# SECOND STAGE OF LABOUR - RECOGNITION OF NORMAL PROGRESS AND MANAGEMENT OF DELAY

*This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.*

## 1. AIM

- To recognise and support normal second stage of labour
- To make a timely diagnosis of delay in the second stage of labour and recommend management that will increase the likelihood of a safe birth

## 2. PATIENT

- A woman who is considered to be in the second stage of labour

## 3. STAFF

- Medical and midwifery staff

## 4. EQUIPMENT

- Sterile gloves
- Lubricant
- Doppler
- Pinard stethoscope
- Amnihook/Amnicot
- Intravenous (IV) cannula
- Fetal monitoring equipment

## 5. CLINICAL PRACTICE

- Confirm the cervix is fully dilated by vaginal examination in a **nulliparous** woman prior to commencing pushing unless the presenting part is on view
- Confirm that the cervix is fully dilated by vaginal examination in a **parous** woman with an urge to push, unless the presenting part is on view within five contractions
- Encourage woman to adopt positions that are the most comfortable for her to aid her expulsive efforts
- Ensure adequate hydration and encourage woman to void, or recommend urinary catheterisation if bladder is palpable and woman is unable to void
- Allow for one hour of passive descent if woman has no urge to push, whether epidural block (EDB) is in situ or not. Assess after one hour to ensure descent has occurred, and presenting part is below ischial spines.
- Auscultate and record the fetal heart rate for at least one minute after every contraction and at least every five minutes once pushing has commenced
- Refer and consult with obstetric medical staff and midwifery team leader if delay is suspected and according to ACM guidelines.
- Determine action plan according to the woman's parity, preferences, analgesia, fetal and maternal wellbeing, and her consent to recommendations, as well as the suspected cause of delay

**Delay in second stage for nulliparous woman**

- Consider delay after two hours of full dilatation if descent/rotation is inadequate, or after one hour of pushing
- Commence Electronic Fetal Monitoring (EFM)
- Consult obstetric medical team/midwifery team leader
- Recommend vaginal examination noting station, position, moulding and caput
- Recommend artificial rupture of membranes (ARM) if appropriate

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- Assess for the following prior to consideration of Syntocinon, in consultation with obstetric registrar and consultant:
    - Fetal compromise and malpresentation
    - Any signs of obstructed labour
    - Uterine scar
    - Contraction frequency and duration
- Reassess one hour after commencing Syntocinon and/or after one hourr pushing if birth not imminent
- Consider second hour of pushing or offer manual rotation/instrumental birth/caesarean section as appropriate
- Ensure neonate is born **within four hours** of onset of second stage. Within these four hours, there must be continuous assessment and surveillance of maternal and fetal wellbeing**.**

**Delay in second stage for parous woman**

- Consider delay after 90 minutes of full dilatation if descent/rotation is inadequate, or after 30 minutes of pushing
- Commence EFM
- Consult obstetric medical team/midwifery team leader
- Recommend vaginal examination noting station, position, moulding and caput
- Recommend ARM if appropriate
- Assess for the following prior to consideration of Syntocinon, in consultation with obstetric registrar and consultant:
    - Fetal compromise and malpresentation
    - Any signs of obstructed labour
    - Uterine scar
    - Contraction frequency and duration
- Consider IV Syntocinon, with caution, if no contraindications after obstetric registrar review and discussion with consultant
- Reassess 30 minutes after commencing Syntocinon and/or after 30 minutes of pushing if birth not imminent
- Consider manual rotation/instrumental birth/caesarean section as appropriate
- Ensure neonate is born **within three hours** of onset of second stage. Within these three hours, there must be continuous assessment and surveillance of maternal and fetal wellbeing

### 6. DOCUMENTATION

- Partogram
- Medical record
- eMaternity

### 7. EDUCATIONAL NOTES

- Women should be informed that in the second stage they should be guided by their own urge to push, although this urge may be impacted by epidural analgesia
- If pushing is ineffective or if requested by the woman, strategies to assist birth can be used, such as support, change of position, emptying of the bladder and changing from spontaneous to coached pushing techniques

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- There is a wide range of "normal" when observing progress in labour and the following factors have been shown to promote physiological labour:
    - Encouraging an atmosphere of calm, privacy and safety
    - Offering continuity of midwifery care whenever possible
    - Encouraging continuous non-professional support persons and/or doulas
    - Listening to the woman and acknowledging her preferences and birth plan
- The midwife needs to be alert to progress (or lack of) and refer to medical staff and midwifery team leader when delay is suspected, to allow planning for timely delivery if delay is diagnosed.
- Offering timely intervention is aimed at reducing the risk of more invasive interventions and complications
- If an epidural is in situ the second stage is more likely to be prolonged and there is an increased chance of an instrumental birth
- A second stage of labour duration of > two hours is associated with an increased risk of postpartum haemorrhage, and appropriate prophylactic measures to reduce this risk should be taken
- Although the maximum durations for second stage of labour are stated as four hours for a nulliparous woman and three hours for a parous woman, these should be considered absolute maximums
- Warm compresses to the perineum at time of birth have been shown to reduce the incidence of third and fourth degree tears.

### 8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- First stage labour care for women with a low risk pregnancy
- Delivery Suite responsibility for review and management of public patients
- Syntocinon induction or augmentation of labour
- Vaginal examinations in labour
- Intrapartum Fetal Heart Rate monitoring
- Caesarean Birth – Maternal Preparation and Receiving the Neonate(s)
- Assisted Vaginal Birth Guideline - see SESLHDGL/050
- Postpartum haemorrhage – Prevention and Management
- Third Stage Management Following Vaginal Birth
- Epidural Analgesia Programmed Intermittent Epidural Bolus (PIEB) and Patient Controlled Epidural Analgesia (PCEA) – Delivery Suite
- ACM guidelines for consultation and referral

### 9. RISK RATING

- Low

### 10. NATIONAL STANDARD

- CC – Comprehensive Care

### 11. REFERENCES

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## SECOND STAGE OF LABOUR - RECOGNITION OF NORMAL PROGRESS AND MANAGEMENT OF DELAY cont'd

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12 Duration of Second Stage of Labour at Term and Pushing Time: Risk Factors for Postpartum Haemorrhage Looft, Emelie1; Simic, Marija1; Ahlberg, Mia1; Snowden, Jonathan M.2; Cheng, Yvonne W.3,4; Stephansson, Olof*,1,5 Paediatric and Perinatal Epidemiology Issue: Volume 31(2), March 2017, p 126–133

**REVISION & APPROVAL HISTORY**

Reviewed and endorsed Maternity Services LOPs 14/8/18 - incorporated previous title *Vaginal Examinations in Labour, approved Quality & Patient Safety Committee 17/7/14 now deleted)*
Approved Quality & Patient Safety Committee 20/9/12
Endorsed Maternity Services Division LOPs group 11/9/12
Replaced *Second Stage Labour Care* – Approved Quality & Patient Safety Committee 17/3/11 (minor amendment by Obstetrics LOP group June 2011; Reviewed Obstewtrics Clinical Guidelines Group Dec 2010; Previously titled '*Second Stage of Labour Guidelines'* Approved Quality Council 16/10/06

**FOR REVIEW : NOVEMBER 2023**