Imminent Unplanned Birth at a Non-Birthing Site Policy

1. Purpose

Every year in the WA Country Health Service (WACHS) there are on average ten imminent unplanned births in emergency departments (ED) of non-birthing sites. These hospitals often do not have consistent on-site access to midwifery expertise or medical practitioners with obstetric experience.

Ideally the pregnant woman is to be transferred, with baby /babies in utero, urgently via the Royal Flying Doctor Service (RFDS) or road ambulance to enable access to expert care and to maintain mother /baby and family together in one location and one logistical pathway. This policy acknowledges that on rare occasions a woman may be required to give birth at the presenting site and the care that is required should that occur.

The purpose of this policy is to provide registered nurses and non-obstetrically trained doctors with a level of confidence and support to immediately manage an unplanned, imminent birth with appropriate transfer pathways for both mother and newborn.

There are to be no planned births at designated non-birthing sites.

2. Policy

2.1 Pregnant Women in Communities Without Maternity Hospitals

All pregnant women who live and work in communities with non-birthing sites are to be referred to an appropriate level maternity service to book for labour and birth care.

Local antenatal care can be provided by primary health services (public or private) as part of shared care arrangements with either a visiting Obstetric or Midwifery Service, or birthing hospital clinicians.

Each pregnant woman is to have a pregnancy management plan documented in their WA Handheld Pregnancy Record, with a discussion about their most appropriate birthing service, when to relocate for birth support, and pathways/resources to assist with relocation and the associated accommodation / Patient Assisted Travel Scheme (PATS) arrangements.

Areas with unpredictable weather conditions, such as cyclone /flood seasons, need to have early discussions with their women around birth planning. If there are any concerns that the woman plans to remain in town/declines to leave, this must be escalated to the health service manager.

Women assessed to be at low risk of pregnancy complications are be referred to the nearest WACHS birthing service or to the birthing service of the woman’s choice. Women assessed at moderate or high risk of pregnancy complications by the nearest WACHS birthing service are to be referred to the closest WACHS regional resource centre or metropolitan maternity sites.

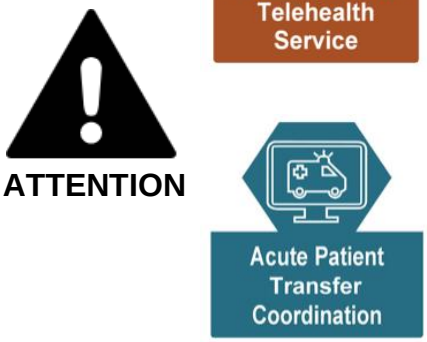
Women at moderate or high-risk pregnancy complications with limited ability to access antenatal care (i.e., living in remote communities or impacted by social determinants of health) are to receive community midwifery care with the aim of encouraging antenatal engagement. This may also be via telephone or videoconference (see Telehealth information). Anecdotal evidence suggested this reduces the likelihood of presentation in late stages of pregnancy or labour at non-birthing sites.

Each WACHS region is to develop maternity care referral pathways for women according to the presence or absence of risk factors as per the Category A, B, or C conditions in the Royal Australian and New Zealand College of Obstetricians and Gynaecologist endorsed Australian College of Midwives National Midwifery Guidelines for Consultation and Referral and with reference to the WACHS Maternal and Newborn Care Capability Framework Policy.

2.2 Imminent Birth Emergency Escalation Processes

Any woman who presents to a non-birthing site with signs of labour is to be triaged by site clinicians as an ATS 1 so that they are escalated to MOETS promptly for specialist consultation.

Refer to the WACHS Patient Assessment and Management in the Emergency Department Policy



Early contact with the Midwifery and Obstetric Emergency Telehealth Service (MOETS) on 1800 422 190 should be made to enable early specialist input.

Acute Specialist Telehealth Service

Early contact with the Acute Patient Transfer Coordination (APTC) service on 1800 951 211 should be made to enable early and timely transfer to a birthing service.

