Shoulder Dystocia

Classification :	Guideline
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Authors Division:	MPDT
Departments/Group this Document applies to:	Obstetrics and Maternity

Approval Group: Women's Health Guideline Review Group Women's Health CIG	**Date of Approval:**	03/02/2024
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	Review Date:	01/02/2024

Unique Identifier: MIDW/GL/26	**Status:** Approved	**Version No:** 7

Guideline to be followed by (target staff): This document applies to midwives and doctors at all levels working within the maternity service. There are training implications required to implement this guideline. Please refer to the Maternity Services Training Needs Analysis.

To be read in conjunction with the following documents:

Are there any eCARE implications? No

CQC Fundamental standards:
Regulation 9 – person centred care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

The reason for developing this document:
This guideline has been developed to support clinical practice in the diagnosis and management of shoulder dystocia. Local and national guidance has been used to inform this guideline in conjunction with the Trust governance process for guideline development.

Executive Summary

Shoulder dystocia is defined as a vaginal cephalic delivery that requires additional manoeuvres to deliver the fetus after the head has delivered and gentle axial traction has failed. (RCOG 2012)

- Shoulder dystocia is an unexpected obstetric emergency, 50% of all shoulder dystocia of which occur in normal birth weight babies.
- Early recognition is paramount in successful management of shoulder dystocia
- McRobert's manoeuvre is successful in up to 90% of cases of shoulder dystocia.
- Accurate and comprehensive documentation after the event is required by using the shoulder dystocia proforma in Appendix 2

When managed appropriately there is still significant perinatal morbidity and mortality associated with shoulder dystocia (cerebral hypoxia, cerebral palsy, fractured clavicle/ humerus, brachial plexus injury), plus increased maternal morbidity including postpartum hemorrhage (11%) and 4th degree tears (3.8%) (Royal College of Obstetricians and Gynaecologists, 2012, p.2).

Fetal brachial plexus injuries (Erb's palsy, Klumpke's paralysis) complicate 4-16% of deliveries complicated by shoulder dystocia with less than 10% resulting in permanent disability. The birth prevalence of CBP in the U.K. and Republic of Ireland in the study period was 0.43 per 1000 live births or 1 in 2300 (Evans-Jones et al, 2000). Both excess downwards traction and maternal expulsive efforts contribute to causing these injuries.

Induction of labour can be considered for women with a suspected LGA (large for gestational age) baby (National Institute for Health Research, 2017), although more research is required, to be confident with that this practice can reduce the incidence of shoulder dystocia. However, in women with gestational diabetes induction of labour at term can reduce the incidence of shoulder dystocia.

Definitions

1.0 Roles and Responsibilities:

Shoulder Dystocia requires timely management, prompt recognition and a measured response that recognises the need to release the bony impaction. All attendants at births must be aware of how to recognise shoulder dystocia, how to summon help and how to manage shoulder dystocia in all birth settings.

Specific Responsibilities of the Midwife:

- Recognising a shoulder dystocia
- Implementing care and manoeuvres
- Recognising when manoeuvres are ineffective and to aid early access to the consultant on call
- In the out of hospital setting, the midwife will be required to recognise the early warning signs, and be prepared for early recourse to summoning the emergency services
- Maintaining skills in the management of shoulder dystocia (mandatory) annually within protected time week

Specific Responsibilities of the Doctor:

- Recognising a shoulder dystocia
- Implementing care and manoeuvres
- Recognising when manoeuvres are ineffective and to aid early access to the consultant on call
- Maintaining skills in the management of shoulder dystocia

2.0 Implementation and dissemination of document

- This document will be disseminated across the maternity unit, through various team meetings and will be uploaded to the 'Womens Health Digital Document Review Group' through Microsoft TEAMS
- The document can be located via the hospital intranet

3.0 Processes and procedures

3.1 Factors associated with shoulder dystocia

Antenatal

- Previous shoulder dystocia.
- Induction of labour
- Maternal Body Mass Index > 30 at booking
- Macrosomia > 4.5kg
- Diabetes mellitus

