Shoulder Dystocia Guideline

Guideline Number:	604	Supersedes:		Classification	Clinical
LOCSSIP Reference:		NATSSIP Standard:	List standard (NATSSIPS Standards)		

Version No:	Date of EqIA:	Approved by:	Date Approved:	Date made active:	Review Date:
1	Standard EqIA	Obstetric Guideline and Audit Group	23.4.2019	30.7.2019	23.4.2022
		Extended whilst review is being undertaken - Obstetric Group	30.06.2022	08.07.2022	30.12.2022

Brief Summary of Document:	To provide early recognition and management of women who encounter shoulder dystocia.
Scope	All Maternity areas within Hywel Dda University Health Board. 'The term "woman/women" in the context of this document is used as a biologically based term and is not intended to exclude trans and non-binary people who do not identify as women.'

To be read in conjunction with:	• Intrapartum Continuous Fetal Monitoring Guideline • All Wales Midwife-led Care Guideline
Patient Information:	RCOG patient information leaflet. Shoulder Dystocia https://www.rcog.org.uk/en/patients/patient-leaflets/shoulder-dystocia/

Owning committee/	Obstetric Guideline and Audit Group.

group	

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	Guideline Update	23.4.2019

Glossary of terms

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

Keywords	Shoulder Dystocia, Brachial Plexus Injury, Humeral and Clavicular Fractures

Contents Page

1. Aim of Guideline

The aim of this guideline is to provide guidance and to standardise the recognition, management and documentation of Shoulder Dystocia.

2. Objectives

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

3. Scope

- Shoulder Dystocia is unpredictable and therefore difficult to prevent.
- During Shoulder Dystocia, traction should only be applied in an axial direction, using the same force as for a normal birth without Shoulder Dystocia.
- 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.
- Have awareness of the complications of Shoulder Dystocia, particularly that permanent brachial plexus injury is not inevitable.

4. Introduction

Shoulder Dystocia is defined as a vaginal cephalic birth that requires additional obstetric manoeuvres to assist the birth of the infant after gentle traction has failed. SD occurs when either the anterior shoulder impacts behind the maternal symphysis pubis or, less commonly, the posterior shoulder impacts over the sacral promontory.

5. Incidence

There is wide variation in the reported incidence of SD. Studies published between 1985 and 2016 reported incidences ranging from 0.1% to 3.0% of all births.

6. Risk factors for Shoulder Dystocia

A number of antenatal and intrapartum characteristics are widely recognised to be associated with Shoulder Dystocia. However, all of the characteristics are poorly predictive, and combining them is similarly poor. Conventional risk factors predicted only 16% of cases of Shoulder Dystocia that resulted in infant morbidity. Therefore, for practical purposes, because Shoulder Dystocia is not clinically predictable, all staff should be prepared for its occurrence at any vaginal birth:

- Previous Shoulder Dystocia
- Macrosomia
- Gestational Age
- Maternal Diabetes Mellitus
- Maternal Obesity
- Prolonged First Stage
- Prolonged Second Stage
- Labour Augmentation
- Operative Vaginal Birth

7. Recognition

- 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 turtle-neck” sign
- Failure to restitute
- The anterior shoulder fails to release with maternal effort and/or when routine axial traction is applied.
- If a woman is giving birth in a pool, she should be asked to get out of the pool as soon as the midwife identifies a delay with the birth of the shoulders. It may not be possible to confirm Shoulder Dystocia at this stage, but the woman should be safely moved out of the pool.
- No manoeuvres should be attempted in the pool.

8. Management

- Call for help (Experienced Obstetrician, Midwife coordinator, additional maternity team assistance, neonatal team, Anaesthetist, Theatre Team).
- Clearly state the Obstetric Emergency.
- Follow Algorithm for the Management of Shoulder Dystocia (appendix 1).

Never Perform:

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

9. Documentation

- Ensure clinical notes and SD Proforma (appendix 2) are fully completed.
- Ensure case is Datix reported under “maternity trigger”.
- Debrief woman offer RCOG SD information leaflet.
- Ensure immediate paediatric review of newborn and ensure findings are clearly documented in baby notes.

