Clinical Practice Procedures:
Obstetrics/Physiological cephalic birth

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<td>Purpose</td>
<td>To ensure a consistent procedural approach for Physiological cephalic birth.</td>
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<td>Scope</td>
<td>Applies to all QAS clinical staff.</td>
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Physiological cephalic birth

Birth is a critical stage in foetal development, representing a transition from direct maternal support to establishment of the newborn’s own respiratory, circulatory and digestive systems.

Labour is defined as the process by which the foetus, placenta and membranes are expelled via the birth canal. In normal labour:

- The foetus presents by the vertex
- The occiput rotates anteriorly
- The result is the birth of a living, mature foetus (37–42 weeks) with no complications

**Indications**
- To assist a woman in labour to deliver her newly born

**Contraindications**
- Breech delivery
- Normal transport to hospital is a viable option

**Complications**
- Malpresentation
- Cephalopelvic disproportion
- Shoulder dystocia
- Infection
- Postpartum haemorrhage
- Prolapsed cord
- Inversion of the uterus
- Amniotic embolism
The following procedure has been adapted from guidelines provided by the World Health Organisation.[2]

**MANAGEMENT**

- Assess the mother and foetus and provide basic cares, including adequate history taking.
- If the membranes have ruptured, note the colour of the draining amniotic fluid.
- Cord presentation or prolapse should be excluded by visual inspection and/or asking the mother to feel for the cord.
- Ensure adequate maternal and foetal oxygenation.
- When delivery is imminent, allow the mother to assume the position she prefers and encourage her to push.

**1. Birth of the head**

a) Ask the mother to pant or give only small pushes with contractions as the baby’s head delivers.

b) To control birth of the head, place the flats of the fingers of one hand against the baby’s head to keep it flexed (bent) and prevent explosive delivery of the head.

c) Once the baby’s head delivers, encourage the mother to continue pushing with each contraction to deliver the shoulders.
d) **If the cord is loosely around the baby’s neck**, gently slip it over the baby’s head.

![Diagram showing a loose cord around the baby's neck]

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e) **If the cord is too tight to slip over the baby’s body but not tight around the neck**, slip it over the shoulders as the baby’s body is born and deliver the baby through the cord.

![Diagram showing the cord slipping over the shoulders and delivering the baby through the cord loop]

**NOTE:** If there is difficulty delivering with the umbilical cord refer to CPP: Nuchal cord.
f) Allow the baby’s head to turn spontaneously.

g) After the head turns, place a hand on each side of the foetal head. Ask the mother to push gently with the next contraction.

h) Move the baby’s head posteriorly to deliver the shoulder that is anterior.

NOTE: If there is difficulty delivering the shoulders, refer to CPG: Shoulder dystocia.
Procedure – Physiological cephalic birth

i) Lift the baby’s head anteriorly to deliver the shoulder that is posterior.

j) Support the baby at all times during the delivery.

k) Place the baby on the mother’s abdomen early and ensure skin to skin contact. Ensure both mother and baby are kept warm.
2. Care of the newly born (postnatal cares)

a) Thoroughly dry the newborn, wipe the eyes and assess the newborn’s breathing.

b) If the newborn is crying or breathing effectively (chest rising at least 30 times per minute) leave the newborn with the mother. If the newborn is not breathing effectively, immediately refer to CPG: Resuscitation – Newly born.

c) Ensure the newborn is kept warm and heat loss is minimised – if required use the baby blanket and beanie from the QAS ‘Maternity Pack’.

d) Assess neonatal and maternal observations:
   - Neonatal observations: APGAR (at 1 and 5 minutes), HR, RR, Temp and muscle tone – every 15 mins
   - Maternal: HR, BP, Temp, PV loss and fundal check – every 15 mins

e) Cord clamping and cutting:
   - Late cord clamping and cutting (3–5 minutes following birth) is recommended for all births, while initiating simultaneous essential neonatal care. Immediate cord clamping (< 1 minute following birth) should only be performed if the newly born is asphyxiated and needs to be moved immediately for resuscitation.[4,5,6,7]
   - Some mothers may request the cord remain intact with placenta attached (not clamped or cut). This request should be respected unless the newborn is required to be moved for resuscitation.

f) If the mother consents, clamp the cord at 10, 15 and 20 centimetres from the newborn and cut between 15 and 20 centimetres.

g) Provide a safe warm environment with uninterrupted skin to skin contact. Encourage breast feeding to promote the production of maternal oxytocin.
3. **Active management of the third stage of labour (oxytocin administration)**

   a) Promote maternal production of oxytocin by providing a safe, warm environment with uninterrupted skin to skin contact between mother and baby, and encourage breastfeeding.

   b) Administer oxytocin (refer to DTP: Oxytocin).

   c) Observe for and confirm signs of placental separation:
      - The uterus rises in the abdomen
      - The uterus becomes firmer and globular (ballotable)
      - Fresh show/trickle of blood
      - Lengthening of the umbilical cord.

   d) Delivery of the placenta.
      - Assist the mother to birth the placenta by her own efforts. Encourage her to adopt an upright position, bearing down to expel the placenta; OR
      - Guard the uterus by placing one hand suprapubically and applying steady controlled cord traction until the placenta is visible. Support the birth of the placenta and membranes by gently twisting to strengthen the placenta and limit the chance of retained products – do not apply increased traction if resistance is felt.

   e) Retain the placenta for visual inspection by the midwife and/or doctor.

   f) Complete a fundal assessment:
      - If the uterus is soft – massage the fundus until it is firm and central. Consider asking the mother to pass urine, as a full bladder can inhibit the contraction of the uterus. Fundal massage is only to be performed following delivery of the placenta.
      - If the uterus is firm – do not massage the fundus as this may cause further bleeding and pain for the mother.

   g) Assess and estimate blood loss (normally around 200–300 mLs).
4. **Physiological management of the third stage of labour (refusal of oxytocin)** [8]

   a) Promote maternal production of oxytocin by providing a safe, warm environment with uninterrupted skin to skin contact between mother and baby, and encourage breastfeeding.

   b) Assist the mother to birth the placenta naturally by her own efforts. Encourage her to adopt an upright position, bearing down to expel the placenta.

   c) Do **not** apply cord traction.

   d) Once the placenta has been delivered, retain for visual inspection by the midwife and/or doctor.

   e) Complete a fundal assessment:
      
      - If the uterus is soft – massage the fundus until it is firm and central. Consider asking the mother to pass urine, as a full bladder can inhibit the contraction of the uterus. Fundal massage is only to be performed **following** delivery of the placenta.
      
      - If the uterus is firm – do **not** massage the fundus as this may cause further bleeding and pain for the mother.

   f) Assess and estimate blood loss (normally around 200–300 mLs).

**NOTE:** If blood loss exceeds 500 mL, refer to CPG: Primary postpartum haemorrhage
**Additional information**

The QAS supplies a sterile 'Maternity Kit' which contains the following:

- 4 x Umbilical Cord Clamps
- 1 x gown (XL)
- 5 x gauze swab (10cm x 10cm)
- 1 x face mask
- 2 x baby blanket
- 2 x combine dressing (20cm x 20cm)
- 2 x sealable bag
- 1 x infant cap (beanie)
- 1 x booties set
- 2 x absorbent underlay (60cm x 40cm)
- 2 x obstetric pad
- 1 x scissors
- 1 x APGAR Score Label