Intrapartum

- Oxytocin augmentation
- Prolonged first stage of labour
- Secondary arrest
- Prolonged second stage of labour

- Assisted vaginal birth

4.0 Management of shoulder dystocia (see algorithm in appendix 1)

Diagnosis- Timely management of a shoulder dystocia requires prompt recognition, observe for:

- Difficult delivery of the face and chin
- The head remaining tightly applied to the vulva or even retracting (turtle-neck sign)
- Failure of restitution of the fetal head
- Failure to deliver the shoulders using routine axial traction with the contraction following birth of the head

Call for Help and declare the emergency – When the diagnosis is made, use the emergency buzzer to summon help, clearly state 'shoulder dystocia' to the arriving team and request the following immediately:

- **DIAL 2222 and ask for 'Obstetric emergency'**
- **DIAL 2222 and ask for 'Neonatal Emergency'**

Ask the person making the two emergency calls to return to the room to confirm that both calls have been made.
Request the resuscitaire and neonatal emergency trolley be brought to the location of the emergency.

During a homebirth, the attending midwives should dial 999 and ask for a 'time critical paramedic ambulance' to provide emergency assistance. This call should be made when a shoulder dystocia is diagnosed, or immediately afterwards in the event of maternal or neonatal compromise.

Once shoulder dystocia is diagnosed the birth attendant should ensure that;

- **Pushing is discouraged**
- **The position of the fetal back is identified (this is essential for manoeuvres)**
- **Evaluate for episiotomy –** An episiotomy will not relieve the bony obstruction of shoulder dystocia but may be required to allow whole hand access when performing the internal manoeuvres.

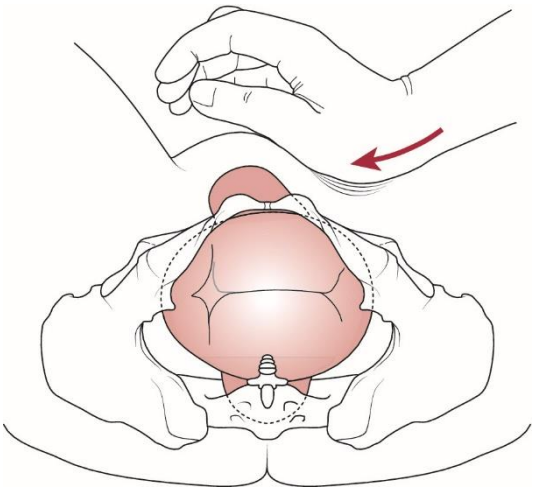
Assist the woman into McRobert's position;

- Lay the woman/bed flat, remove pillows (may have one under the head)
- Bring maternal buttocks to edge of bed and remove the end of the bed.
- With one assistant either side, the woman's legs should be hyper-flexed and abducted, positioning the maternal thighs on either side of the abdomen. When positioned correctly, the buttocks should be lifted off the bed.
- If the woman is in lithotomy at the time of diagnosis, her legs will need to be removed from the supports, straightened back down and then placed into McRobert's.

  Mc Robert's straightens the lumbosacral angle, rotates the maternal pelvis and increases the anterior-posterior diameter of the pelvis.
  Success rates are reported as high as 90% using McRoberts Manoeuvre alone.

Suprapubic pressure;

- Suprapubic pressure can be applied together with McRoberts position.
- Suprapubic pressure reduces the fetal bisacromial diameter and rotates the anterior fetal shoulder into the wider oblique pelvic diameter.
- Suprapubic pressure is applied by the assistant on the same side as the fetal back in the direction of the fetal chest (a downward lateral direction at 45 degree angle) using a cardiac massage style hand position just above the maternal symphysis pubis.
- Constant or rocking pressure can be used for up to 30 seconds.
  This has two possible effects;
  a) Adducting the shoulders and reducing the bisacromial diameter
  b) Rotation of the anterior shoulder towards the larger oblique diameter of the inlet.
- Routine axial traction should only be used if movement of the impacted anterior shoulder is felt.



