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Calvary Maternity Education Program

1.1 Antenatal and When to Call the Hospital

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Program Outline and Contacts

• Antenatal	Ward Clerk (8am-3pm Mon-Fri) (02) 6281 8730
• Birthing	Birth Suite (24hrs) (02) 6281 8732
• Postnatal	Postnatal (24 Hrs) (02) 6281 8731
• Ward Tour	Special Care Nursery (24 Hrs) (02) 6281 8768

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Antenatal

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Antenatal Outline

- Normal last trimester
- When to contact your doctor or hospital
- Coming in to Hospital
- What you need
- Support
- Anatomy & Physiology
- Hormones

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Normal Last Trimester

You might notice

- The baby 'drops' (engaged, 'lightening'.)
- Backache
- Braxton-hicks contractions
- Increased vaginal discharge
- Bowel/bladder habits change
- The 'show'
- Sleep disturbances

Things you might do

- Nesting
- Antenatal Expressing
- Perineal Massage
- Plan care arrangements as needed
- Make food for freezer when home with baby
- Plan how to get to the hospital

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Contact your Doctor/Hospital

Vaginal bleeding or Ruptured membranes or contractions **before 37 weeks** (regardless of regularity or strength)

- Put on a pad
- Take note of the colour
  - Blood (Red Pink or Brown)
  - Liquor (Clear, Pink, Brown/Green)
- How much?
  - Was it a gush or a trickle?
- Don't discard used pads place them in a bag and bring them with you
- What were doing at the time?
- Any abdominal pain or contractions?
- Are baby's movement unchanged?

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Contact your Doctor/Hospital

- Lack of Movement from your baby
- Excessive abdominal pain
- Excessive vomiting
- Pain with passing urine
- A sudden change in another medical condition you may have
- Severe headache with or without visual changes
- Severe or sudden oedema (swelling) (often in hands or feet)
- Epigastric Pain

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Contact your Doctor/Hospital

Ruptured membranes or regular contractions **after 37 weeks**

- 2 – 3 in a 10 minute period
- Becoming longer and stronger (lasting 30 – 60 seconds)
- Requiring pain management and support

Please also advise us if you had a planned caesarean

If it concerns you, then it concerns us

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Coming in to Hospital

Where to go

- Front Entrance
- Maternity Entrance
- Postnatal Desk
- Birth Suite

What to bring

- Antenatal Card
- Birth Ideas
- Packing List

What Happens next?

- CTG
- Observations
- Discuss your history
- Examination as needed
- Discuss and make plan with you and your obstetrician

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Support

Support	**Role**
Partner	Protective
Midwife	Reliable
Obstetrician	Reassuring
Anaesthetist	Advocate
Paediatrician	Positive
Physiotherapist	Participating

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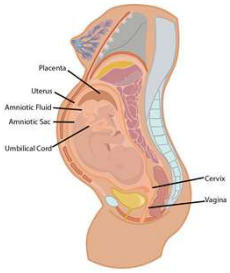
Anatomy and Physiology



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Hormones - Oxytocin

What is it?
- Key Hormone throughout pregnancy, labour and breastfeeding
- Promotes bonding
- Causes uterine contractions
- Reduces stress and anxiety
- Reduces how we perceive pain
- "Love Hormone"

Increased/Released
- by your body in response to the above

Decreased by
- Adrenaline
- Discomfort
- Opiates and Epidurals
- Synthetic oxytocic drugs

What helps you relax?
What strategies could you in your birth plan?

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Hormones - Endorphins

What is it?
- A natural opiate produced by the body that increase from week 12 of pregnancy and has a sudden reduction after birth (day 3 blues)
- Helps moderate stress and pain and has an amnesic effect
- Alters your perception of time and space
- "Feel Good" Hormone

Increased by
- Labour
- physical effort and
- feeling good

Decreased by
- Anaesthetics
- Adrenaline

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Hormones - Adrenaline

What is it?
- Part of our fight or flight reflex
- In labour it can reduce oxytocin and alter uterine action (slow labour), reduce our endorphins (increase pain),
- Reduce blood supply to uterus and baby

Increased by
- Danger/fear
- Anxiety/stress
- Pain

Decreased by
- Emotionally safe space
- Reducing external stimulation
- Familiar people
- Knowledge and information

What Triggers Adrenaline for you?

What are your strategies going to be to *reduce* adrenaline?

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1.2 Birthing Overview

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Birthing

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Birthing Outline

- Spontaneous, Induction and Augmentation of Labour
- Labour Stages Overview
- Early Labour
- Established Labour
- Transition
- Stage 2
- Stage 3
- Stage 4
- Managing Labour
  - Headspace and comfort
  - Non-Pharmacological
  - Pharmacological
- Assisted Birth
- Caesarean Section
- Less Common Outcomes

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Spontaneous Labour

Spontaneous Labour
- Your body naturally starts labouring on its own
- With or without membranes breaking

When to call the Hospital
- Put on a pad
- Take note of the colour
- 2 – 3 in a 10 minute period
- Becoming longer and stronger (lasting 30 – 60 seconds)
- Requiring pain management and support
- Please also advise us if you had a planned caesarean

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Induction of Labour

Why do we induce labour?
- Postdates (41 Weeks)
- Prolonged Rupture of Membranes (PROM)
- Oligohydramnios
- Blood Pressure Disorders
- Gestational Diabetes
- Chorioamnionitis
- Other Maternal Conditions

How do we induce labour?
- Prostaglandins
- ARM
- Oxytocin Infusion
- When to come in
- What happens and when
- Why things might change

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Induction of Labour

Risks
- Failed Induction
- Assisted Birth
- Overstimulation of Uterus
- Fetal Bradycardia
- Increased chance of bleeding

Induction not suitable
- Prior Classical caesarean
- Placenta Previa
- Baby is Transverse
- Cord Prolapse
- Other Medical Conditions
  - Multiple Pregnancy
  - Breech – discuss with your doctor
  - VBAC – Vaginal Birth After Caesarean – discuss with your doctor

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Augmentation of Labour

Augmentation of Labour
- Your body started the process
- Perhaps slowed down or stalled this process
- We then used one (or more) of the Induction procedures to resume that process

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Vaginal Birth After Caesarean

VBAC – Should I have one?
- Depending on why you had a caesarean previously, on your subsequent pregnancies, you may consider a planned VBAC
  - For example – Uterine Rupture (Contraindicated) versus Previous baby was breech (go for it)
- If you want a VBAC and there isn't a medical reason to not have a vaginal birth for you or your baby, then your obstetric team will support you

Risks
- Increased risk of Uterine Rupture
  - Further increased postdates
- Increased infection rates
- A Caesarean may still be required (as with any labour)
- Lower success rates with previous
  - 'failure to progress' and
  - 'cephalo-pelvic disproportion'

QLD Health VBAC Guidelines

Page 10 of this guideline compares the risks of a planned VBAC compared to an Elective Repeat Caesarean Section

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VBAC – Success?

Factors increasing success
- Overall 60-80% Success rates
- Previous Vaginal birth (before or after caesarean – increased to 90%
- Spontaneous onset of labour prior to 41 Weeks
- Dilatation of 4cm or more at admission
- Less than 4kg baby
- Younger maternal age
- Previous reason for caesarean
  - Fetal distress
  - Malpresentation

Benefits
- Lower rates of DVT
- Faster recovery rates and improved mobility earlier
- Increased opportunity for skin to skin with baby
- Avoiding surgery
- Mental Health benefits to mum if successful and if a vaginal birth is important to mum (be aware that if unsuccessful this can have the reverse effect)

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1.3 Birthing – Stages of Labour

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Labour Stages Overview

Pre Labour/Early labour
- Cervix thins and begins to open (the 1st 4cm)
- Contractions are mild and irregular

1st stage of labour
- Cervix is dilating (4cm -10cm)
- Contractions are regular and more intense (2-3 in 10 minutes lasting 30-60 seconds)
- Transition (the last few centimetres)

2nd stage of labour
- Cervix is fully dilated (10cm)
- Pushing begins and baby is born

3rd stage of labour
- Placenta is born

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Labour – Checking in

Monitoring Mum
- Discussing your medical history and birth ideas/plan
- Asking mum how she is and noting how contractions are progressing throughout labour
- Observations (Blood pressure, pulse, temperature)
- Noting regular emptying of bladder or quantity/colour if an IDC is insitu

Monitoring Baby
- Palpate position (external)
- Listen to heart rate with a doppler or CTG – especially around contractions
  - Intermittent or Continuous as appropriate in your situation
  - Telemetry monitoring may also be available to enable ease of movement

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Labour – Checking in

Internal Examinations
- Always with consent
- Are invasive and therefore only requested if we need to obtain information (progress, baby position etc)
- Depending on your circumstances, may be requested on admission to help form a 'baseline' to help form a plan with you and your doctor

Your Obstetrician
- Will be notified of your arrival and will make a plan with you
- They will be called if any queries or concerns arise and/or if birth may be imminent

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Early Labour

What is it?
- Onset of contractions
- Gradual effacement (thinning) and dilatation (opening) of the cervix.
- Early phase-dilatation from 0-4cm.
- Contractions' every 5-30mins apart, lasting 15-40 seconds

Contractions
- May be irregular to start and then become regular
- Get closer together
- Become stronger
- Last longer
- Up right makes them stronger
- Lying down does not make them go away
- May start in the back & radiate to the front

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Early Labour

What to expect
- Physical discomfort is *relatively* mild
  - still able to talk through contraction
  - back pain is common
  - period like cramps
- Mixed emotions - excited, yet anxious

