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midwifery birthcentre

INCLUDED IN THIS PACK:

- Breech Birth
- Cord Prolapse
- Shoulder Dystocia
- Vaginal Examination
- Shoulder Dystocia Risk
- Uterine Hyperstimulation
- Persistent Hyperstimulation
- Hyperstimulation/Tachystole
- Third Stage Management Active
- Third Stage Management Physiological
- Retained or Incomplete Placenta

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BIRTH CENTRE

BREECH BIRTH

BREECH - The buttocks, foot or feet are presenting instead of the head.

- **FRANK:** Hips flexed, legs extended.
- **COMPLETE:** Hips and knees flexed, the breech is presenting.
- **FOOTLING:** One or both feet are presenting.

DO NOT PULL ON THE FETUS UNTIL THE UMBILICUS IS VISIBLE, AND EVEN THEN TRACTION IS NOT NECESSARY IF THE BIRTH CONTINUES TO PROGRESS

LEGS: may birth spontaneously. If not assist by inserting a finger behind the knee to flex the knee and abduct the thigh.

- Gentle downward traction to birth the torso towards the floor at a 45-degree downward axis. (grasp fetal pelvis with thumbs on the sacroiliac regions).
- Never pull on the body. (this extends the Arms & Head).

TRUNK: may occur quickly and without effort. If required rotation of the fetal back from one anterior oblique to another (Lovsett Maneuver) this encourages the fetal arms to gather in a flexed position across the chest.

*KEEP THE BACK UPPERMOST DURING BIRTH TO ENABLE THE FETAL HEAD TO ENTER THE PELVIS OCCIPUT ANTERIOR

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BIRTH CENTRE

THIRD STAGE MANAGEMENT PHYSIOLOGICAL

ALLOW THE PLACENTA AND MEMBRANES TO BE BIRTHED BY MATERNAL EFFORTS.

- Placental Separation and expulsion spontaneous without intervention.
- No oxytocic drug is administered.
- Third stage may take 15-60 minutes.

MANAGEMENT

Wait for S & S of separation and descent of the placenta.

- Small fresh blood loss.
- Lengthening of the cord.
- Fundus becomes rounder and smaller.

IF THE PLACENTA AND MEMBRANES REMAIN INSITU AFTER 30 MIN, NOTIFY RMO.

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BIRTH CENTRE

HYPERSTIMULATION/TACHYSYSTOLE

THIS MAY CAUSE DISRUPTION TO PLACENTAL BLOOD FLOW THAT MUST BE MANAGED PROMPTLY.

The goal is to maintain normal labour uterine patterns for all stages of labour. (+/- Oxytocin, induction agents)

1ST STAGE OF LABOUR - Aim to maintain 4 contractions in 10mins and minimum relaxation time of 60 seconds.

2ND STAGE OF LABOUR - Aim to maintain 5 contractions in 10mins and minimum relaxation time of 45-50 seconds.

MAY OCCUR WITH OR WITHOUT FETAL HEART RATE/CTG CHANGES.

NON REASSURING FEATURES:

- Rising baseline - uncomplicated baseline 100-109 or 161-170
- reduced variability - variable decelerations

(2 or more of these features = ABNORMAL)

ABNORMAL FEATURES:

- Tachycardia - bradycardia - prolonged decelerations
- complicated variable decelerations - late deceleration
- absent variability - saltatory (increased variability)
- sinusoidal.

THE INTRODUCTION OF OXYTOCIN TO STABILISE CONDITION SHOULD FOLLOW LOCAL PROTOCOL AND MEDICAL ADVICE

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BIRTH CENTRE

CORD PROLAPSE

THE UMBILICAL CORD LIES IN FRONT OF OR BESIDE THE PRESENTING PART IN THE PRESENCE OF RUPTURED MEMBRANES.

INCIDENCE

- 0.2-0.5% of births.

RISK FACTORS

- High/ill fitting presenting part.
- High parity.
- Prematurity.
- Multiple Pregnancy.
- Polyhydramnios.
- Malpresentations.
- Obstetric manipulation.

DIAGNOSIS

- Visual inspection or palpation during Vaginal Examination (VE) where the umbilical cord is felt below or beside the presenting part.
- Suspected if CTG abnormality (bradycardia, severe variable decelerations), soon after spontaneous or artificial rupture of membranes.
- If there are predisposing risk factors, a VE should be performed after rupture of membranes or if there is fetal bradycardia after rupture of membranes.

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