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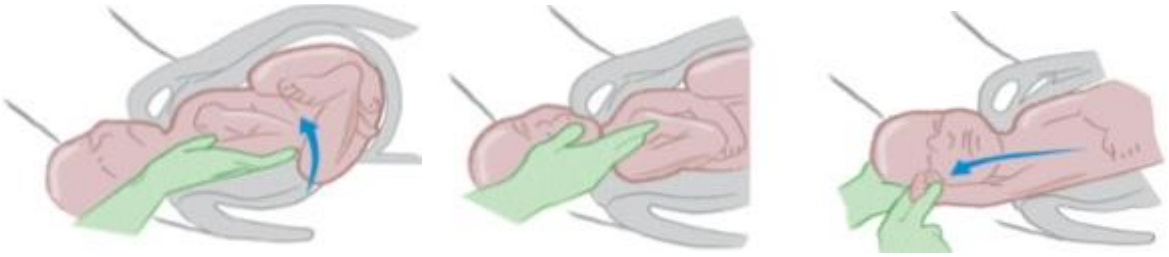
Internal manoeuvres - removal of the posterior arm, other internal manoeuvres;

There is no advantage between delivery of the posterior arm and internal rotation manoeuvres, therefore clinical judgement and experience can be used to decide their order.

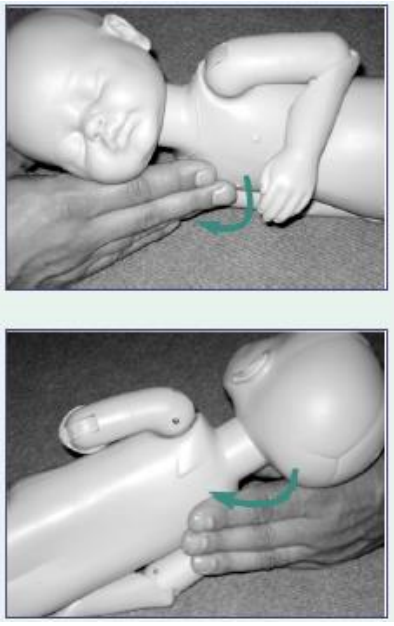
- Access for any internal manouevre should be gained by inserting the whole hand into the sacral hollow
- The whole hand should be used as insertion of two fingers will not be adequate to reach the correct fetal part or provide adequate pressure

Delivery of the posterior arm;
The fetal wrist should be grasped and the posterior arm should be gently withdrawn from the vagina in a straight line.



Internal rotation manoeuvres;
Rotation can be most easily achieved by pressing on the anterior or posterior aspect of the posterior shoulder.
1. Applying pressure on the posterior or anterior aspect of the posterior shoulder has the additional benefit of reducing the shoulder diameter by adducting the shoulders and can be performed in conjunction with suprapubic pressure). The shoulders should be rotated into the wider oblique diameter.
2. Apply pressure on the posterior aspect of the anterior shoulder to adduct and rotate the shoulders into the oblique diameter.

1.



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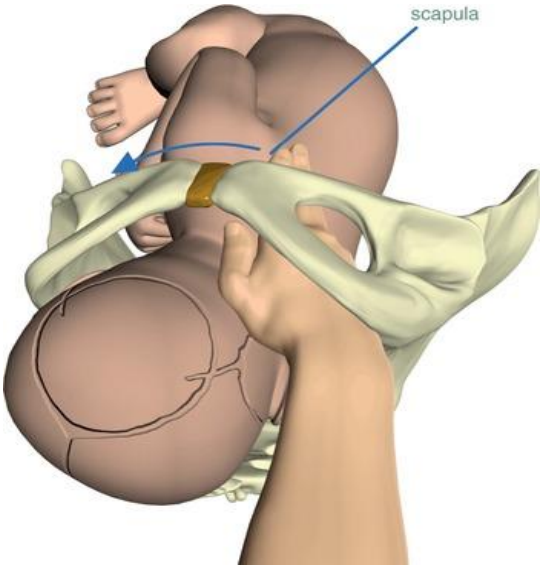

