring fora woman in labour, to provide guidance and to standardise the recognition, management and documentation of Shoulder Dystocia

The guidance uses the term “woman” (pronouns she or her) to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women’s health and reproductive services. Therefore, this should include people who do not identify themselves as women but who are pregnant or have recently given birth. Obstetric and midwifery services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex that they were assigned at birth.

To be read in conjunction with: Shoulder Dystocia (Green-top Guideline No. 42) | RCOG - opens in new tab

Patient information:
Include links to Patient Information Library
https://www.rcog.org.uk/en/patients/patient-leaflets/shoulder-dystocia/ - opens in new tab

Owning group:
Maternity Guideline, Audit and Research Group
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Keywords
Shoulder Dystocia, Brachial Plexus Injury, Humeral and Clavicular Fractures

Glossary of terms

PROMPT	Practical Obstetric Multi-Professional Training
RCOG	Royal College of Obstetricians and Gynaecologists
SD	Shoulder Dystocia

Contents

Scope
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Aim
The aim of this guideline is to reduce fetal mortality/ morbidity by ensuring early recognition and correct management of Shoulder Dystocia utilising PROMPT guidance.

Objective
The aim of this guideline will be met by the following objectives:

- Have awareness of the complications of Shoulder Dystocia, particularly that permanent brachial plexus injury is not inevitable.
- All Obstetricians and Midwives will be able to perform the manoeuvres required to release the shoulders during Shoulder Dystocia.
- To understand the importance of clear and accurate documentation.

Introduction

Definition
Shoulder Dystocia is an acute obstetric emergency which requires prompt, efficient action. It is defined as a vaginal cephalic birth that requires additional obstetric manoeuvres to assist the birth of the infant after gentle traction has failed.

Shoulder dystocia occurs when either the anterior shoulder impacts behind the maternal symphysis pubis or, less commonly, the posterior shoulder impacts over the sacral promontory.

Incidence
There is wide variation in the reported incidence of Shoulder Dystocia. The largest studies reported incidences ranging between 0.58% and 0.70%. Most cases of shoulder dystocia are unexpected with conventional risk factors only predicting 16% of cases.

Complications of shoulder Dystocia

- Brachial Plexus injury (BPI) occurs in 2-16% shoulder dystocia births. Permanent BPI rates (lasting over a year) are 3 per 10,000 live births in UK.
- Neonatal injuries – fracture of the clavicle /or humerus.
- Increased incidence of 3rd degree tear (3.8%) and post-partum haemorrhage (11%)
- Increased incidence of neonatal morbidity and mortality (Hypoxia and stillbirth).

Risk Factors for a Shoulder Dystocia

Antenatal	Intrapartum
Previous Shoulder Dystocia (1 in 10 recurrence rate)	Induction of labour/ oxytocin augmentation

Maternal BMI≥30kg/m^2	Prolonged first or second Stage of labour
Maternal Diabetes Mellitus (2-4 fold increased risk) compared with infants of the same birth weight born to non-diabetic women.	Secondary arrest in labour
Gestational Age	Assisted vaginal birth
Macrosomia>4.5kg	

NOTE. 48% of Shoulder Dystocias occur in babies below 4kg

These are the most commonly associated antenatal and intrapartum risk factors. Previous Shoulder Dystocia being the most significant risk factor, increasing the baseline risk by 10 times. However, all of the characteristics are poorly predictive, and combining them is similarly poor.

Therefore, for practical purposes, because Shoulder Dystocia is not clinically predictable, the midwife/ obstetrician must always be prepared for the possibility of shoulder dystocia at all births.

The RCOG Green Top Guideline recommends shared decision-making for mode of birth for women who have had a previous Shoulder Dystocia.

Risk of shoulder suspected

Where the risk of Shoulder Dystocia is suspected the woman should be reviewed by a Registrar or Consultant and a written plan documented in notes. Obstetric Registrar should be present on the labour ward for second stage.