A priority transfer is to be considered for all women presenting in labour at non-birthing sites.

Acute Patient Transfer Coordination

Local Senior Staff Required

The Regional Director of Nursing and Midwifery, the Health Service Manager, Midwife, Senior Clinical Nurse, or the most experienced person at site is to assume the role of team leader for the birth in consultation via videoconference with the MOETS Midwife.

The emergency on-call District Medical Officer (DMO) / General Practitioner (GP) is to be called to attend:

- additional nursing /midwifery / medical support as per local medical emergency response (MER) escalation pathway

- local community midwife or child health nurse / midwife (CHNM) if available and willing
- staff with NeoResus training if available.

2.3 Midwifery and Obstetric Support

MOETS is to be called to provide clinical assessment support and determine if birth is imminent or transfer in utero is possible. MOETS can assist to escalate to the regional and metropolitan obstetric teams whilst site clinicians can focus on clinical care. For example, within the Wheatbelt, a local Midwifery Group Practice midwife may be able to be deployed to support neighbouring non birthing sites.

Use of Command Centre Video Conferencing facilities or teleconference facilitates enables efficient coordination /prioritisation of the woman's or newborn's transfer and clinical care involving multiple parties including receiving site specialists, MOETS, APTC, Newborn Emergency Transport Service WA (NETSWA) and the transferring site doctor.

Site and/or MOETS can notify NETSWA for awareness of imminent birth.

2.4 Transfer to the most appropriate maternity site

A high priority transfer is to be considered for all women presenting in labour at **non-birthing sites**. This is to be discussed with MOETS in the first instance, who will liaise with APTC to facilitate SJA / RFDS / NETSWA logistics.

A conference call between MOETS, the regional on-call obstetric and/or paediatric doctor, the planned receiving site obstetric / neonatal team, and APTC can be arranged if necessary to determine appropriate priority and destination.

APTC in collaboration with MOETS will prioritise the transfer and determine the most appropriate means of transport based on clinical information, location, site capacity, and resource availability

Where a metropolitan public maternity service is the closest available birthing unit, the on-call obstetric medical officer for that service will be the most appropriate point of consultation.

MOETS can direct referring sites and APTC to the most appropriate receiving site.

Refer to the WACHS Assessment and Management of Interhospital Patient Transfers Policy

2.5 Requirement to Suppress Labour

Preterm

After discussion with the on-call Regional or Metropolitan Obstetric team, for most women in preterm labour (less than 37 weeks), immediate initiation of labour suppression therapy is appropriate by following:

- WACHS Preterm Labour Policy
- KEMH Preterm Labour Clinical Practice Guideline
- RFDS Clinical Manuals are currently under review please seek guidance from APTC on **1800 951 211.**

While awaiting the woman's or newborn's transfer, MOETS and the advising obstetrician(s) can continue to provide clinical advice and bedside support via videoconference modalities.

At Term

For women in labour at term, the decision to suppress or await progression of labour is to be made in consultation with either the on-call Regional or Metropolitan Obstetric Consultant. Consideration of individual circumstances including:

- antenatal history
- current clinical assessment including stage of labour and co-morbidities
- the onsite availability of obstetric / midwifery and neonatal expertise
- distance to nearest maternity service and available transport resources.

2.6 Clinical Management of the Unplanned Imminent Birth

Obtain the Emergency Birth Equipment Box checklist (Appendix A) and follow the Imminent Birth Quick Reference Guide (Appendix B).

For guidance on the management of normal labour / birth and immediate post birth care, refer to the MOETS Midwives who follow the WACHS and KEMH clinical guidelines (Section 8 Document Summary).

ATTENTION

Nurses and doctors are not expected to, nor should they, undertake assessments which require specialised skills that are outside their scope of practice i.e., vaginal examination, listening to the fetal heart rate (FHR), abdominal palpation, or bedside ultrasound.