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All Fours position:

The 'all-fours' position has a high success rate but use of this technique will need to be assessed based on clinical judgement;

The individual circumstances should guide the healthcare professional as to whether to try the 'all-fours' technique before or after attempting internal rotation and/or delivery of the posterior arm.
Early all fours position may be appropriate for;

- Mobile woman without epidural anaesthesia
- Community setting
- Single birth attendant

For a less mobile woman with epidural anaesthesia in place, internal manoeuvres are more appropriate.

Other methods
Several third-line methods have been described for those cases resistant to all simple measures as described above.
These include;

- Cleidotomy (bending the clavicle with a finger or surgical division)
- Symphysiotomy (dividing the symphyseal ligament)
- Zavanelli manoeuvre (Cephalic replacement of the head, and delivery by caesarean section).

A senior doctor will evaluate the whole picture before any of these manoeuvres are undertaken

Post-delivery management;
Birth attendants should be aware of the increased possibility of;

- Postpartum haemorrhage
- 3rd and 4th degree tears (and or other severe perineal/vaginal trauma)
- The need for neonatal resuscitation
- Fetal injury (brachial plexus injury, fractures, pneumothoraces and hypoxic brain damage)
- The need for formal debrief for the woman, her family and staff.

5.0 Documentation

A trained designated person should be identified to act as the person responsible for record keeping (scribe) when a shoulder dystocia is identified

The scribe will use the shoulder dystocia proforma which is on the scribe clipboard in each delivery room (Appendix 2)

It is very important to clearly document all delivery details including;

- Time of head delivery
- Head-body delivery time interval

- Position of fetal back in relation to the mother
- Manoeuvres used (in order performed), by whom, and the time performed
- Maternal perineal and vaginal examination (episiotomy performed/other trauma?)
- Arterial and venous cord gases

Datix must be completed

6.0 Paediatric Management

- If dystocia suspected, both SHO and Registrar to attend delivery.
- The baby must be examined and findings documented even if resuscitation is not necessary.
- If brachial plexus injury suspected obtain X-ray and review by Senior Paediatrician and identify management plan.
- Record any signs of limb weakness and ensure neonatal follow up
- Refer to physiotherapist for review and advice about passive movements.
- Analgesia if necessary (e.g. musculoskeletal injury)
- Physiotherapy to start by the end of the first week
- Consultant out-patient appointment review by 4-6 weeks
- Ensure follow up appointment attended
- Further review at 4-6 weeks

7.0 Debrief

Full and clear explanations should be given to the parents. The professionals involved should be offered the chance to discuss the case in a supportive environment.

8.0 Skills drills

Training for all birth attendants in the management of shoulder dystocia is mandatory to ensure optimal management of shoulder dystocia.

- All birth attendants are advised to attend regular in house 'skills and drills' training to maintain the competency for the management of shoulder dystocia.
- Midwives must attend obstetric emergencies training which includes shoulder dystocia. (attending protected time annually).

9.0 Rationale for main recommendations;

The rationale for the main recommendations is made based on the seriousness of encountering a shoulder dystocia, its early recognition and the implementation of manoeuvres to illicit delivery whilst minimising risk to mother and baby.

