



Consensus Statement: **Facilitating the Birth of the Placenta**

This guideline concerns the management of labour in the period from the birth of the baby until the complete birth of the placenta/whenua and membranes, also known as the third stage of labour .

The birth of the placenta is a part of the continuum of birth, a time of adjustment. The woman is becoming a mother and adjusting to the hormonal, physical and emotional changes that follow birth. Her baby is adjusting to extra-uterine life [1]. Uninterrupted mother and baby contact (skin to skin is optimal) in a calm warm environment can support the natural production of oxytocin, thereby sustaining uterine contraction and supporting breastfeeding initiation [2].

Rationale

The New Zealand College of Midwives (Inc) recognises that women can expect physiological placental birth when they have had a physiological labour and birth [3]. Women should receive information during pregnancy in relation to the management of the birth of the placenta. There is emerging evidence that for low risk women, supporting physiological third stage is a safe option [4, 5]

Guidelines/Recommendations:

Midwives must be competent in both supporting physiological placental birth, and implementing active management of the birth of the placenta. Midwives must also recognise the need to change from physiological to active management when appropriate, while having an awareness of the potential benefits of physiological birth to both the woman and her baby.

When there has been an identified intervention in labour or birth or when the woman has an increased risk of post partum haemorrhage (PPH), active management of the third stage should be considered as the first option.

The woman continues to be assessed for blood loss and any physiological impact of this loss during both physiological placental birth and active management of the third stage.

Midwives must always have uterotonic drugs and the necessary emergency equipment immediately at hand when attending a birth. To the best of their abilities, midwives should ensure that all uterotonic drugs are stored according to the manufacturer's recommendation.

Following the birth of the baby the midwife unobtrusively [6]:

- Facilitates undisturbed maternal baby interaction, encourages skin to skin contact; keeps mother and baby warm.
- Encourages the woman to adopt a comfortable position for her – preferably upright to aid descent of the placenta and observation of blood loss.

Physiological Placental Birth (Expectant or watchful waiting [6])

Following a physiological labour and birth the midwife does not administer an uterotonic.

Controlled cord traction is not used.

The cord is left alone until either it stops pulsating, or preferably, the placenta is born so the baby receives an optimal blood supply to start extra uterine life, the cord may then be clamped/tied and cut. The decision to clamp and cut the cord should be on a case by case basis and in accordance with the woman's wishes. This may include keeping the cord intact for those choosing a lotus birth.

The midwife may unobtrusively observe for signs of placental separation. These are:

- The woman may become uncomfortable, experience contractions or feel that she wants to change her position. She may also indicate heaviness in the vagina and a desire to bear down.
- There may be some blood loss from separation bleeding.
- The uterus may be observed to become smaller, rounder and the fundus may rise in the abdomen and become more mobile.

Once there are signs of placental separation or if the woman is uncomfortable [6]:

- The mother's position may be changed (support upright positions) to aid the descent of the placenta (e.g. kneeling or squatting position).
- Encourage maternal effort to expel the placenta.
- If the placenta is in the vagina gentle traction on the cord may be used to guide the placenta out.
- A relaxed atmosphere, privacy and emptying the bladder may help to facilitate placental birth.

Once separated the placenta may be caught in cupped hands or a container (a container that has held food may be culturally unacceptable). The midwife can assist slow membranes to be born complete by holding the placenta in two hands and gently turning until the membranes are twisted, then exert gentle tension to complete the birth [6] or by asking the woman to cough.

Practice Notes:

- Cord blood may be collected from the large vessels on the surface of the placenta.
- If the baby requires resuscitation there are some indications that it may be beneficial to leave the cord intact for resuscitation efforts, as long as resuscitation can be managed optimally [7-9].

**Controlled cord traction must NOT BE USED
unless an uterotonic drug has been administered**

Active care of the Third Stage of Labour [10]

- To support neonatal transition and the equilibrium of blood volume the cord is not clamped and cut for at least 3 minutes following the birth [7-9, 11].
- When cord clamping is delayed the optimal timing for administration of the uterotonic is currently unknown and the effect of the administration of an uterotonic on neonatal health when given prior to clamping of the cord is also unknown. Until further evidence to support practice is collated, it is advised that the uterotonic drug of choice be administered after the cord has been clamped and cut.
- The placenta is born by maternal effort or controlled cord traction. Controlled cord traction is regarded as optional (except when syntometrine/ergometrine has been administered) and dependent on whether the woman and the midwife consider the small reduction in blood loss and small reduction in the duration of the third stage as important [12].
- If using controlled cord traction, wait for signs of placental separation [13]. The uterus is supported suprapubically with one hand while continuous tension is applied to the cord in a downward direction following the pelvic arc.
- Once separated the placenta may be caught in cupped hands or a container (a container that has held food may be culturally unacceptable).
- The midwife can assist slow membranes to be born complete by holding the placenta in two hands and gently turning it until the membranes are twisted, then exert gentle tension to complete the birth [6] or by asking the woman to cough.

Care following the birth of the placenta

- The uterus is assessed regularly to ensure that it is well contracted and bleeding is minimal.
- If there is bleeding present the uterus is massaged firmly until the bleeding stops. Uterotonic administration (or repeated administration) is considered if bleeding becomes heavy. The woman's health is assessed frequently to ensure there are no adverse effects to the woman's health.

Women and their whanau are the decision makers in the disposal of the whenua/placenta following birth.

Length of third stage and retention of placenta

There is little consensus as to the length of the third stage and when a placenta should be defined as "retained" and intervention initiated.

The following timelines have been provided as a guide only and based on available evidence. The context of care, the place of birth, the length of time required for transfer, blood loss and the type of third stage care undertaken will all have an impact on decision making.

- During a physiological third stage and in the absence of bleeding the third stage may last more than an hour without an increased risk of PPH [4].
- For an active third stage if the placenta has not separated and delivered within 30 minutes further treatment and/or consultation should be considered [12]. If there is no bleeding the woman can be observed for a further 30 minutes before treatment for retained placenta is initiated [12].

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Ratification:

This statement was ratified at the NZCOM AGM on 14th August 2013

Original Statement ratified May 2006

References updated August 2013

The purpose of New Zealand College of Midwives Consensus Statements is to provide women, midwives and the maternity services with the profession's position on any given situation. The guidelines are designed to educate and support best practice.
All position statements are regularly reviewed and updated in line with evidence-based practice.