Nurses and Medical doctors with no midwifery or obstetric training must not listen to the fetal heart rate. A point in time FHR does not communicate the full picture of fetal wellbeing; non-birthing sites are not resourced to act on an abnormal FHR and clinicians may either be inadvertently listening to the maternal heart rate or be unable to locate the FHR which could result in unnecessary stress and trauma for the woman, their family and the clinicians involved.

MOETS will discuss and support the local site clinicians to undertake screening tests and procedures.

The MOETS midwife is to guide the local staff on the clinical and administrative processes for the mother / newborn prior to their transfer to the designated birthing site.

2.7 Use of Community Midwives or CHNMs

WACHS employed Community Midwives / CHNMs who have indicated they would be willing to attend (if available) to provide support during an imminent birth may be called in to attend for the birth. If available, these staff will often be the most skilled and experienced to provide support for the woman, baby, and hospital staff during these situations.

Community Midwives / CHNMs are to communicate their willingness, or otherwise, to be contacted regarding emergency birth situations to the Director of Nursing and Midwifery Services at the commencement of employment.

Sites are to provide professional development support and clinical placements for community midwives / CHNMs to maintain their confidence in imminent birth and/or maternity emergencies where they express a desire to do so. This includes attending relevant obstetric professional development and clinical placements at these sites.

2.8 Immediate Postnatal Care Awaiting Transfer

Postnatal transfer is to occur as soon as possible, even when the mother and baby appear to be well. Separation of mothers and newborns should be avoided.

For consideration: after discussion with MOETS and an Obstetric doctor, if the woman and baby have no risk factors, the woman had good antenatal care, the woman agrees, and there is a local midwife available to attend and provide daily postnatal assessments and care until minimum of day five, then the woman and newborn may remain at site until ready for discharge.

While awaiting transfer the postnatal observations are to be recorded for the mother using the MR140B Maternal Observation Response Chart (M-ORC) and baby using MR140D Newborn Observation Response Chart (N-ORC) for a minimum of:

- every 15 minutes for the first two hours,
- hourly twice, and
- then two-hourly twice (if within normal range).

More frequent observations may be required depending on maternal and newborn condition. MOETS and NETSWA will advise of this

Newborns are to be kept dry, warm, and look and remain pink, be offered a breastfeed, expressed breastmilk, or breast milk substitute as soon as possible and within the first hour of birth (dry, warm, pink, sweet).

2.9 Documentation for an Unplanned Birth

To enable the receiving maternity sites to complete the WA legislated birth documentation, the responsible nurse, midwife, or doctor from the unplanned birth site must provide the receiving site with a completed copy of each of the following documents. They must advise that the legislated document requirements have either been completed for the birth or are be completed by the receiving site midwife.

Documentation:

- MR71 WACHS Labour and Birth Summary
- mother's medication chart (MR170A WA Hospital Medication Chart – Short Stay)
- baby's medication chart (MR170D Paediatric Short Stay Medication Chart)
- mother's observation chart (MR140B Maternal Observation and Response Chart (M-ORC))
- baby's observation chart (MR140D Newborn Observation and Response Chart (N-ORC))
- detailed account of the event in the woman and/or baby's progress notes (both mother and baby)

- email advice to the Operations Manager and Regional Director of Nursing and Midwifery
- initiate Investigation via the Datix Clinical Incident Management System (Datix CIMS)
- a Notification of Case Attended (NOCA) form must be completed by the nurse, midwife or doctor who attends the birth. Non-maternity sites can obtain this form via:
  - by emailing birthdata@health.wa.gov.au**, or**
  - the WA Health Notification of Case Attend Form (MR15) on the Midwives Notification System website.

Further documentation required by the *Births, Deaths and Marriages Registration Act 1998* to be completed by the non-birthing site, and receiving maternity hospital:

- a Birth registration form, Part A needs to be completed by health care professional who delivered the child
- a Centrelink Parent Pack Newborn Child Declaration completed by the doctor, nurse, or midwife present at the birth
- a Personal Health Record (Child Health purple book) with mother and baby birth details.

