Monitoring during third stage

Why monitoring continues after birth

The birth of the baby is not the end of the immediate obstetric assessment. During the third stage, the placenta separates from the uterine wall and is expelled, while the uterus contracts to reduce blood flow from the placental implantation site. This contraction is a key physiological mechanism for limiting haemorrhage. A uterus that remains soft or poorly contracted, known as uterine atony, may allow substantial bleeding to develop.

Postpartum haemorrhage can occur unexpectedly, including in people without recognized risk factors. For this reason, observation continues even when the pregnancy and labour have been uncomplicated. Monitoring also helps identify delayed placental delivery, retained placental tissue, genital tract trauma, or maternal deterioration. The aim is not to create unnecessary alarm but to detect changes while the mother is still able to communicate and before blood loss or circulatory compromise becomes more severe.

The immediate postpartum period is also important for assessing the mother’s transition after exertion, pain, and blood loss, and for supporting early contact with the newborn. Clinical surveillance should be explained clearly and carried out with privacy, dignity, and consent wherever possible.

Core maternal observations

Guidance from NICE recommends observing the mother’s colour, respiration, general condition, and vaginal blood loss during the third stage. These observations complement formal measurements such as pulse, blood pressure, respiratory rate, temperature when indicated, and level of consciousness. A change in skin colour, new pallor, unusual breathlessness, dizziness, confusion, weakness, or reduced responsiveness may indicate that urgent assessment is needed, particularly when accompanied by bleeding.

Vaginal blood loss should be assessed continuously in context rather than judged only by appearance. Clinicians may estimate or measure blood loss, inspect pads or collection equipment, and consider the pace of bleeding. Rapid blood loss can be clinically significant even before a person develops obvious symptoms. Conversely, small amounts of blood may appear during normal placental separation, but the pattern and amount must be interpreted by the attending midwife or obstetric team.

Monitoring should include regular communication with the mother. Questions about pain, nausea, light-headedness, chills, chest discomfort, or feeling unwell can reveal changes that are not immediately apparent from observation alone. The team should document findings and communicate any change promptly so that escalation is coordinated.

Assessing uterine tone and placental delivery

After the placenta is delivered, the uterus is assessed through abdominal palpation to determine whether it is firm and contracted. A firm uterus is reassuring, although it does not eliminate the need to assess bleeding. A soft, enlarged, or intermittently relaxing uterus may suggest inadequate contraction and requires prompt clinical attention. The location and height of the uterine fundus may also be considered alongside bleeding and other observations.

The placenta and membranes are examined after delivery to assess whether they appear complete. Suspected retained placental tissue can interfere with uterine contraction and contribute to ongoing bleeding. The cord and placenta may be inspected according to local practice, and any concern about incomplete

delivery should be communicated to the obstetric team.

The timing of placental delivery matters. If the placenta does not deliver within the expected timeframe for the management approach being used, the team assesses for a retained placenta and considers the mother's condition, bleeding, analgesia, and need for further intervention. This is a clinical decision requiring trained professionals; a person giving birth should not attempt to pull on the cord or manually remove tissue.

Physiological and active management

Monitoring is adapted to whether the third stage is managed physiologically or actively. Physiological management generally allows the placenta to separate and deliver without routine administration of a uterotonic or planned cord traction. Active management usually includes a prophylactic uterotonic, appropriate timing of cord clamping according to the clinical situation, and controlled cord traction by a trained professional after signs of placental separation. The choice should be discussed antenatally or during labour when circumstances allow, taking account of preferences and clinical factors.

Both approaches require observation of maternal condition, bleeding, uterine contraction, and placental delivery. Active management may reduce the risk of postpartum haemorrhage for some patients, but it does not replace ongoing assessment. Similarly, physiological management is not an absence of care: the midwife or doctor remains attentive to bleeding, symptoms, vital signs, and progress.

Following birth, the uterus is assessed promptly and then rechecked at intervals. WHO material on active management describes assessing uterine tone immediately after placental delivery and checking it every 15 minutes for the first 2 hours, with more frequent monitoring if uterine atony occurs. Local protocols may specify additional observations, particularly for people with risk factors or abnormal findings.

Recognizing concerns and escalating care

Escalation is based on the whole clinical picture, not on a single observation. Concerning findings may include heavy or rapidly increasing vaginal blood loss,

a soft uterus that does not become firm with appropriate clinical measures, a placenta that has not delivered within the expected timeframe, suspected retained tissue, persistent tachycardia, falling blood pressure, altered mental status, pallor, respiratory difficulty, or collapse. Severe pain, especially if disproportionate or associated with instability, also warrants assessment.

When a concern arises, the team may call for additional help, increase the frequency of observations, establish or maintain intravenous access, obtain blood tests, administer treatments according to the clinical protocol, or move the mother to a setting with greater monitoring and intervention capacity. Management depends on the cause and severity of the problem. Possible contributors to postpartum haemorrhage include uterine atony, retained placental tissue, genital tract trauma, and coagulation abnormalities, and these require different clinical responses.

Monitoring becomes especially frequent when postpartum haemorrhage, retained placenta, maternal collapse, or another significant concern is present. The mother and her support person should receive concise explanations about what is happening, what is being assessed, and why additional staff or interventions may be needed. Calm, direct communication can reduce fear while urgent care is organized.

The mother’s role and the immediate recovery period

Parents are not expected to interpret clinical measurements, but their observations are valuable. Tell the midwife or doctor promptly if you feel faint, unusually weak, short of breath, confused, very cold, nauseated, or suddenly unwell. Report increasing abdominal or vaginal pain, a sensation of flooding, or bleeding that seems heavier than expected. A support person can help by noticing changes, asking for clarification, and ensuring that concerns are heard when the mother is focused on the newborn.

After the placenta is delivered, surveillance continues into the immediate postpartum period. The team may reassess uterine tone and vaginal loss, check vital signs, inspect for trauma, review pain and bladder needs, and support feeding or skin-to-skin contact when appropriate. The newborn’s transition is assessed separately, while care is coordinated to preserve early contact whenever clinically safe.

Recovery should include an explanation of what was observed, whether the placenta appeared complete, any estimated blood loss, medicines or procedures provided, and what warning signs require urgent help. Monitoring does not end simply because the third stage has finished; early postpartum observation remains important because bleeding and maternal deterioration can develop after placental delivery.