Things to do
- Snack, drink, rest, try rocking back and forth, or a shower or bath, walk, read, check you are packed
- Call the Hospital and stay in touch; this also allows us to make any necessary arrangements to ensure things are ready for you later on
- Make arrangements for other children, pets or other caring responsibilities

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Established Labour

What is it?
- Cervix 4cm dilated or more and thinning
- Regular, painful contractions

What to expect
- Contractions become stronger, longer and more intense
- 2-5 minutes apart lasting 45-60 seconds

How to Manage
- Drink/small amounts of food
- Vertical and upright
- But do rest when needed
- Changing positions – circuit
- Using your preferred coping strategies
- Medications

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Transition

What it is
- Dilating 8-10cms

What to Expect
- Contractions at their strongest
  - every 2-3 mins
  - lasting 45-90 seconds
- May feel out of control, nauseated, irritable
- May experience pressure on bowel with contractions

How to Manage
- Role of support person very influential
- Use coping strategies to stay focused/calm
- Change positions as needed

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Stage 2

What is it?
- Cervix fully dilated -10 cm
- Now that the cervix has dilated, baby will still need to descend

What to expect
- Active Pushing - urge to push with contractions
- Contractions become expulsive
- longer gap between contractions
- Perineum stretches as head descends - burning/stinging

How to Manage
- Focus on breathing/each contraction
- Rest between contractions
- Cool face washer
- Open hips/alter position
- Listening to your support person, midwife and doctor

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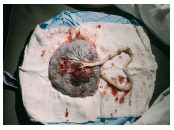
Stage 3 From birth of baby to birth of the placenta

- Active Management of third stage – Syntocinon injection
- Delayed Cord Clamping (if possible)
- Cord clamped and cut (support person can often do this)
- Placenta delivered
- Blood collected (if needed)
- Fundus rubbed to control bleeding and prevent PPH
- Suturing (if needed)
- Baby checked throughout this period and remains skin to skin with mum (wherever possible)



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Stage 4 – The Early Postnatal Period Birth Suite

Woman
- Skin to skin
- Bonding time
- Uterus
- Perineum
- Observation
- Refreshments
- Shower and a wee

Baby
- APGAR's
- First breast feed
- Weigh and measure
- ID bands
- Vitamin K Injection
- Hepatitis B immunisation

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1.4 Birthing – Less Common Outcomes and Assisted Birth

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Less Common Outcomes

Antenatal/Early Labour

- Anaemia
  - Iron Infusion
- Antepartum Haemorrhage
  - Uterine Rupture
- Vasa Previa
- Born Before Arrival
- Premature Labour
- Malposition of baby
  - Eg Brow Presentation
- Placenta Previa
- Meconium Stained Liquor
- GBS Positive

Labour

- Precipitous Labour
- Posterior Labour
- Fetal Bradycardia
  - Head Compression
  - Recovery after Contractions
  - FSE – Fetal Scalp Electrode
  - Fetal Distress
- Cord Prolapse
- Shoulder Dystocia
- Lack of Progress/changes to the cervix

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Less Common Outcomes

Postnatal

- Postpartum Haemorrhage
- Perineal Trauma
- Retained Placenta
- Assistance for baby
  - Discussed further in Special Care Nursery Section

Other

- Maternal Illness
- Transfer of mother or baby to a tertiary hospital
- Hospital Bypass

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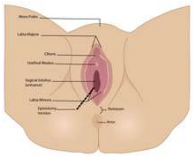
Assisted Birth

Assisted Birth Overview

- Assisted birth options are generally used to allow baby to be born more quickly
- None of these options are routine and are generally considered to prevent, or in the event of, an obstetric emergency
- We will monitor both the health of mum and baby throughout your labour and alongside your obstetrician, discuss with you any concerns or potential course of action

Episiotomy

- Small incision at an angle to allow access or to help to prevent tearing along the perineum (towards the anus)



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Assisted Birth

Vacuum – Mityvac or Kiwicup

- Procedure performed by your obstetrician
- Used in conjunction with contractions
- Adequate pain relief
- Temporary bruising and swelling on the head
- May increase risk of jaundice in the baby

Forceps

- May be performed in theatre
- Procedure done by your obstetrician
- Different types used in different situations for example if rotation is needed
- Adequate pain relief
- May leave temporary bruising to the face
- Paediatrician may be present

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Assisted Birth – Caesarean

Unplanned/Emergency Caesarean

- Because assisted birth options are used in the event of obstetric emergencies, if they do not work, then or are not viable then an emergency caesarean may be recommended.
- Things move quickly in emergencies but we will always discuss what is happening with you to help you make informed decisions for you and your baby.
- Our focus is always on your wellbeing and that of your baby/babies.
- Your doctor will make the arrangements including organising an anaesthetist and the on call paediatrician,
- Your support partner will come with you to theatre whenever possible.