Recognition of Shoulder Dystocia

The diagnosis is made once an additional obstetric manoeuvre has been used to release the shoulders. However, timely management of a Shoulder Dystocia requires prompt recognition. The delivering attendant should routinely observe for:

- Difficulty with the birth of the face and chin
- When head is born, it remains tightly applied to the vulva
- The chin retracts and depresses the perineum –'the turtleneck' sign.
- Failure of restitution of fetal head.
- The anterior shoulder fails to release with maternal effort and/ or when 'routine' axial traction is applied.

Management of Shoulder Dystocia

- Use emergency buzzer to CALL FOR HELP - include Experienced Obstetrician, Midwife coordinator, additional maternity team assistance, neonatal team, Anaesthetist, (Theatre Team).

- Clearly state the obstetric emergency 'Shoulder Dystocia'
- Note the time head was delivered
- Ask the woman to stop pushing
- Manage systematically according to PROMPT Algorithm for the Management of Shoulder Dystocia (Appendix 1) – opens in new tab.

What to avoid

Do not perform:

- Fundal Pressure
- Excessive and/ or downward traction
- Twisting or bending of the neck

These manoeuvres are all strongly associated with higher rates of brachial plexus injury. Fundal pressure is also associated with uterine rupture.

Birthing in water

For pool births, the woman should be evacuated from the pool when the midwife recognises signs of delay with the birth of the shoulders. It may not be possible to confirm a Shoulder Dystocia at this stage, but the woman should be safely moved out of the pool so that standard release manoeuvres can be performed safely and efficiently.
It is recommended that manoeuvres are not performed in the pool, or with the woman standing up, or on the edge of the pool.

Community / free standing Midwifery Led Unit

- In a community or stand-alone birth centre once Shoulder Dystocia is diagnosed; CALL for HELP).
- Ring 999 or give instructions to someone else to phone 999 for an ambulance: Request a Paramedic and state *"Shoulder Dystocia'. It is an obstetric emergency and requires an immediate emergency transfer to nearest hospital with attached obstetric led unit."*
- Inform Obstetric unit of situation.
- Manage systematically according to PROMPT Community flowchart (Appendix 2) – opens in new tab.
- On arrival of assistance (second midwife, HSW or ambulance crew) declare the emergency (Shoulder Dystocia).

If unable to make call at time of Shoulder Dystocia (e.g. only a midwife present) then call immediately afterwards for transfer for a neonatal review of the baby.

Communication

- Mothers with identifiable risk factors for Shoulder Dystocia should be informed about the incidence of its occurrence.
- Debrief of parent/s: Following occurrence of Shoulder Dystocia full and clear explanations should be given to the parent/s by the obstetrician and/or the senior midwife.

- The RCOG Patient Information leaflet should be given and discussed with the mother following an event:
- https://www.rcog.org.uk/en/patients/patient-leaflets/shoulder-dystocia/ – opens in new tab.
- The healthcare professionals involved should also be offered the chance to discuss the case in a supportive environment.

Documentation

- Ensure clinical notes and Shoulder Dystocia proforma (Appendix 3) – opens in new tab are ***fully completed***.
- When the event is occurring. If available, a staff member should be asked to note times, manoeuvres and staff present on the proforma.
  - Head and body delivery times.
  - Staff attendance and the times they arrived.
  - Which manoeuvres were performed and their order.
  - The degree and direction of traction applied.
  - The anterior shoulder at the time of the dystocia.
  - Condition of the baby at birth.
  - Apgar's.
  - Cord PHs.
- Ensure case is Datix reported under 'maternity trigger'.
- Debrief woman and offer RCOG Shoulder Dystocia patient information leaflet.
- Ensure immediate paediatric review of newborn and ensure findings are clearly documented in baby notes.

