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31 January 2022

By email: cpuresponses@coronerscourt.vic.gov.au

CPU Responses
Coroners Court Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Sir/Madam

Investigation into the death of [redacted]
Your ref: COR 2017 004991

I refer to the Finding of Deputy State Coroner English in this matter dated 8 November 2021, and to Her Honour's recommendation that '*Werribee Mercy Hospital amend relevant guidelines to require a partogram to be completed for each labour and birth*'.

I confirm that Her Honour's recommendation has been implemented and I enclose for the Court's information a copy of the relevant '*Labour and Birth Clinical Guideline*' (the **Guideline**), which was last reviewed and updated in May 2021.

As you will see from page 2 of the Guideline, once it is considered that a woman is in the active first stage of labour, staff are directed to document the relevant clinical information on the partogram record, until the birth has been completed.

This direction is repeated on pages 4 and 7 of the Guideline.

In addition, I enclose for the Court's information a copy of the '*Antenatal or Intrapartum Vaginal Examination Procedure*' (the **Procedure**), which was last reviewed and updated in April 2018. As you will see from page 2 of the Procedure, staff are required to document certain information following a vaginal examination, and if the woman is in active labour, staff are directed to document that information on the partogram.

Accordingly, there is an expectation of all staff working in the birth suite that the results of vaginal examinations undertaken upon labouring women will be documented on the partogram. This expectation forms part of staff orientation, and any failure to document the relevant information on the partogram is required to be escalated and managed as a performance issue.

I otherwise confirm that, as previously advised, staff have been reminded of the importance of complete and thorough documentation, and specifically the need to complete the partogram with all relevant information.

Regards,

Mercy Health
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Enclosures: Labour and Birth Clinical Guideline, May 2021
Antenatal or Intrapartum Vaginal Examination Procedure, April 2018

Title: Antenatal or Intrapartum Vaginal Examination Procedure

Division: Health Services

Facility or Program: Women's and Children's Services

Approved by: Program Director Women's and Children's Services

Policy Link: Care of the Patient Policy

Purpose

Vaginal examination (VE) is a tool to assess the cervix's favourability for induction or to measure progress in labour. VE should be carried out only with the woman's consent and when the examination will add important information to the decision making process.

Who Must Comply

Medical Staff
Midwives
Medical and midwifery students on clinical placement under direct supervision

Indications for vaginal examination

- Clinical staff should aim to keep the number of VE's to a minimum.
- A VE should be undertaken within 2- 4 hours of admission in labour

Indications

- To assess progress in active labour every four hours
- If clinical concerns are identified
- To perform artificial rupture of membranes
- To apply a fetal scalp electrode
- To exclude cord prolapse after spontaneous rupture of membranes where there is an ill-fitting presenting part
- To assess favourability of cervix before induction
- To administer prostaglandin for Induction of Labour (IOL)
- To diagnose preterm labour

VE with caution

- Pre-labour Spontaneous Rupture of Membranes (SROM). VE should only be done in this instance to expedite labour.
- Placental site not known
- Unstable lie

Contraindications

- Maternal consent not obtained
- Placenta praevia
- Presence of active herpes

Cervical assessment for Induction of Labour

A vaginal examination to assess the cervix is required prior to induction of labour. The Modified Bishop score is used to assess the cervix and to inform the method of induction. Each feature of the cervix is scored and then the scores are totalled. The state of the cervix is one of the most important predictors of success in induction of labour.

Modified Bishop Score

Bishop Score	0	1	2	3
Cervical Dilatation (cm)	0	1-2	3-4	≥ 5
Cervical Length (cm)	3	2	1	0
Station	-3	-2	-1 , 0	+1, +2
Consistency	Firm	Medium	Soft	
Position	Posterior	Mid	Anterior	

An unfavourable cervix (modified Bishop score <8) may benefit from cervical ripening as clinically appropriate

Title: Antenatal or Intrapartum Vaginal Examination Procedure

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Findings of this vaginal examination are recorded in the notes

Procedure

Prior to VE

- Review history and most recent ultrasound results
- The woman must be provided with an explanation of what a vaginal examination is and why a VE is required. Acknowledge that a VE can be distressing to some women.
- The woman must provide verbal consent to the VE. The clinician must be aware that consent may be withdrawn at any time during the procedure, and stop the examination immediately. The woman should be given the opportunity to ask for and have a chaperone. A chaperone may be a support person, or another clinician,
- Ensure the woman's bladder is empty.