10.0 Other Associated Documents

None

11.0 Statement of evidence/references

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12.0 Governance

12.1 Document review history

Version number	Review date	Reviewed by	Changes made
6.1			Section 12.3 – Audit frequency changed to annual from ongoing
6			Reviewed and updated

12.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Ed Neale	Divisional Director	09/02/18	14/02/18	No comments	Yes
Cath Hudson	Lead Midwife – Risk and Quality Improvement	09/02/18	09/02/18	Minor comments returned to author	Yes
Julie Cooper	Head of Midwifery	09/02/18	02/05/18	Minor comments returned to author	Yes
Maternity guideline Group	Maternity	27/01/21	27/01/21	Minor comments	Yes

12.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
a) Monitoring practice against recommendations within guideline b) Monitoring documentation of practice and use of shoulder dystocia proforma c) Monitoring maternal and neonatal outcome against guideline (incidence of severe perineal injury and neonatal complications)	a) Statistics b) Audit c) Statistics	Practice Development Midwife	Annual	Maternity Guidelines Group

12.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women and Children	Department	Maternity
Person completing the EqIA	Jodie Halliwell	Contact No.	
Others involved:		Date of assessment:	03/02/21
Existing policy/service	Yes	New policy/service	No

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*Maternity staff*

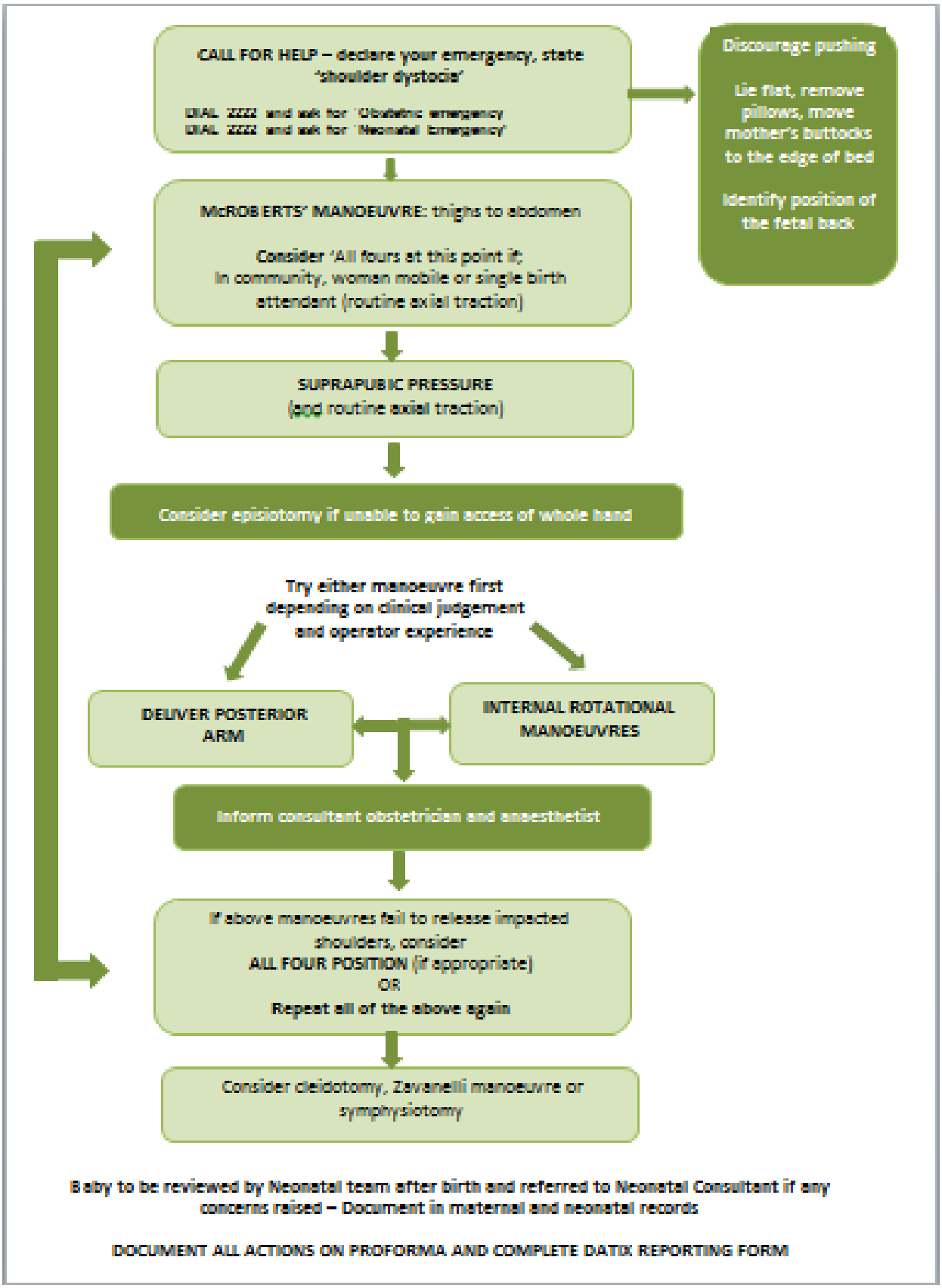
Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?
emails
How are the changes/amendments to the policies/services communicated?
emails
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA	03/02/2021		

