GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Guideline For Management of Third Stage of Labour

Author:	Maternity Services
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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.

ACTIVE MANAGEMENT – this is advised for all women in the medium to high risk categories with the Consultant as the Lead Professional

Definition: Active management of the third stage involves a package of care which includes all of the following three components:

1. Routine use of uterotonic drugs

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

a) Hypertension (diastolic above 90 mmHg) **Syntocinon 10 units IM** to be given
b) Maternal Cardiac Disease give **Syntocinon 10 units IM**
c) Multiple pregnancy - only given after last infant delivery
d) Allergy
e) Woman's choice to decline
f) While the woman is in the birthing pool

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

2. Cutting and clamping of the cord.

Current evidence suggests delaying clamping of the umbilical cord in healthy term infants for at least one minute or until the cord stops pulsating which improves iron status through early infancy. For preterm babies in good condition at delivery, delaying cord clamping for up to 3 minutes results in increased blood pressure during stabilisation, lower incidence of intraventricular haemorrhage and fewer blood transfusions. However babies were more likely to receive phototherapy. There is insufficient evidence to define an appropriate time to clamp the cord in babies'

apparently needing resuscitation (Tolosa J.N. et al 2010) (Resuscitation Council UK 2010). This guideline therefore suggests current clinical practice should reflect this recent evidence.

3. Controlled cord traction

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.

PHYSIOLOGICAL MANAGEMENT – can be offered to low risk women where the midwife is the lead professional

Further research is needed on the third stage management of women using hydrotherapy as there is currently no reliable evidence that can be used to inform women regarding the benefits and risks of experiencing the third stage of labour under water. Therefore the woman should be asked to leave the pool for delivery of the third stage.

Definition: Physiological management of the Third Stage involves a package of care which includes all of 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.

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.
- Vaginal blood loss

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

- Transfer her to Obstetric led care
- Carry out frequent observations to assess whether resuscitation is needed

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 60 minutes with physiological management.

- 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.
- 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, women 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 women 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 manual removal of the placenta is required, this must be carried out under effective regional anaesthesia (or general anaesthesia when necessary).

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 MEW's chart

References

National Institute of Clinical Excellence. Clinical Guideline . Intrapartum Care, care of healthy women and their babies during childbirth CG 190 -2017

Resuscitation guidelines. Resuscitation Council UK 2015

Directorate of Women & Child Health

Checklist for Clinical Guidelines being Submitted for Approval

by Quality & Safety Group

Title of Guideline:	Guideline for the Management of 3rd Stage of Labour
Name(s) of Author:	
Chair of Group or Committee supporting submission:	Labour Ward Forum
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* To be completed by Author and submitted with document for ratification to Clinical Governance Facilitator