Equipment;

- sterile gloves
- sterile lubricant
- clean linen / underpads.

Performing the vaginal examination

- When a VE is performed for assessment of progress of labour, it should be preceded by an abdominal palpation.
- During the examination the woman's privacy and dignity should be respected.
- The woman should be in a semi recumbent position with her knees bent, ankles together and knees parted.
- Gently insert the first two fingers of the examining hand in to the vagina, in a downward and backwards direction along the anterior wall to locate the cervix.
- If performing a VE whilst the woman is in labour, perform the VE between contractions
- Discussion should be relevant and free of unnecessary comments.
- Upon completion of the VE, the woman should be left clean and comfortable. A full explanation of the findings of the VE should be provided. The fetal heart should be performed and recorded.

Documentation

The following information must be recorded in the woman's labour progress notes following a VE:

- Verbal consent received
- Rationale for performing VE
- Findings of VE
- If the woman is in active labour, the findings should be charted on the partogram

The following areas should be commented on following a VE:

- External genitalia; any abnormalities/signs of infection
- Cervix:
    - Cervical dilatation should be recorded as one figure i.e. 6cm
    - Effacement
    - Position: described as posterior, central or anterior
    - Consistency: firm, medium or soft
- Presentation: It should be noted how well the presenting part is applied to the cervix

- Presence of umbilical cord or membranes
- Station
- Vaginal loss
- Caput: present or not present
- Moulding
- Position

Definitions

Term	Definition
Effacement	Length of cervix and degree to which it protrudes in to the vagina
Station	The distance between the presenting part and the ischial spines in CM. Above spines is –cm and below spines is +cm

Links to Related Documents

- Labour and Birth Guideline
- Oxytocin Infusion for Induction and Augmentation of Labour Clinical Guideline
- Induction of Labour with Dinoprostone (PGE2) Continuous Release Vaginal Pessary (Cervidil®) Clinical Practice Guideline
- ProstaglandinE2 Gel (Prostin) CG
- Consent for Obstetric Procedures procedure

Key Legislation, Acts, Standards & References

1. Mid Essex Hospital Services NHS (2016) Assessment and procedure for performing a vaginal examination
2. Queensland Health (2017) Queensland Clinical Guideline: Induction of Labour
3. Queensland Health (2017) Queensland Clinical Guideline: Normal Birth

Acknowledgements

N/A

Keywords

VE, vaginal assessment

Version History & Author / Contributors

V.	Date Created *(MM/YYYY format)*	Section(s) Changed *(eg procedure / definitions / references)*	Created/Amended by *(position title)*
1	07/2009	New procedure	RM
2	10/2014	Review. Minor changes only.	RM Sarah Hay, Deputy Director Women's and Children's Services
3	04/2018	Full review. Name changed to Antenatal or Intrapartum Vaginal Examination Procedure. All sections updated.	Karen Edge, Maternity Educator Julie Kane, Birthing Services NUM, MHW

Title: Labour and Birth Clinical Guideline

Division: Health Services - MHVL

Facility or Program: Women's and Children's Services

Approved by: Program Director – Women's and Children's Services

Policy Link: Care of Patients Policy

Background
To guide clinicians in the care of women during labour and birth.

Who Must Comply
All clinical staff

Introduction
Care in labour and birth is collaborative between midwives and obstetricians and includes individualised, woman and family centered care. Women should participate in shared decision making about their care.

All interventions require explanation and consent from the woman. In an emergency situation where fetal or maternal wellbeing is at risk, the process of consent may need to be modified.

Wherever possible, consultation and consent should be undertaken with a qualified interpreter for non-English speaking women. However, it is recognized that in emergency or after hours' situations a family member may need to be used as the interpreter.

All care in labour needs to take into account the staffing, workload and acuity in the birth suite, and other relevant areas of the hospital, and be undertaken in consultation with senior midwifery and medical staff.

All care takes place within the context of the entire clinical picture for that woman.

This guideline is applicable in the management of labour in the context of:

- Term gestation
- Cephalic presentation
- Singleton
- Spontaneous onset of labour, induced and augmented labour
- No previous cesarean section

Aetiology
The onset and duration of labour is poorly understood.

Antenatal education should ideally ensure that all women and their families are aware of the wide range of normal duration of (passive and active) labour, the options for pain relief available and the role of interventions to actively manage labour and/ or expedite birth.

Definitions of normal and abnormal progress in labour are used to inform the need for intervention.

Management
Phone calls to Birthing Services/Maternity Assessment Unit (MAU)

When the woman contacts Birthing Services:

- The call should be taken by a senior clinician, or junior midwife in consultation with a senior clinician.
- Relevant events in the pregnancy, previous pregnancies and in recent days must be considered
- All calls must be documented on BOS in the "antenatal events" section under "phone advice".

The woman should be asked to present for assessment and a management plan if:

- She is in established labour. *(For some nulliparous women with no antenatal complications or other morbidities, it may be appropriate to remain at home in early labour, but remain in close communication with the hospital.)*
  - She has made three related calls to the Birth Suite, the Emergency Department or MAU about pains or the onset of labour OR
  - She reports persistent uterine activity without labour for:

  - Nulliparous woman 16 to 20 hours
  - Multiparous woman 8 to 10 hours or
- She is distressed or wishes to come in or
- There is a clinical indication of maternal or neonatal concern
  - Decreased fetal movements
  - Vaginal bleeding other than blood stained mucous or a show.
  - Spontaneous rupture of membranes (SROM)
- Other concerns are noted by the clinician, including where there are underlying concerns about
  - fetal compromise (such as fetal growth restriction or decreased fetal movements);
  - where it is anticipated that additional maternal care will be needed in labour (medical or anesthetic complexity) or
  - where it is anticipated that additional paediatric care will be needed at birth (known fetal anomalies)

Admission and initial assessment of the woman to Birthing Services/MAU

See: Patient Identification Procedure

Assessment and observation:
On presentation, assess the woman:

- Presenting symptoms and reason for presentation
- Review past medical, surgical and obstetric history, medications, allergies
- Review current pregnancy history, including gestation, parity, pathology and social circumstances or issues, antenatal events, recent ultrasound findings and complications
- Review the medical record
- Perform abdominal palpation – fundal height, fetal lie and presentation, station and descent of presenting part into pelvis
- Assess contraction pattern by palpation for frequency, duration and strength, time of onset of contractions
- Assess membrane/liquor status and vaginal loss including colour, volume, odour, bleeding
- Perform maternal vital signs and urinalysis for protein.
- Consider a vaginal examination (VE). Depending on the clinical assessment, a VE should be performed within 2 hours of presentation to Birthing Services or MAU to establish the stage of labour: See Antenatal or Intrapartum Vaginal Examination Procedure
- Assess fetal wellbeing: See Intrapartum Fetal Surveillance Clinical Guideline
- Define the stage of labour

Once the woman is in Birthing Services unit:

- Document the admission in the Obstetric Admission form (MR0220). When the active first stage of labour is made, documentation can continue on the Partogram Record (AD1680) and Birth Record Continuation AD1700.
- Complete the Maternal and Newborn Safety Risk Assessment AD 2811 and Medication Chart AD 4890.
- Complete labour onset details in BOS
- All patients who are admitted require
  - notification to the medical team and
  - written documentation including timing of next review, plan for fetal surveillance, and any other another concerns.

Latent first stage of labour/Spurious labour:

Some women have periods of spurious labour before progressing into the latent first stage of labour. Prolonged pre-labour/spurious labour can lead to maternal distress and fetal distress, particularly in an already compromised fetus.

The latent first stage of labour is defined as from the beginning of labour until the cervix is 5 cm dilated (WHO, 2018). It may stop and start, and may consist of regular or irregular contractions.

Once regular painful contractions start, the duration of the latent first stage of labour can be long in women who continue on to deliver vaginally, with or without augmentation. The median time for low-risk nulliparous women in spontaneous labour to dilate from 2cm to 5cm is 5 hours and the 95th centile for this dilation has been described at between 9 to 13 hours (see Abalos 2020). In other words, it is normal for a spontaneous labour to take time to become established.

Care should be taken to consider these parameters before diagnosing labour dystocia in the latent phase. No change in cervical dilatation in 4 hours of this stage of labour is not an indication for caesarean section but would generally be an indication to assess pain relief options and the need for ARM or augmentation of labour with syntocinon.

Strategies to improve progress in the first stage of labour include mobilization, adequate hydration, ensuring an empty bladder, continuous midwifery 1:1 support in labour, ARM and/or syntocinon augmentation.

Care needs to be taken to not perform ARM in women in whom a diagnosis of active labour has not been made, as this may result in an induction where one was not appropriate or required.

Discharging the woman in pre-labour/spurious labour or latent first stage of labour

- Where assessment, observation and fetal surveillance findings (including CTG) are normal, women in pre-labour/spurious labour or in the latent first stage of labour may be suitable to go home and await the active first stage of labour.
- The decision for discharge home in early labour requires input from the midwife, medical obstetric team and the woman. Consider how the woman is coping, available transportation and home supports
- The plan should be documented in the Obstetric Admission form (MR0220) or Partogram Record (AD1680).
- Advise the woman to contact Birthing Services or return to hospital for
    - Decreased fetal movements
    - Increase in strength or frequency of uterine activity
    - SROM
    - Vaginal bleeding
    - Is not coping at home
    - Any other concerns
- If the uterine activity continues, the woman should be advised to re-present within 12 to 24 hours for a further assessment and CTG.
- Discharge medication can be prescribed in early labour. The maximum tablets in a 24 hour period is
    - Paracetamol 500 mg (4 tablets)
    - Codeine 30 mg (2 tablets)

Title: Labour and Birth Clinical Guideline

Division: Health Services - MHVL
Facility or Program: Women's and Children's Services
Approved by: Program Director – Women's and Children's Services
Policy Link: Care of Patients Policy

Management of Active First Stage of Labour
The diagnosis of the active first stage of labour (established labour) is central to the management of labour.

Intrapartum Observations for Maternal Wellbeing:
Document observations on the Partogram Record (AD1680) and escalate according to Code Pink Escalation of Care Procedure and Adult Rapid Response Procedure

30 minutely	Pulse Uterine activity – for 10 minutes documenting frequency, strength and length and uterine rest time Vaginal loss
2 hourly	Abdominal palpation to assess descent of the presenting part Bladder care Urinalysis BP – unless epidural in situ: see: Epidural Analgesia Management Procedure
4 hourly	Temperature and respiratory rate

Fetal surveillance
See Intrapartum Fetal Surveillance Clinical Guideline

Eating and drinking during labour
See Oral Intake During Labour Clinical Guideline

Bladder care
Encourage regular voiding every 2/24. If the woman is unable to void after 4 hours, and/ or if the bladder is palpable or it is considered that a full bladder may be impeding labour progress, perform urinary catheterization, either as an in/out catheter or an indwelling catheter.

Management of pain in labour:

For pharmacological techniques, refer to:

- Standing Orders - Maternity Clinical Guideline
- Epidural Analgesia Management Procedure

Management of Delay in Active First Stage of Labour

In nulliparous women the active first stage of labour (defined as 5 or more cm cervical dilation), labour should progress at 1 cm per 2 hours or faster. The duration of first stage may be up to 10 hrs.

Once the active phase of labour has been reached, the rate of cervical dilation is generally more rapid. The average rate is around 2 cm per hr from 5cm for both primips and multips. For nulliparas in spontaneous labour, normal progress may however be quite a lot slower at up to ½ cm per hour (95%ile).

For multiparas in the active phase of spontaneous labour the 95th centile remains <1 cm / hr (Abalos 2020).

In some situations, including request for analgesia, concerns regarding the strength of contractions, concerns regarding fetal wellbeing, or slow progress, earlier clinical assessment including vaginal examination and subsequent consideration of augmentation of labour may be recommended.

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Assess the following signs of obstructed labour, before making any further changes to management of labour:

- Maternal tachycardia
- Fever
- Haematuria
- Fetal tachycardia
- Severe caput/ moulding

*The importance of considering **parity** in the assessment of labour dystocia is crucial. Multiparous labours tend to be quicker particularly in the second stage, inefficient uterine action is rarely a cause of poor progress, and the implications of obstruction are more serious. Decision making around duration of labour, augmentation of labour, frequency of assessment and second stage management must always consider whether the woman is in her first or subsequent birth.*

Consultation with the ANUM and registrar or consultant should occur when a diagnosis of delay in the first stage is suspected or confirmed, to enable shared decision making about subsequent management.

Women requiring Induction of Labour

Determining the transition from the latent phase to the active phase in an induced as opposed to spontaneous labour is difficult and does not simply relate to cervical dilatation. It is inappropriate to apply the allowed duration of latent phase labour to a woman already induced by Amniotomy with Oxytocin. Once determined to be in active labour, duration of labour may be considered consistent for induced and spontaneous labour and should remain within the maximum duration of first stage recommendations.

It should be noted that these normal thresholds were derived from spontaneous labours resulting in vaginal birth with normal neonatal outcomes. Induced labours may have a very different maternal or fetal risk profile, or other related factors that need to be considered when assessing appropriate labour duration

When planning for an induction of labour, particular attention should be made towards ensuring optimal cervical ripening through appropriate choice of cervical ripening agent and timely insertion.

Please refer to:

- Induction of Labour Booking Clinical Guideline
- Oxytocin Infusion for Induction and Augmentation of Labour CG
- Induction of Labour with Balloon Catheter Clinical Guideline
- Induction of Labour with Dinoprostone (PGE2) Continuous Release Vaginal Pessary (Cervidil®) Clinical Practice Guideline

Nulliparous patient

Delay is usually due to inadequate uterine contractions. Active management aims to improve uterine action in order to reduce operative birth rates and maternal and neonatal morbidity.

a. Membranes intact:
- Perform ARM
- Consider whether to commence oxytocin augmentation. Suggest reassess 2 hours later and if cervical dilation has not increased by 1 or more cm, commence oxytocin augmentation.

b. Membranes ruptured:
- Confirm forewaters are ruptured, if not, perform ARM.
- Consider oxytocin for augmentation, after excluding obstructed labour. See Oxytocin Infusion for Induction and Augmentation of Labour CG
- After commencing syntocinon, reassess, including a vaginal examination, after no more than 4 hours, except where the cervical dilation is 9cm, a repeat vaginal examination should occur within 2 hours. Vaginal examination may also be indicated by analgesic requirements, CTG concerns, or to aid decision making regarding the onset of the 2nd stage of labour.

Caesarean section should be considered when labour arrest is diagnosed, or after consideration of the entire clinical picture, including maternal and fetal well being and the woman's preferences.

Timing of reassessment and decision for cesarean section in the face of poor progress may consider the timing of starting syntocinon and periods where syntocinon is stopped for insertion of epidural or other reasons.

Multiparous patient

- Delay in the progress of labour of a multigravid patient is unlikely to be due to inadequate uterine contractions and is more likely due to relative /absolute CPD. In addition the consequences of an obstructed labour in a multigravid patient are significant and include ruptured uterus with associated maternal and fetal morbidity.

a. Membranes intact:
- Consider ARM
- Perform a vaginal examination 2 hours later, and if progress is less than 2cm, senior review should take place. After initial diagnosis of delay in active phase of labour, progress of cervical dilation of 1 cm per hour is expected.

b. Membranes ruptured:
- Oxytocin augmentation may be considered only in consultation with the Obstetric Consultant or Fellow, and after exclusion of evident obstruction or a deflexed or brow presentation. Oxytocin augmentation of a spontaneous multiparous labour is rarely required and at an advanced cervical dilatation is rarely appropriate. See: Oxytocin Infusion for Induction and Augmentation of Labour CG

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Management of the Second stage of labour

General Principles:

- Women should be in a comfortable position
- One to one midwifery care
- The second stage of labour can be divided into a passive phase of descent and rotation at full dilatation, where pushing is inappropriate and generally unhelpful, and an active phase or pushing phase.
- Delay in second stage may occur due to ineffective pushing, a full bladder, pain, malpresentation, or CPD. In nulliparous women, delay in the passive phase of the second stage may be due to inadequate contractions. In multiparous women slow progress in the second stage is not due to inadequate contractions and obstruction or a brow presentation must be considered. The ANUM should be kept updated of the woman's progress in second stage.

Observations during the second stage:

Record observations on the Partogram Record (AD1680) and notes on the Labour and Birth Record Continuation (AD1700):

15 minutely	Pulse
30 minutely	Color of amniotic fluid Uterine activity – for 10 minutes documenting frequency, strength and length and uterine rest time
Hourly	BP – unless epidural in situ see Epidural Analgesia Management Procedure Temperature and respiratory rate Abdominal palpation

Fetal surveillance in the second stage

- See Intrapartum Fetal Surveillance Clinical Guideline

In the second stage of labour, fetal heart rate monitoring is by continuous CTG monitoring, or if still appropriate, intermittent auscultation. Intermittent auscultation in the second stage of labour requires auscultation during the second half of the contraction AND for 30-60 seconds after completion of the contraction If any abnormality is heard on auscultation, CTG monitoring should commence and be continued from then on.
Particularly in the second stage of labour be always mindful of monitoring the fetal heart rate separate to the maternal heart rate.

Intermittent loss of contact and/or accelerations that occur with contractions should prompt the clinician to investigate whether they are appropriately monitoring the fetus or the mother. The use of a fetal scalp electrode and a maternal pulse oximeter is recommended if there is any doubt or difficulty in discerning the fetal heart rate pattern. .

Nulliparous women:

Birth is expected to occur within 2 hours of active pushing (within 3 hours of commencement of 2nd stage).
Notification of ANUM and registrar and consideration for oxytocin augmentation or instrumental delivery should be made if

- The woman has been actively pushing for 1 hour or
- If the head is on view for more than 30 minutes or
- if progress is considered inadequate

Refer to the Oxytocin Infusion for Induction and Augmentation of Labour CG or Assisted Vaginal Birth Clinical Guideline

Multiparous women:

- Birth is expected to occur within 1 hour of active pushing (within 2 hours of commencement of 2nd stage).
- Suspect delay after 30 to 45 minutes of actively pushing, or if progress at any stage is inadequate. If the birth is not considered imminent, consultation and review to take place with the obstetric registrar or consultant immediately
- Intervention to expedite birth is usually necessary if birth has not occurred after 1 hour of active pushing. Refer to: Assisted Vaginal Birth Clinical Guideline
- The obstetric consultant on duty must be informed if an instrumental delivery is considered necessary for dystocia or poor progress in the multiparous woman.
- Poor progress in the second stage of a multiparous patient must consider disproportion and macrosomia, or a secondary brow presentation, ie a deflexing posterior position.

Clinicians required for birth:

- Ensure at least two practitioners in the room for the birth.
- Where a pediatrician is required to attend the birth, aim to notify the pediatrician with enough time to arrive and to provide a handover

Role of the second clinician at birth:

- Support the woman, her birth partner and accoucheur as required
- Re-check the neonatal resuscitation equipment
- Check the oxytocic in preparation for 3rd stage.
- Note the time of birth and commence Apgar timer
- Administer the oxytocic, see Third Stage of Labour Clinical Guideline
- Take responsibility for care of the newborn from birth, see Immediate Care of the Healthy Term Newborn after Birth
- Attach baby identification labels
- Complete initial count of accountable items on birth trolley. See Management of Accountable Items in Birthing Services Procedure
- Assist in collecting cord blood gas for analysis, where required and collect cord blood for Rhesus negative women
- The second midwife may leave the room once care for the woman and the baby can safely be provided by primary midwife, see MHW Birth Suite, Maternity Ward and Theatre Neonatal Escalation of Care Procedure

Episiotomy

- Refer to the Episiotomy Procedure

Birth

Mercy Health recommends a "hands on" technique:

- Support the perineum
- Apply a warm compress between 38 and 44 degrees Celsius to the perineum, at the commencement of perineal stretching
- Apply gentle counter pressure on the fetal head
- If the shoulders do not deliver spontaneously, apply gentle traction to release the anterior shoulder
- Allow the posterior shoulder to be released, following the curve of Carus
- Routine checking for nuchal cord is not recommended
- Clamping and cutting of the nuchal cord before delivery of the head is only occasionally required.
- Delayed cord clamping may be performed depending on the condition of the neonate and the woman's wishes.
- Place the baby skin to skin with the mother immediately following birth, if appropriate

Management of Third stage of labour:

- Refer to Third Stage of Labour Clinical Guideline
- Postpartum Hemorrhage: Refer to Postpartum Haemorrhage Clinical Guideline

Cord Blood sampling

Paired cord blood gas samples should be taken for analysis of pH and lactate on all (i) assisted vaginal births, (ii) all emergency Caesarean sections and (iii) all 'unexpectedly' flat babies or babies requiring resuscitation.

Immediate Post Birth Care

Inspect the perineum and make a decision about the need for suturing. Refer to the Perineal Trauma Repair Clinical Guideline

Observations:

Record all postnatal observations on the Maternity Observation and Response Chart (AD 4440). See Care of Postnatal Patients on the Maternity Ward Clinical Procedure and Adult Rapid Response Procedure and Postpartum Haemorrhage Clinical Guideline

Time and frequency	Observation
Immediately following delivery of placenta, or within 15 mins of birth (whichever is sooner)	Full set of physiological observations (Temperature, blood pressure, pulse, respiratory rate) Uterine tone and height, Blood loss, Perineum, Pain and discomfort
15 minutely until 60 mins	Pulse and respiratory rate Uterine tone and height, Blood loss
60 mins after first set of observations	Full set of physiological observations (Temperature, blood pressure, pulse, respiratory rate) Uterine tone and height, Blood loss, Perineum, Pain and discomfort
Ongoing observations	As indicated. Prior to patient transfer or 4 hours post birth, whichever is sooner.

If there is delay to the delivery of the placenta, commence maternal observations 15 minutes after the birth.

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Division: Health Services - MHVL

Facility or Program: Women's and Children's Services

Approved by: Program Director – Women's and Children's Services

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Bladder Care:

- Refer to the: Bladder Care - Postpartum Clinical Guideline

Other:

- Facilitate skin to skin contact of the mother and baby. Aim for breastfeed within the first hour of birth, particularly for babies requiring blood glucose monitoring. Refer to Newborn Requiring Blood Glucose Monitoring Clinical Guideline (Excluding Neonatal Services MHW)
- Ensure the woman is clean, dry and comfortable, and provide emotional support as needed.
- Offer analgesia as required

Handover for postnatal care:

- The birth suite midwife should commence the postnatal care pathway AD3715. Ensure a handover to the Postnatal Ward staff as per the Clinical Handover Procedure and Interdepartmental Clinical Handover Checklist AD 2505.

Evidence

As per references

Precautions & Contraindications

As above

Definitions

Term	Definition
ARM	Artificial rupture of membranes
CTG	Cardiotocograph
Cervical effacement	The shortening of the cervix
Cervical dilatation	The diameter of the cervical os

Links to Related Documents

Pre-labour Spurious / Labour Clinical GuidelinePatient Identification Procedure
Intrapartum Fetal Surveillance Clinical Guideline
Oxytocin Infusion for Induction and Augmentation of Labour CG
Antenatal or Intrapartum Vaginal Examination Procedure
Oral Intake During Labour Clinical Guideline
Water Immersion in Labour Clinical Guideline
Standing Orders - Maternity Clinical Guideline
Epidural Analgesia Management Procedure
Intradermal Sterile Water Injections Clinical Guideline
Third Stage of Labour Clinical Guideline
Umbilical Cord Blood Gas Sampling Procedure
Bladder Care - Postpartum Clinical Guideline
Clinical Handover Procedure
Meconium stained amniotic fluid clinical guideline
Management of Accountable Items in Birthing Services Procedure
Immediate Care of the Healthy Term Newborn after Birth Clinical Procedure
Shoulder dystocia clinical guideline
Induction of Labour Booking Clinical Guideline
Oxytocin Infusion for Induction and Augmentation of Labour CG
Induction of Labour with Balloon Catheter Clinical Guideline
Induction of Labour with Dinoprostone (PGE2) Continuous Release Vaginal Pessary (Cervidil®) Clinical Practice

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Guideline

Evaluation

A range of tools will be used to evaluate policy compliance. Feedback systems such as incident reports, complaints, performance indicators and specific audits will be used to facilitate evaluation of compliance. Feedback is linked with the policy review process.

Risk Rating

Moderate (3 year document review period)

Key Legislation, Acts, Standards & Reference

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1	10/2013	New	Andrea Williamson, Anna Seaborn, Michael Rasmussen, Megan Burgmann, Neil Israelsohn, Bernadette White
2	September 2014	Reviewed. Made MPHI	Deputy Director Women's and Children's Services
3	May 2015	Reviewed – amendment to observations in second stage and Respiratory rate	Andrea Williamson - Birthing Services NUM, MHW Birthing Services; Bernadette White - Clinical Director, Administration
4	June 2017	Reviewed. Immediate Post Birth Maternal Observations section added. Links to Related Documents updated	Bernadette White, Clinical Director, Obstetric and Maternity Services, MHW Julie Kane, NUM, Birth Suite, MHW
5	May 2021	Full review and revision. All sections updated.	MHW Division of Obstetrics and Maternity WMH Division of Obstetrics and Gynaecology