Remember!
The majority of Shoulder Dystocias are unpreventable and unpredictable, and clinicians should be alert to the possibility of Shoulder Dystocia with any birth. All clinicians and midwives should attend mandatory annual training on PROMPT

Auditable standards

- Datix reporting of all Shoulder Dystocia incidents
- Audit completion of proforma in the event of Shoulder Dystocia
- Monitor neonatal outcomes following event

References

McFarland, M., et al., Are labor abnormalities more common in shoulder dystocia? Am J Obstet Gynecol, 1995. 173(4): p. 1211-4. 740.

Baskett, T.F. and A.C. Allen, Perinatal implications of shoulder dystocia. Obstet Gynecol, 1995. 86(1): p. 14-7. 742.

Gherman, R.B., J.G. Ouzounian, and T.M. Goodwin, Obstetric maneuvers for shoulder dystocia and associated fetal morbidity. Am J Obstet Gynecol, 1998. 178(6): p. 1126-30. 744.

Gross, T.L., et al., Shoulder dystocia: a fetal-physician risk. Am J Obstet Gynecol, 1987. 156(6): p.1408-18.

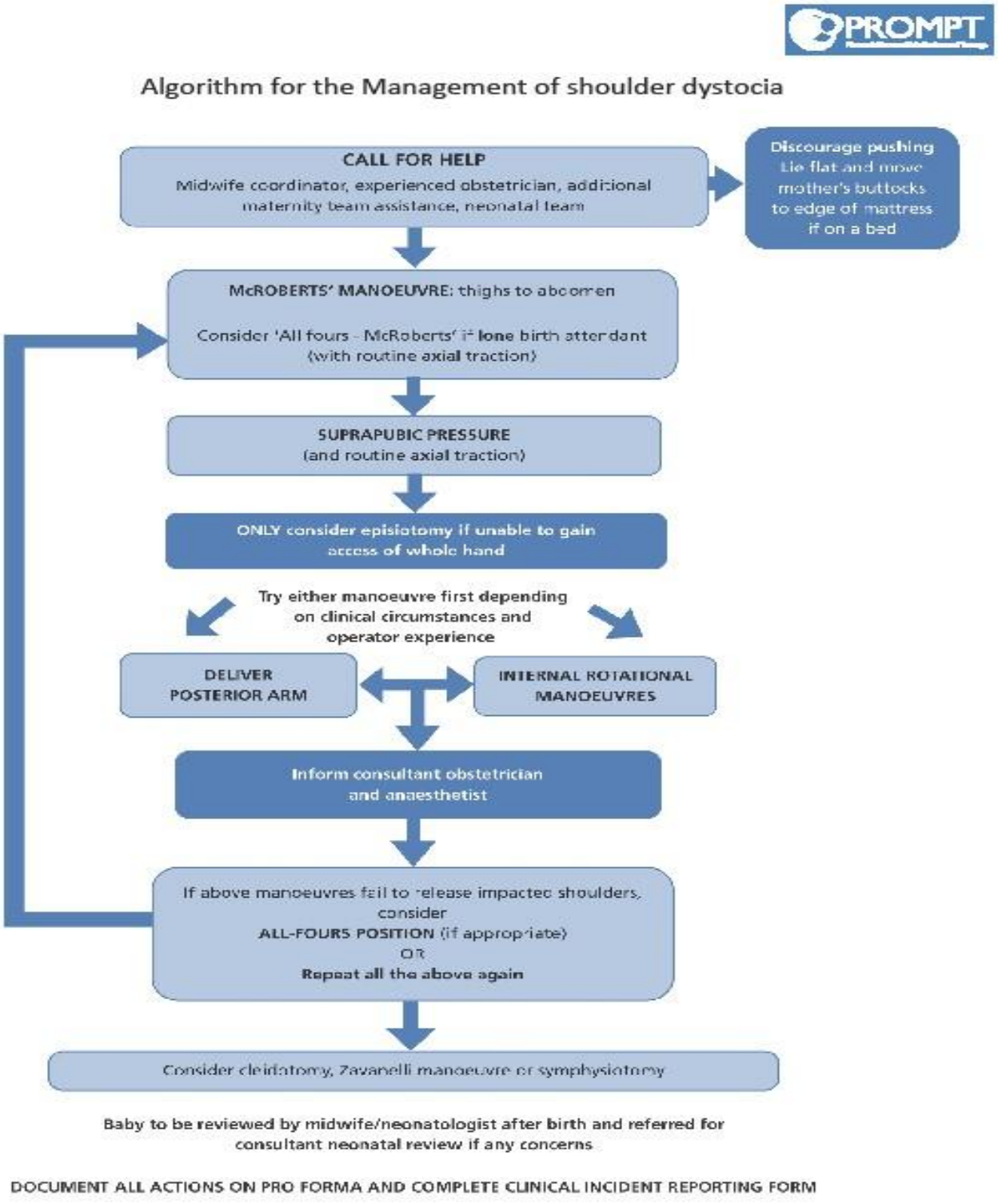
McFarland, M.B., et al., Perinatal outcome and the type and number of maneuvers in shoulder dystocia. Int J Gynaecol Obstet, 1996. 55(3): p. 219-24.

