Clinical Practice Procedures: Obstetrics/Physiological cephalic delivery

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Purpose: To ensure a consistent procedural approach for Physiological cephalic delivery.

Scope: Applies to all QAS clinical staff.

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URL: https://ambulance.qld.gov.au/clinical.html
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 labouring woman in the delivery of 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

Figure 3.75
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 examination in labour after spontaneous rupture of membranes (ask mother to feel for the cord).
- Ensure adequate maternal and foetal oxygenation.
- When delivery is imminent, allow the woman to assume the position she prefers and encourage her to push.

1. **Birth of the head**
   
   a) Ask the woman to pant or give only small pushes with contractions as the baby’s head delivers.
   
   b) To control birth of the head, place 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, ask the woman to cease pushing.

*Head is delivered and women ceases pushing*
d) **If the cord is loosely around the baby’s neck**, gently slip over the baby’s head.

![Loose cord](image)

![Slip cord over head](image)

**NOTE:** If there is difficulty delivering with the umbilical cord, see CPP: Nuchal cord

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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.

![Cord too tight to slip over baby’s head but not tight around the neck](image)

![Slip cord over baby’s shoulders](image)

![Delivery of the baby through the cord](image)

![Continued delivery of the baby through the cord](image)
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.

f) Allow the baby’s head to turn spontaneously.

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

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

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

j) Support the rest of the baby’s body with one hand as it slides out.

k) Place the baby on the mother early to ensure skin to skin contact. If baby is well, the baby should stay with the mother skin to skin for transport to hospital. Cover both and keep baby warm.
2. Care of the newly born (postnatal cares)

a) KEEP THE NEWLY BORN WARM

b) Assess breathing or crying, muscle tone, heart rate – CPG: Resuscitation – Newly born

c) Place the newborn on the mother’s abdomen, providing skin to skin contact.[3] Thoroughly dry the baby, wipe the eyes and assess the newborn’s breathing.

d) If the newborn is crying or breathing (chest rising at least 30 times per minute) leave the newborn with the mother.

e) KEEP THE NEWLY BORN WARM by skin to skin contact with mother, cover head.

f) Assess APGAR score at 1 and 5 minutes, then assess mother and newborn continually very five minutes.

g) Late cord clamping (performed approximately 3–5 min after birth) is recommended for all births, while initiating simultaneous essential neonatal care.[4,5,6,7]

h) Cord clamping (< 1 minute after birth) is not recommended unless the neonate is asphyxiated and needs to be moved immediately for resuscitation.[4,5,6,7]

i) If possible attempt initial ventilations with cord unclamped to maximise placental shunt to the baby.

j) Clamp cord at 10, 15 and 20 centimetres from the newborn and cut between 15 and 20 centimetres.

k) KEEP THE NEWLY BORN WARM, ensure the newborn is kept warm en route to the receiving facility, maintain skin-to-skin with the mother and cover the newborn’s head and back with a warm blanket, skin-to-skin contact between a mother and her baby at birth reduces crying, and promotes breast-feeding.[3]

l) The mother may breastfeed if she wishes.
3. **Physiological management of the third stage of labour**

*(refusal of oxytocin)* \(^8\)

Delay clamping and cutting of the umbilical cord for at least 3–5 minutes, until the cord stops pulsating or when the placenta and membranes have been birthed, depending on the mother’s request.

   a) Provide a safe, warm environment, with uninterrupted skin to skin contact between mother and baby, encourage breastfeeding.

   b) Clamp and cut cord (if not already).

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

   d) Do not pull on the cord or apply fundal massage. Massaging a fundus that is firm, central and contracted may interfere with normal placental post birth separation and worsen bleeding.

   e) Deliver placenta into a bowl or plastic bag and keep with blood loss for inspection by midwife or doctor.

   f) Fundal massage should only be applied when placenta is birthed, massage the fundus until it is firmly contracted.

   g) Assess and estimate blood loss (should be 200–300 mLs).

**NOTE:** *Should blood loss exceed 500 mL, see CPG: Primary post-partum haemorrhage*
4. Active management of the third stage of labour (oxytocin administration)

   a) Prepare Oxytocin as per DTP when birth is imminent.

   b) Provide a safe, warm environment, with uninterrupted skin to skin contact between mother and baby, encourage breastfeeding.

   c) When the cord stops pulsating (3–5 mins post birth), administer Oxytocin according to the DTP.

   d) Observe the 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.

   e) Clamp and cut the cord.

   f) Guard the uterus by placing a hand suprapubically and apply steady cord traction until placenta is visible, then support birth of the placenta and membranes.

   g) Do not apply increased traction to cord if resistance is felt.

   h) Apply fundal massage after (never before) the placenta is birthed until it is firm and contracted.

   i) Assess and estimate blood loss (should be 200–300 mLs).