# Birthplan Reading

## LABOUR POSITIONS

Think about mobilizing during labour, staying upright, changing your position to what feels comfortable for you. Remember your options are kneeling, squatting, lying down, birthing stool, shower, swiss ball and support from your birthing partner.
Try to stay relaxed and allow labour to progress. Your own hormones are being released to help you relax and your uterus to contract.
Consciously relax your shoulders and jaw, abdomen and legs. Trust your instincts.

## WHAT WILL YOU NEED IN HOSPITAL

Wear your own clothes to labour in, an old tshirt clean of course.
A clean pillow with coloured pillowslip (white or blue ones might get mistaken for hospital issue)
Energy drinks like lucozade, lemonade or powerade.
Your own blanket, music, aromatherapy, hotpack and cold water spray.
Some food for after the arrival of your baby. Most women do not eat when they are in labour.
Lip salve is a must

## ALTERNATIVE THERAPIES

Often there is a birthing pool in the delivery room, swiss balls and birthing stools.
Bring in your own electric aromatherapy device
Massage, hypnotherapy, acupuncture and homeopathy are all recognized forms of therapies during your birth which you must research and take advice from the relevant professional with regard to your own special needs and circumstance. Talk your ideas over with your midwife.

## MONITORING YOUR BABY

Routine cardio tocograph (CTG) is not needed in low risk, normally progressing labour but if a CTG is requested then this usually means that you are immobilized as the best recordings are obtained if you are lying on the bed. You can get up and stand / walk within the limits of the electric cable.
Usually your midwife will listen to your baby's heart rate with a battery operated hand held Doppler unit similar to the ones you have already seen in clinic.

## SIGNS OF FETAL DISTRESS

An unusually fast or slow heart rate or the passing of meconium into the liquor around your baby often means that we need to carefully monitor your baby for the rest of the labour.
This is done by attaching a small clip (FSE) onto the baby's scalp and/or taking a Fetal Blood Sample (FBS)

## INDUCTION OF LABOUR

There might be a clear and urgent reason that you labour needs to be induced earlier than it would naturally happen.
The methods are:

- Prostin Gel- a hormone gel inserted vaginally
- Artificial Rupture of Membranes (ARM)
- Syntocinon infusion administered through a luer in your arm once your membranes have been broken.

**LATENT PHASE OF LABOUR**

Here you need to be aware that you labour might stop and start for 3-7 days. This can be very exhausting for everyone including your partner who will also be anxious.
How are you going to cope with this pain? What are you going to eat and drink?
Do you have any paracetamol, a TENS machine, a hotpack?

**PROGRESS OF LABOUR**

It is your midwife's responsibility to check if your labour is progressing normally. Here you must consider how you are going to cope with the pain bearing in mind that the average labour is about 18 hours long. You need to consider how you are going to rest.

**ESTABLISHED LABOUR**

Now that your cervix has dilated to a minimum of 3 cms and if your membranes have broken your labour could be at least another 7-12 hours with normal progress.
What if your condition or the baby's changes?
You need to consider your coping strategies, your pain relief options, rotating your birth partner support with a friend or relative.

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**AUGMENTATION OF LABOUR**

This refers to the use of intervention so that your labour continues to progress. The methods are

- Artificial Rupture of Membranes – a painless but uncomfortable procedure performed vaginally by your midwife.
- Intravenous prostaglandins to help your uterus to contract more efficiently. This treatment is very commonly used and a luer is also sited in your arm

**INSTRUMENTAL DELIVERY**

Sometimes the delivery of the baby might need assistance by a doctor. The method the doctor chooses is directly related to the specific situation so it is inappropriate to request one method above the other. The professional's opinion ie the doctor must be considered here.

Methods include forceps or ventouse .

These methods are sometimes performed in the operating theatre just in case the procedure needs to be abandoned and an operative delivery performed

**CAESAREAN SECTION**

Here you need to be aware of a few procedures that will make the operation safe.

-Epidural anaesthesia is usual and this can be performed in the operating theatre or you may already have one in situ during your labour, which will be 'topped up".

-Do not eat or drink anything once you know that you will be having an operation

-You will be changed into a hospital gown, jewelry removed or taped and underwear removed.