Ouzounian, J.G. and R.B. Gherman, Shoulder dystocia: Are historic risk factors reliable predictors? Am J Obstet Gynecol, 2005. 192(6): p. 1933-5.

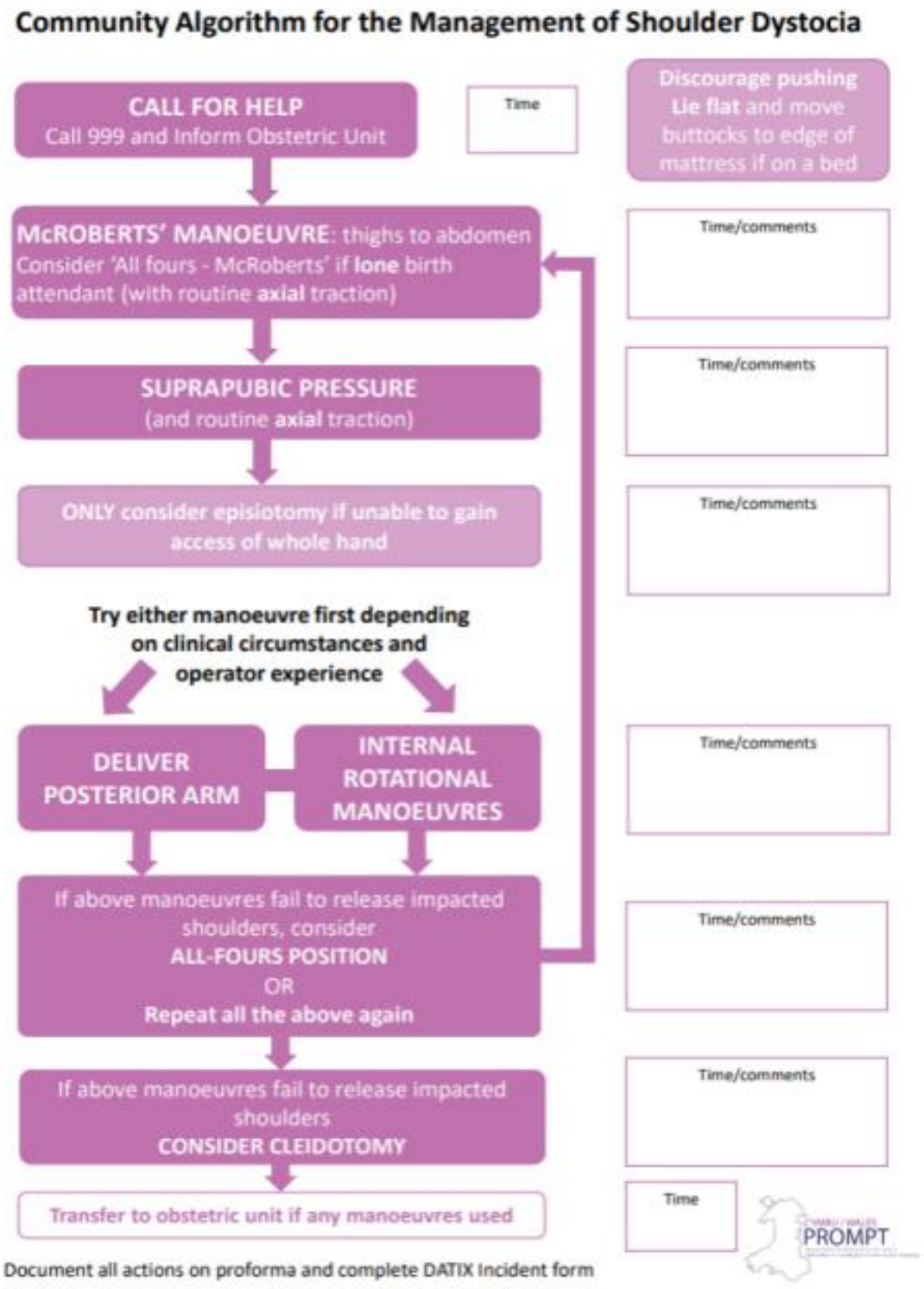
Winter,C. Crofts,J. Draycott,T (2017), PROMPT, Practical Obstetric MultiProfessional Training, Cambridge:Cambridge University Press.

