Guideline for the Management of Third Stage labour

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Definition:
The third stage of labour is the time from the birth of the baby to the expulsion of the placenta and membranes.

Management of the third stage
Discuss with the woman antenatally, during her initial assessment and in labour:

- The different options for managing the third stage of labour and what to expect with each option
- The benefits and risks associated with active and physiological management of the third stage

1. ACTIVE MANAGEMENT

This is recommended for all women who are highlighted as high risk using 'stage 0' of the Obs Cymru risk assessment.

Definition:
Active management of the third stage involves the following components:

1.1 Routine use of uterotonic drugs

Syntometrine (5 units syntocinon and 500mcg ergometrine) is to be administered intramuscularly immediately following delivery of the infant except in cases of: -

- Hypertension (blood pressure above 140/90 mmHg). Syntocinon 10 IU intramuscularly to be given
- Maternal Cardiac Disease. Syntocinon 10 IU intramuscularly to be given
- Multiple pregnancy - only given after last infant delivery
- Allergy
- Woman's choice to decline

NB. While the woman is in the birthing pool to give in the deltoid muscle

The administration of Syntometrine or Syntocinon should be discussed with the mother and administered with her informed consent.

1.2 Clamping and cutting of the cord

After administering the uterotonic, clamp and cut the cord, however:

- The options for managing cord clamping and the rationale should be discussed with parents before birth.
- Where immediate resuscitation or stabilisation is not required, aim to delay clamping the cord for at least 60 seconds. A longer period may be more beneficial.
- Clamping should ideally take place after the lungs are aerated.
- Where adequate thermal care and initial resuscitation interventions can be safely undertaken with the cord intact, it may be possible to delay clamping whilst performing these interventions.

Preterm infants

Preterm babies should be managed in the same way as term babies with these considerations:

- Consider alternative/additional methods for thermal care e.g. polyethylene wrap.
- Gently support, initially with CPAP, if breathing.

1.3 Controlled cord traction

After cutting the cord, perform controlled cord traction as part of active management only after administration of oxytocin and signs of separation of the placenta.

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. PHYSIOLOGICAL MANAGEMENT

Definition:

Physiological management of the third stage includes the following three components:

1. No routine use of uterotonic drugs
2. No clamping of the cord until pulsation has ceased
3. Delivery of the placenta by maternal effort within one hour, by maternal effort only. Management should never include pulling the cord or palpating the uterus.

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

- Haemorrhage
- Failure to deliver the placenta within one hour
- The woman's desire to artificially shorten the third stage.

2.1 Observations in the third stage of labour

- General physical condition of the woman, as shown by her colour, respiration and her own report of how she feels.
- Cumulative blood loss measurement

In addition, in the presence of haemorrhage, retained placenta or maternal collapse, or any other concerns about the woman's wellbeing:

- Transfer the woman to obstetric led care
- Carry out frequent observations to assess whether resuscitation is needed. Observations must be documented on a MEWS chart

Management of retained placenta

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

- Conservative management of retained placenta if the woman is not bleeding includes;
  - Putting the baby skin to skin with woman and offer a breast feed if that is the woman's preferred method of feeding. If the woman does not wish to breastfeed, consider nipple stimulation following discussion with woman
  - Empty bladder, either asking woman to sit on bedpan or offer in out catheter
  - Change position to upright position

- Intravenous access should always be secured in women with a retained placenta and bloods taken for FBC and group and save.
- Do not use umbilical vein agents if placenta is retained.
- Do not use intravenous oxytocic agents routinely to deliver a retained placenta.
- Only give intravenous oxytocic agents if the placenta is retained and the woman is bleeding excessively.
- If the placenta is retained and there is concern about the woman's condition, the woman should be offered an assessment of the need to remove the placenta. Women should be informed that this assessment can be painful and they should be advised to have analgesia or even anaesthesia for this assessment.
- If a woman reports inadequate pain relief during the assessment, the healthcare professional must immediately stop the examination and address this need immediately.
- If uterine exploration is necessary and the woman is not already in an obstetric unit arrange urgent transfer.
- If in a community setting consider giving a 2nd syntometrine if active bleeding
- If manual removal of the placenta is required, this must be carried out under effective regional anaesthesia (or general anaesthesia when necessary) by a trained obstetrician.

2.2 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 MEWS chart

References

National Institute of Clinical Excellence. Clinical Guideline. Intrapartum Care 2023

RESUSCITATION COUNCIL UK 2021 GUIDELINES: Newborn resuscitation and support of transition of infants at birth Guidelines

Directorate of Women & Child Health

Checklist for Clinical Guidelines being Submitted for Approval

by Quality & Safety Group

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