Appendix 1: Algorithm for the management of shoulder dystocia

Adapted from: Royal College of Obstetricians and Gynaecologists (2012) *Shoulder dystocia.* [Green-top Guideline No.42]. [Online]. 2nd ed. Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_42.pdf [Accessed 8 December 2020



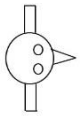
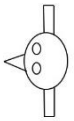
Appendix 2: Shoulder dystocia proforma (print both sides)

Shoulder dystocia proforma

Mothers Name: **MRN:**
Date: **Time:**
Assigned Midwife:
Other staff present at delivery:

2222 OBSTETRIC EMERGENCY - Time of call:
2222 NEONATAL EMERGENCY - Time of call:

Time of birth of head		**Spontaneous**		**Instrumental – Vacuum/Forceps**	

Fetal position during dystocia	Head facing maternal **left** **Left** fetal shoulder anterior 	Head facing maternal **right** **Right** fetal shoulder anterior 

Procedures used to assist birth	**By whom**	**Time**	**Details**	**Reason if not performed**
Bed flat **Remove pillows** **Remove end of bed** **Move to edge of bed**				
McRoberts' Position				
Suprapubic pressure			From maternal **left/right** (Circle as appropriate)	
Evaluate vaginal access (?episiotomy)				
Delivery of posterior arm			**Right/left** arm (Circle if appropriate)	
Internal rotational manoeuvres performed		**Pressure applied to:**	**Anterior aspect of posterior shoulder TIME:** / **Posterior aspect of posterior shoulder TIME:** / **Posterior aspect of anterior shoulder TIME:**	
Other manoeuvres used e.g. cleidotomy, symphysiotomy, zavanelli manoeuvre				

ADDITIONAL STAFF ATTENDING

NAME	ROLE	TIME ARRIVED

Shoulder dystocia proforma – page 2

Other information:

Maternal position when shoulder dystocia occurred (i.e. prior to any procedure to assist):	Semi - Recumbent	Lithotomy	Side-lying	All fours	Kneeling	Standing	Squatting	Other
Maternal position at delivery:	Semi - Recumbent	Lithotomy	Side-lying	All fours	Kneeling	Standing	Squatting	Other

Neonatal information (use neonatal emergency proforma to scribe full

Time of birth of baby:		Head-to-body birth interval:			
Birth weight	kg	Apgar	1 min:	5 mins:	10 mins:
Cord gasses	Art pH:	Art BE:	Venous pH:	Venous BE:	
Explanation/debrief to parents	Yes		**Risk incident form completed if clinical concerns**	Yes	N/A
Neonatologist called: Yes/No **Time arrived:** **Neonatologists name:**					

Baby assessment at birth (maybe done by MW) Any sign of arm weakness?	**Yes**	**No**	**If yes to any of these questions, for review and follow up by Consultant Neonatologist**
Any sign of potential bony fracture?	**Yes**	**No**	
Baby admitted to Neonatal Intensive Care Unit?	**Yes**	**No**	
Assessment by:			

Additional comments/documentation: