Protocol – Management of the Third Stage of Labor

Definition: "The third stage of labor begins with the birth of the baby and ends with the birth of the placenta" (Tharpe et al., 2017).

Main Concern Excessive Blood Loss:

"Postpartum hemorrhage (PPH) and blood loss complications constitute one of the most common causes of maternal mortality and morbidity" (Güngördük et al., 2018). It is a potentially life-threatening, preventable condition, that persists as a leading cause of maternal death, even in developed countries. Proper management of the third stage may help prevent severe PPH and maternal morbidity and mortality.

Watch for rapid weak pulse, a drop in blood pressure, pale and cold skin, shortness of breath, feeling that they can't get enough air, or sweating. Changes may be slow at first and then suddenly pulse rises and BP drops.

Check for uterine atony, massage fundus until firm, administer synthetic uterotonics, use bimanual compression if necessary.

Inspect for lacerations, locate source of bleeding, clamp vessel, pack if needed, repair immediately.

If placenta is not complete perform manual exploration of uterus and removal of placental fragments.

Monitoring and Assessing:

Monitor maternal vital signs (BP, pulse, and temperature), monitor and assess bleeding and estimate blood loss, and monitor and assess uterine involution after delivery of the placenta.

Monitor fetal vital signs (HR, respirations, and temperature), and general transition to extrauterine life.

Delivery of the Placenta:

Observe client for signs of placental separation including a gush of blood, cord lengthening, a rise in the uterus when firm and round.

Follow expectant, active, or mixed management.

If placenta does not come within 1 hour, begin plant-based stimulants or synthetic uterotonics. For those with higher risk use active management.

Verify that the placenta is intact through visual examination of all surfaces, note the size, feel the maternal side searching for any missing pieces, identify the type of cord insertion and examine vessels (1 vein 2 arteries), look for any identifiable changes in placenta including calcification.

Offer to show the placenta to family, discuss plans for placenta.

Expectant Management (Physiologic):

"Expectant management of the third stage of labour is commonly only considered appropriate following a labour where there has been no interference with the natural release of oxytocin, for example, where oxytocin augmentation, induction, epidural or narcotic analgesia, or both, have not been used" (Begley et al., 2019). It is also only considered appropriate for those who are not at risk for hemorrhage, do not have a history of PPH, bleeding disorders, or other conditions that might influence the body's natural ability to attain hemostasis.

After birth of baby, facilitate skin-to-skin and encourage breastfeeding, delay clamping the cord until done pulsating or at least 3 minutes, watch for signs of placental separation for up to 1 hour, once separated client can push placenta out on their own, squatting may be helpful, midwife may use gentle cord traction while guarding the uterus to guide placenta out,

After birth of the placenta check for firmness, encourage breastfeeding to help with natural oxytocin release, massage uterus only if necessary, encourage client to empty bladder, if placenta does not come naturally within 1 hour use plant-based stimulants (Castor oil, Cotton root, crampbark, Motherwort, Red raspberry, Evening primrose oil, Yarrow, Black and blue cohosh), synthetic oxytocin only for uterine atony (10 IU intramuscular).

Active Management:

"Active management of the third stage of labour reduces the risk of postpartum blood loss (postpartum haemorrhage (PPH)), and is defined as administration of a prophylactic uterotonic, early umbilical cord clamping and controlled cord traction to facilitate placental delivery" (Salati et al., 2019).

Administer uterotonic drug (synthetic oxytocin) after the birth of the fetal head or with the birth of anterior shoulder or as soon as possible afterwards, double clamp and cut the cord, wait for signs of placental separation, once separated firmly grasp the clamp, and apply controlled cord traction while guarding the uterus with other

hand, when placenta is visible in vagina guide it out, if any trailing membranes twist out, have client cough repeatedly to tease membranes out completely.

Mixed Management:

Mixed management includes using at least one of the procedures from active management combined with at least one of the procedures from expectant management. This course of treatment may be appropriate for those with a history of PPH that desire a physiologic birth or for those with other risk factors.

Research suggests that just giving a uterotonic without the other parts of active management might be sufficient at reducing severe bleeding.

The National Institute for Health and Care Excellence (NICE) recommends active management with delayed cord clamping…" (Tharpe et al., 2017).

Estimation of Blood Loss:

"To obtain a reasonable idea of the amount of blood lost, an estimate is made and the figure is doubled" (Posner et al., 2013).

Palpate the uterus often to make sure it is not filing with blood, save used chux pads to estimate blood loss or weigh used pads for a more accurate estimate, if in water estimate by how clear water is, save any blood or clots that came out with the placenta to add to the estimate.

Laceration Assessment:

Evaluate the Perineum, Vagina, Periurethral area, Labia, Cervix and Rectum for abrasions, tears, and lacerations.

Repair any damage as needed, if repair is out of scope transfer care for repair.

For perineal swelling apply cold pack, comfrey compress, or arnica oil.

Transfer Care for:

Retained placenta, placental abruption, severe hemorrhage, 3rd or 4th degree tear or complicated 2nd degree tear, or any other complications that are out of the scope of midwifery care.

References

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