10 Communication

- Mothers with identifiable risk factors for shoulder dystocia should be informed about the incidence of its occurrence
- Following occurrence of shoulder dystocia the incident should be discussed with the mother 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/

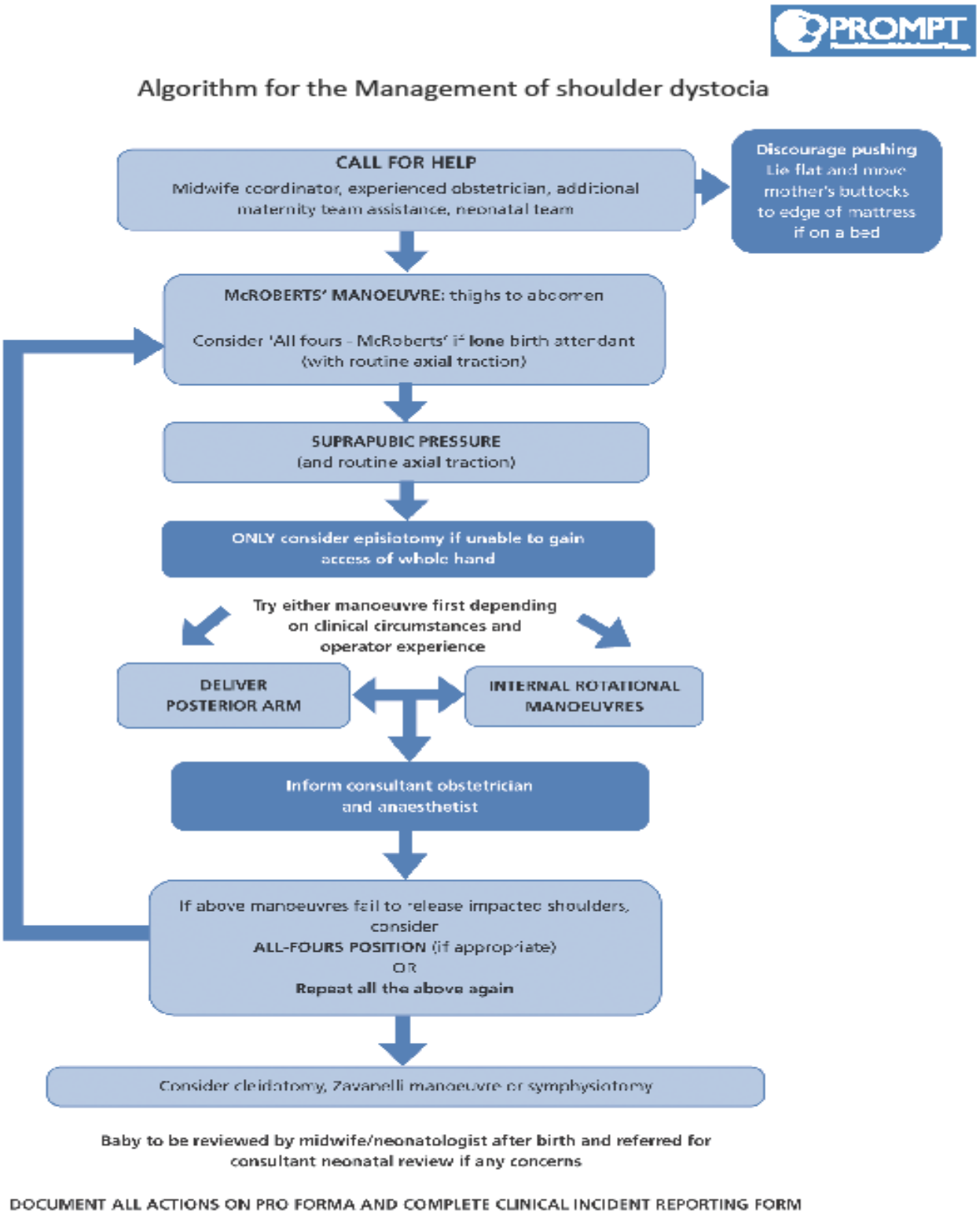
11 Auditable Standards

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

13. References

- Winter,C. Crofts,J. Draycott,T (2017), PROMPT, Practical Obstetric Multi-Professional Training, Cambridge:Cambridge University Press.
- RCOG. Green-top Guideline No. 42. (2012), Shoulder Dystocia.

Appendix 1. Algorithm for Management of Shoulder Dystocia



Appendix 2 (available from emergency folders in all areas)

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):		
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		

If yes to any of these questions, for review and follow up by Consultant neonatologist

Version 4.2

MCP 2920B