“I REALLY NEED TO PUSH”

Precipitate Labour in the Emergency Department

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Learning Objectives

- Understanding and recognising the 2nd Stage
- Delivery Management
- Precipitate Labour
- Neonatal Management
- Documentation
- RELAX and Reflect
- 3rd Stage Management & initial Post Natal Care

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Precipitate Labour

• precipitate labour
  very rapid labour ending in delivery of the fetus.
  "http://medical-dictionary.thefreedictionary.com/precipitate+labor">precipitate labour

• Strong frequent contractions from the onset of labour resulting in rapid completion of the first and second stages
Maternal Effects

- Intense Contractions from onset
- Increased risk of lacerations/tears to perineum
- Increased risk of retained placenta
- Delay in maternal bonding
- No build up of Endorphins

Increased risk of PPH

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Neonatal Effects

- Maternal co-morbidities
- Place of birth associated risks
- Hypothermia
- Facial suffusion, Petechiae, Subconjunctival Haemorrhages
- Possible Trauma
- Shocked or slow to respond
- Fractious/Unsettled

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2nd Stage of Labour

- Signs of Imminent Delivery
  - Contractions become stronger, longer and more expulsive
  - Urge to push
  - Rupture of membranes
  - Dilatation and gaping of anus
  - Presenting part visible

Normal Mechanism of Labour

*The passive way in which the fetus makes its way through the birth canal*

- Descent – before or during labour
- Flexion of the head decreasing diameter
- Internal Rotation of head to OA position
- Crowning – fetal head visible under pubic arch
- Extension – Face and chin deliver
- Restitution – head resumes its natural position in relation to shoulders
- External Rotation – shoulders rotate to OA position indicated by external rotation of the head
- Delivery of the body – may require gentle axial traction to aid delivery of anterior shoulder
Mechanism of normal delivery
Delivery Management

**Cord Management**

- Avoid handling the cord unnecessarily.
- Cord around the neck will not impede delivery.
- Allow delayed cord clamping for 30 to 60 seconds following delivery.
- Do not clamp and cut the cord routinely however this is necessary if:-
  - Resuscitation of mother or baby is required
  - Cord has snapped/ruptured
  - Short cord
- To clamp the cord:-
  - place one clamp 1–2 cm from the baby’s abdomen
  - a second clamp 2–3 cm distally to the first.
  - Ensure that they are firmly closed and cut between
  - Protect yourself from spray

- Obtain skilled help ASAP
- Support and reassurance
- Privacy, dignity and environment
- Analgesia
- Encourage mother to breathe and work together (eye contact)
- MDT Communication
- Utilise a “hands on approach”
- Support the head once delivered (Never Suction airway on perineum)
- Place baby skin to skin, dry and cover, apply hat.
Emerging evidence supports a ‘hands-on’ approach with controlled head delivery to minimise perineal trauma.

Note:
- Perineal hand ‘pulls’ the perineal skin towards midline, reducing tears.
- Hand on head, controls delivery of the head – slow delivery.
Neonatal Management

Initial Assessment (APGARS)
Delayed Cord Clamping
Neonatal resuscitation
Keep warm/Skin to skin/Hat

*Remember a crying baby is a well baby*

https://www.resus.org.uk/resuscitation-guidelines/

![Figure 1: APGAR Scoring](https://www.resus.org.uk/resuscitation-guidelines/)
3rd Stage Management & initial Post Natal Care

- Is there only one??
- Maternal effort only (Do not pull on the cord)
- Retain placenta for inspection
- Has the bleeding stopped?
- Use of uterotonic drugs
- Baseline observations
- Transfer to delivery suite

- Placental separation

**Signs of Separation**
- Contractions return/period like cramp
- Separation bleed
- Cord Lengthens
- Urge to push/heaviness in vagina
• Pregnancy Health record
• Contemporaneous records
• Timing of events
• Persons present
• Reflective account/personal statement.
• Litigation
Thank you.