-the top bit of your pubic hairline will be shaved and a catheter will be inserted into your bladder (when epidural is working) and removed the next day.

-your support person will need to change into theatre clothes if they want to come with you.

-A paediatrician may also be at your birth.

-If you intend taking photos, great, but do not take photos of the midwives or doctors without their permission and no flash photography.

-Often you can cuddle your baby skin-to-skin after the initial baby check

-Sometimes you can take music into the theatre

-there will be plenty time to feed your baby when you get to the recovery room

**YOUR PLACENTA AND THE THIRD STAGE OF LABOUR**

If all is normal then a physiological third stage can be performed and you can wait up to an hour for the placenta to be expelled without an ecbolic injection.

Often an ecbolic injection is given to help the uterus to contract and minimalize the risk of bleeding. Your midwife will know at the time of your delivery if this is needed.

Consider hospital disposal of the placental in which case we will need your written consent (we have a form) or do you want to take it home. We can wrap it up for you.

**YOUR PERINEUM**

Nature designed this area to stretch and/or tear during childbirth but also is designed to heal really quickly.

An episiotomy is rarely performed but if this has been necessary then your skin will be sutured using a local anaesthetic or your epidural cover.

NO-ONE performs an episiotomy unless ABSOLUTELY NESSESARY.

Your natural tear will usually heal well with good suturing, pain relief and good perineal hygiene.

Sutures are usually subcuticular so you will not see them and they will eventually dissolve.

You might want to consider perineal massage in the antenatal period?

**CORD BLOODS**

Taken if the baby has shown signs of distress in labour or if you have organized stemcell collection or you have a Rhesus Negative blood group

**VITAMIN K FOR BABY**

Recommended by paediatrician's, this is a very small injection given to your baby after birth.

It helps prevent bleeding into the baby's brain caused by a traumatic delivery or a condition called Haemorrhagic Disease of the Newborn

You can read about it on out clinic website but we will need your consent and will not administer it otherwise.

It can also be given orally at birth, one week then one month of age.

**WHO WILL BE AT THE BIRTH WITH ME?**

You and your midwife of course.

Your partner / husband / baby's father

Any relatives but the control of these must be enforced by yourselves and not your midwife.

Consider rotating your support in the early part of your labour so everyone gets some rest, a coffee break or some fresh air.

Remind relatives that this is a special time for you and your partner and no one has the automatic right to be there.

**CARSEAT**

Hire one (Plunket) or buy one.

Get it fitted and PRACTISE with it and a medium sized teddy bear.

Put the back straps on the lowest setting and make sure you can get it in and out of the car quickly

**OTHER PLANS???**

Your midwife is always well trained, up to date and competent in all aspects of your care, the progress of normal labour and ALL emergency procedures.

She can manage epidural infusions, hormone infusions, blood administration and support in theatre if necessary but all of these procedures are deemed secondary care and at any time the midwife can handover your care to the core hospital staff.

It is usual that your care is handed over if you are going to have a ceasarean section or if your labour is being induced then your midwife will not usually care for you until your labour is definitely established.

Violence, threatening behavior or verbal abuse will not be tolerated from your partner or yourself towards each other or the midwife.

## PLEASE COMPLETE THE BIRTHPLAN CHECKLIST NEXT

# BIRTHPLAN CHECKLIST

Do I know when to contact my midwife?

Do I know the signs of Labour?

Did I go to antenatal classes?

Did I go to the epidural talk at the hospital?

What pain relief, if any, shall I consider in:

- Latent stage
- During the start of labour
- After a long labour
- If I have an instrumental or operative delivery
- After the birth

What positions shall I try

Do I want alternative therapies?

Do I understand about

- Fetal Distress
- Fetal monitoring
- The normal progress of labour
- Augmentation of labour
- Induction of labour
- The latent stage of labour
- The third stage of labour

Whats your decision on:

- Vitamin K for baby (injection or orally)
- Ecbolic for myself
- Placental disposal
- Planned postnatal stay
- Method of feeding your baby

Who will be present at the birth?

Is my bag packed by week 37

Is the baby bag packed by week 37

Have I practiced using the car seat?

**Is there anything else my midwife needs to know?**