RCOG. Green-top Guideline No. 42. (2012), Shoulder Dystocia.
Shoulder Dystocia (Green-top Guideline No. 42) | RCOG - opens in new tab

Appendix 1. PROMPT algorithm for management of shoulder dystocia



Appendix 2. Community Algorithm for management of shoulder dystocia



Appendix 3. PROMPT Shoulder Dystocia Proforma

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PROMPT

SHOULDER DYSTOCIA DOCUMENTATION

Date ..... Time .....

Person completing form .....

Designation .....

Signature .....

Mother's Name _____

Date of birth _____

Hospital Number _____

Consultant _____

Called for help at:			Emergency call via switchboard at:					
Staff present at birth of head:			Additional staff attending for birth of shoulders					
Name	Role		Name		Role		Time arrived	
Maternal position when shoulder dystocia occurred - please circle (i.e. prior to any procedures to assist)	Semi-recumbent	Lithotomy	Side-lying	All fours	Kneeling	Standing	Squatting	Other ...

Procedures used to assist birth	By whom	Time	Order	Details	Reason if not performed
McRoberts' position					
Suprapubic pressure				From maternal left / right (circle as appropriate)	
Episiotomy				Enough access / tear present /already performed (circle as appropriate)	
Delivery of posterior arm				Right / left arm (circle as appropriate)	
Internal rotational manoeuvre					
Description of rotation					
Description of traction	Routine (as for normal vaginal birth)	Other -		Reason if not routine	
Other manoeuvres used					

Mode of birth of head	Spontaneous		Instrumental – vacuum / forceps		
Time of birth of head		Time of birth of baby		Head-to-body birth interval	
Fetal position during dystocia	Head facing maternal left Left fetal shoulder anterior		Head facing maternal right Right fetal shoulder anterior		
Birth weight kg	Apgar	1 min :	5 mins :	10 mins :	
Cord gases	Art pH :	Art BE:	Venous pH :	Venous BE :	
Explanation to parents	Yes	By	Risk incident form completed if clinical concerns	Yes	N/A

Neonatologist called: Yes / No Time arrived: ..... Neonatologists name: .....

Baby assessment at birth (maybe done by M/W):			If yes to any of these questions, for review and follow up by Consultant neonatologist
Any sign of arm weakness?	Yes	No	
Any sign of potential bony fracture?	Yes	No	
Baby admitted to Neonatal Intensive Care Unit?	Yes	No	
Assessment by			

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