2.10 Resources and Training

Nursing staff and non-obstetric doctors working in EDs must familiarise themselves with the:

- Emergency Birth Equipment Box - contents checklist (Appendix A)
- Imminent Birth Quick Reference Guide (Appendix B)
- ANZCOR Newborn Life Support Algorithm (Appendix C),
- attend an Imminent Unplanned Birth for Non-Midwives Workshop (IMCN 001). For enrolment purposes go to MyLearning LMS.

Trainer resources**:**

- teaching/training resources (lesson plans etc.) for a one-day Imminent Unplanned Birth for Non-Midwives (IMCN EL4) workshop are located via MyLearning (LMS)
- each region must allocate staff development resources to provide this training to identified sites on a regular basis and ensure ED nurses and doctors have access to the training as required.

Neonatal Resuscitation Programs

These are available for ED staff working via:

- NeoResus online learning via MyLearning LMS
- face to face Advanced NeoResus © and 1st Responder courses– contact the WACHS Clinical Midwife Educator via the Maternity and Neonatal Education page (sharepoint.com).

3. Roles and Responsibilities

All sites are to have available via close on-call, as a minimum, one health professional with advanced life support competence (including neonatal / paediatrics).
Regional Directors of Nursing and Midwifery are to determine the requirements for non-birthing site senior nurses to have a midwifery qualification or training in assistance with an imminent unplanned birth. This is to include consideration of the specific needs at sites where unplanned, imminent births occur more frequently.

Regional Medical Directors are to determine the emergency obstetric skills training and upskilling requirements for visiting medical practitioners (VMPs) GP, senior medical officer (SMO), DMO and Fellowship of Australasian College Emergency Medicine (FACEMs) providing emergency medical services at non birthing sites.

On-call Regional Obstetricians are to where available, provide guidance to the site staff, dependent on the available local expertise and the individual woman or baby circumstances including gestation, antenatal history, current clinical assessment, and co-morbidities.

Onsite Director of Nursing and Midwifery or senior clinical nurses are to assume the role of emergency coordinator.

Senior medical and nursing staff are to assist with care of women giving birth if necessary.

Clinicians working at non-birthing service sites must be confident and competent in the use of ETS and associated equipment.

Available local community midwife or CHNM's (if competent, confident, and willing) are to be called to lead the labour and birth care, supported by the hospital staff.

Midwifery and Obstetrics Emergency Telehealth Service (MOETS), a group of Clinical Midwife Consultants (CMCs) role and responsibility includes:

- being available to all WACHS sites 24/7 via videoconference to provide midwifery, obstetrics, gynaecology, and neonatology expertise
- working closely with APTC, the on call regional obstetrics teams, and NETSWA to escalate and facilitate specialist advice and support to WACHS clinicians.

Acute Patient Transfer Coordination Service (APTC) role and responsibility includes working alongside WACHS sites, transport service providers and receiving sites to facilitate timely and safe transport of the woman and/or baby and is a centralised coordination service stream.

All staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

4. Monitoring and Evaluation

4.1 Monitoring

Monitoring of compliance with this policy is to occur via review of all unplanned imminent births at non birthing sites by the Regional Director of Nursing and Midwifery, the Regional Obstetric Leadership Group (OLG), and the MOETS team for preventability. Where it is determined that health care or lack of health care could have or did lead to unintended harm then the incident is to be notified as a clinical incident into Datix CIMS as per MP 0122/19 – Clinical Incident Management Policy 2019. MOETS Midwife should be added to these investigations as a Command Centre representative. The WACHS Clinical Midwife Educator is responsible for ensuring this policy is updated with the latest version of the ANZCOR Newborn Life Support Algorithm (Appendix C).

4.2 Evaluation

This policy will be evaluated by the Obstetric Leadership Group (OLG), the Midwifery Advisory Forum (MAF), and the Emergency Nurses Advisory Forum (ENAF) to determine the effectiveness, relevance, and currency. The OLG and MOETS team will also monitor and investigate unplanned imminent birth rates and present them quarterly at the OLG, MAF, and ENAF meetings.

5. Compliance

This policy is aligned to the *Health Services Act 2016* and is a mandatory requirement of the *Births, Deaths, and Marriages Act 1998*.

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to Section 26 of the *Health Services Act 2016* and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies and procedures is mandatory.

6. References

Australian College of Midwives. National Midwifery Guidelines for Consultation and Referral 4th Edition [Internet]. 2021. Available from: https://midwives.org.au/common/Uploaded%20files/_ADMIN-ACM/National-Midwifery-Guidelines-for-Consultation-and-Referral-4th-Edition-(2021).pdf

Flowcharts - Australian Resuscitation Council [Internet]. Available from: https://resus.org.au/flowcharts-3/

Imminent Birth Ask the woman [Internet]. Available from: https://www.health.qld.gov.au/__data/assets/pdf_file/0024/931623/f-ib.pdf

Statements and guidelines directory [Internet]. RANZCOG. Available from: https://ranzcog.edu.au/resources/statements-and-guidelines-directory/

7. Definitions

Term	Definition
Imminent Birth	Signs: strong regular contractions associated with bulging membranes/spontaneous rupture of membranes, rectal pressure/urge to push, large bloody/mucous show, perineal bulging or presenting fetal part crowning/on view.
Normal birth	Singleton pregnancy, cephalic presentation (head first) between 37 and 42 weeks' gestation

8. Document Summary

Coverage	WACHS wide
Audience	Clinical staff working at non-birthing sites
Records Management	Health Record Management Policy
Related Legislation	*Births, Deaths, and Marriages Registration Act 1998* *Health Services Act 2016*
Related Mandatory Policies / Frameworks	• MP 0122/19 – Clinical Incident Management Policy 2019 • Clinical Governance, Safety and Quality Framework
Related WACHS Policy Documents	• Assessment and Management of Interhospital Patient Transfers Policy • Maternal and Newborn Care Capability Framework Policy • Patient Assessment and Management in the Emergency Department Policy • Preterm Labour Policy • Resuscitation, Education and Competency Assessment Policy
Other Related Documents	• ANZCOR Newborn Life Support • KEMH First stage of Labour Clinical Practice Guideline • KEMH Postnatal: Immediate Care of Mother in Labour and Birth Suite Following Birth • KEMH Preterm Labour Clinical Practice Guideline • KEMH Second Stage of Labour and Birth Clinical Practice Guideline • WNHS Labour: Third Stage Clinical Practice Guideline • WNHS Neonatal care Clinical Practice Guideline
Related Forms	• MR140B Maternal Observation and Response Chart • MR140D Newborn Observation and Response Chart (N-ORC) • MR170A WA Hospital Medication Chart – Adult Short Stay • MR71 WACHS Labour and Birth Summary • WA Health Notification of Case Attend Form (MR15)
Related Training Packages	Via MyLearning LMS: • NeoResus • Imminent Unplanned Birth for Non-Midwives Workshop • Imminent Unplanned Birth for Non-Midwives Trainer Resources • ALS: Adult and Paediatric Basic and Advanced Life Support
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 3102

National Safety and Quality Health Service (NSQHS) Standards	1.1c, e, & f; 1.7b & c; 1.20c; 1.25a; 1.27a; 4.14, 6.1a, b & c; 6.8f; 8.1a, b & c; 8.6c.
Aged Care Quality Standards	Nil
Chief Psychiatrist's Standards for Clinical Care	Nil

9. Document Control

Version	Published date	Current from	Summary of changes
4.00	5 April 2024	5 April 2024	• legislations and references added • addition of the Midwifery and Obstetrics Emergency Telehealth Service (MOETS) and Acute Patient Transport Coordination (APTC) Service • changes to Evaluation and Compliance Measures/Tools and groups • updated Education packages added.
4.01	8 May 2024	5 April 2024	Minor amendment: • Appendix A – Equipment for Actual birth inclusion of SGA (LMA) iGEL size 1.

10. Approval

Policy Owner	Executive Director Nursing and Midwifery Services
Co-approver	Executive Director Medical Services Executive Director Clinical Excellence
Contact	WACHS Coordinator of Midwifery
Business Unit	Midwifery
EDRMS #	ED-CO-16-37069

This document can be made available in alternative formats on request.

Appendix A: Emergency Birth Box for Non-Birthing Sites

Check monthly including all expiry dates.

NAME OF SITE: _____ DATE: _____

Equipment for Actual birth		COMMENTS
• Sterile delivery bundle (*obtained from nearest birthing site*) contains: ○ 1 bowl (for placenta) ○ 1 bowl (for collecting and weighing blood loss) ○ 2 metal clamps (for clamping cord) ○ 1 cord scissors ○ 1 yellow cord clamp ○ Drapes	**1**	
• Sterile gloves (latex free)		
• Plastic apron + goggles (eye protection)		
• Large disposable under-pads for under mother's bottom (or lots of blueys)		
• Neonatal resuscitation bag and mask (in case baby not breathing at birth)	**1**	
• SGA (LMA) iGEL size 1	**1**	
• ANZCOR Newborn Life Support Flowchart	**1**	
• WACHS Policy Imminent Birth Flow Chart	**1**	
• Towels (to dry baby and then a fresh one to keep baby warm)		
In case of perineal repair (by doctor with obstetric experience or midwife only)		
• Lidocaine 1% injection	**2**	
• tagged large surgical packs or tagged sterile tampons (obtain from nearest birth site or theatres)	**3**	
• 2/0 vicryl rapide (cutting edge)	**1**	
• Disposable suture set	**1**	
To manage post-delivery haemorrhage ONLY (≥ 500 mLs following birth). Not to use to augment labour		
• Oxytocin 10 units injection – light sensitive	**10**	
• Ergometrine 500 microg injection – light sensitive. Stored in fridge	**1**	
• Misoprostol 200 microg tablet	**8**	
• 14G cannula x 2 (cannulate both arms for rapid volume infusion) • IDC equipment – catheter, syringe, bag, lubricant (full bladder most common cause of PPH)	**2**	

Record post birth observations mother and baby (15 minutely first two hours, half hourly twice, hourly twice, then two hourly twice)		
• MR140B Maternal Observation and Response Chart (M-ORC)	**1**	
• MR140D Newborn Observation and Response Chart (N-ORC)	**1**	
Extras		
• Gloves (sterile, latex free) - 6.0, 6.5, 7.0, 7.5, 8	**2ea**	
• Syringe 10 mL	**2**	
• Needles 23 G	**2**	
Documentation (obtain each of these forms from the nearest birthing site)**:**		
• MR71 WACHS Labour and Birth Summary	**1**	
• MR80 WACHS Vaginal birth care plan	**1**	
• MR75 WACHS Newborn Care Plan (*complete the birth history page*)	**1**	
This box is to be checked monthly and after every use.		
No action required		
Minor problem(s) corrected		
Disposable supplies replaced		
Major problem(s) identified. ACTION(S) TAKEN		
Name		
Signature		
Designation		

Appendix B: Imminent Birth Flow Quick Reference Guide

Adapted from: Qld Health, Office of the Chief Nursing Officer, Emergency Birth Management Guideline.

IMMINENT BIRTH

NORMAL BIRTH IS NOT AN EMERGENCY:

- ❑ Remain calm and reassure the woman, breath calmly with her
- ❑ The baby will come of its own accord, just prepare to receive the baby

IF TIME – ASK ABOUT:

- ❑ How many weeks pregnant?
- ❑ When did the contractions start?
- ❑ Has there been any vaginal fluid or bleeding?
- ❑ Has the baby been moving today?

SIGNS OF SIGNIFICANCE:

- ❑ Contractions coming every 3 to 4 minutes
- ❑ Uncomfortable urge to push or open bowels
- ❑ Baby's head visible at the vulva

CALL FOR HELP

Each site is to insert contact details and phone details below:

- ❑ < Local midwife (Community Health or DON) or obstetric doctor >
- ❑ < MOETS on 1800 422 190 >

PREPARE FOR BIRTH:

- ❑ Obtain and open the emergency birth kit
- ❑ Warm the room and warm some bath towels
- ❑ Put on a plastic apron, gloves, and eye protection

POSITION THE WOMAN COMFORTABLY:

- ❑ Either on all fours, kneeling, side-lying or semi-recumbent – DO NOT LIE HER FLAT ON HER BACK
- ❑ Don't encourage pushing, let her push with her own natural urges

Continues next page

ALLOW THE BABY TO COME NATURALLY - YOU DON'T NEED TO HELP

AT THE BIRTH:

- ❑ If there is cord around the baby's neck – don't cut it - allow the baby to birth through the cord loops (you may loosen it as the baby comes)
- ❑ Note the exact time of birth
- ❑ Place and keep the baby skin-to-skin on mum's chest (keeps baby warm and relaxed by her heartbeat)
- ❑ Dry the baby off and cover in a warm, dry towel

AFTER THE BIRTH:

- ❑ Once the cord has stopped pulsating, double clamp and cut between the two clamps (can ask her partner to cut it)
- ❑ Monitor baby's breathing, colour and heart rate in good light regularly (use the MR140D N-ORC)
- ❑ Keep the mother warm
- ❑ Monitor the mother's pulse, BP and PV loss regularly
- ❑ Regularly check the tone of the mother's uterus is firm (at umbi level)

MANAGEMENT OF BIRTH OF THE PLACENTA

NORMAL BIRTH IS NOT AN EMERGENCY:

- ❑ Up to 500 mL of blood loss is normal (weigh the blood loss from birth)
- ❑ The placenta should birth under the mother's own efforts naturally
- ❑ The placenta will usually come within 60 minutes of the baby

AFTER BIRTH OF THE BABY:

- ❑ Keep the baby skin-to-skin on mum's chest
- ❑ Encourage her to breastfeed (helps contractions to deliver the placenta)
- ❑ Position mum comfortably / observe for bleeding
- ❑ The cord may be cut once it has stopped pulsating

OBSERVE FOR SIGNS OF PLACENTAL SEPARATION:

- ❑ Fundus becomes firm
- ❑ Further trickle of PV blood
- ❑ The remaining cord gets longer
- ❑ Can encourage mum to bear down if she feels cramps or a desire to do so

BIRTH OF THE PLACENTA:

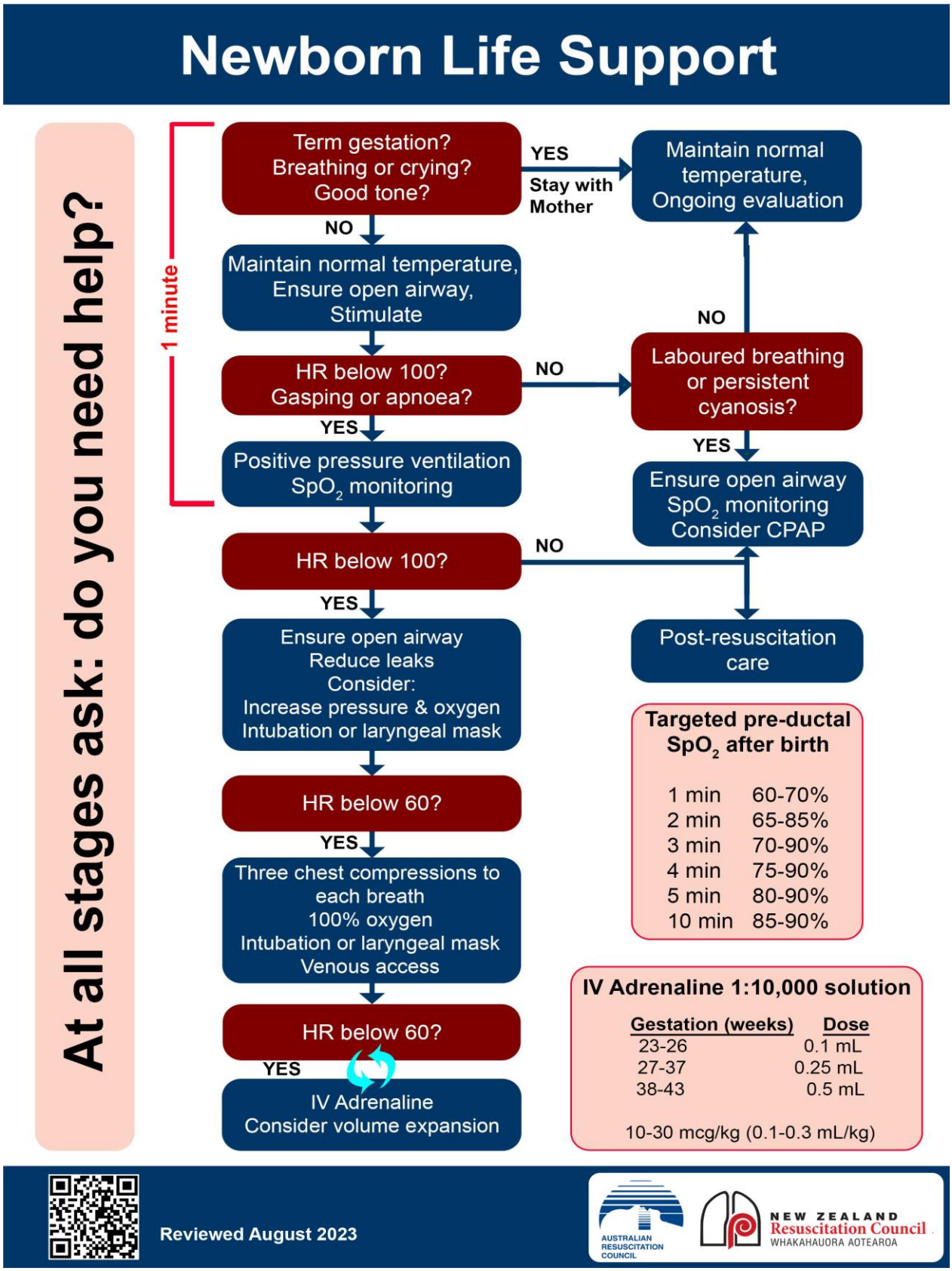
- ❑ Upright positions help i.e. on commode or toilet with bowl in situ
- ❑ Emptying her bladder will help contract the uterus
- ❑ Keep the placenta in a sealed container to send with mum (for the receiving maternity site to confirm it is complete)
- ❑ After the placenta, check the top of the uterus abdominally to see if it is firm and contracted – usually at the level of the umbilicus & central

CALL THE REGIONAL OBSTETRIC DOCTOR, MIDWIFE OR MOETS IF:

- ❑ blood loss is > 500 mL
- ❑ placenta not delivered within 60 minutes of baby
- ❑ increasing maternal HR and / or falling BP
- ❑ before giving any oxytocic medications

Appendix C: Resuscitation Algorithm for the Newborn

Source: **Australian Resuscitation Council**



(The WACHS Clinical Midwife Educator is responsible for ensuring this policy is updated with the latest version of this flowchart).