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 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. Record the maternal pulse simultaneously to differentiate between the maternal and fetal heartbeats
- 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

- Recommend vaginal examination noting station, position, moulding, and caput
- Diagnose delay after two hours of full dilatation if descent/rotation is inadequate, or after one hour of involuntary and or active pushing
- Commence Continuous Electronic Fetal Monitoring (CEFM)

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- Ensure a request for consultation and review by obstetric medical team and midwifery team leader. A medical review consists of:
  - attendance of the medical officer in the birthing room
  - assessment of the fetal welfare
    - CTG interpretation and documentation co-signed with the midwife, where CEFM is used
    - assist in initiating CEFM, if not already commenced
    - undertaking a clinical examination and plan for delivery if fetal concerns
  - if no fetal concerns, negotiate ongoing plan with the woman, her partner/support person and midwife
- Recommend artificial rupture of membranes (ARM) if appropriate
- Assess for the following prior to consideration of oxytocin, in consultation with obstetric registrar and consultant:
  - fetal compromise
  - fetal malpresentation
  - signs of obstructed labour
  - contraction frequency and duration
- Consider IV Syntocinon® with caution, if no contraindications, after obstetric registrar review and discussion with consultant
- 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

- Recommend vaginal examination noting station, position, moulding, and caput
- Diagnose delay after 90 minutes of full dilatation if descent/rotation is inadequate, or after 30 minutes of involuntary and/or active pushing
- Commence CEFM
- Ensure a request for consultation and review by obstetric medical team and midwifery team leader. A medical review consists of:
  - attendance of the medical officer in the birthing room
  - assessment of the fetal welfare
    - CTG interpretation and documentation co-signed with the midwife, where CEFM is used
    - assist in initiating CEFM, if not already commenced
    - undertaking a clinical examination and plan for delivery if fetal concerns
  - if no fetal concerns, negotiate ongoing plan with the woman, her partner/support person and midwife
- Recommend ARM if appropriate
- Assess for the following prior to consideration of oxytocin, in consultation with obstetric registrar and consultant:
  - fetal compromise
  - fetal malpresentation
  - signs of obstructed labour
  - contraction frequency and duration
- Consider IV Syntocinon® with caution, if no contraindications, after obstetric registrar review and discussion with consultant
- 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

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6. DOCUMENTATION

- Partogram
- Medical record

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
- 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 Woman with a Low Risk Pregnancy
- Delivery Suite - Responsibility for Review and Management of Public Patients
- Oxytocin for induction or augmentation of labour
- Maternity - Fetal Heart Rate Monitoring – MoH GL2018/025
- 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

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REVISION & APPROVAL HISTORY

Reviewed and endorsed Maternity LOPs November 2020
Amendment Maternity LOPs Committee - 3/9/2020
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 Obstetrics Clinical Guidelines Group Dec 2010; Previously titled '*Second Stage of Labour Guidelines'* Approved Quality Council 16/10/06

FOR REVIEW: DECEMBER 2025

Appendix 1

MANAGEMENT OF DELAY IN SECOND STAGE

Delay diagnosed - Medical review required for:

- Nulliparous woman after:
  - 2 hours of full dilatation, including 1-hour passive descent, with inadequate descent/rotation and/or
  - 1 hour of involuntary and/or active pushing
- Multiparous woman after:
  - 90 minutes of full dilatation, including 1-hour passive descent, with inadequate descent/rotation and/or
  - 30 minutes of involuntary and/or active pushing*

*This is a locally agreed variance to the ACM guideline

- **Commence continuous electronic fetal monitoring** (CEFM/CTG)
- If in birth centre, transfer to delivery suite if safe to do so
- **Inform Team Leader** of need for review by obstetric registrar or consultant

Medical Review:

- Initial discussion using ISBAR may take place outside of woman's room to aid in minimising disruption of birth space
- Midwife to introduce medical officer to woman and support people
- Assessment of maternal and fetal welfare by medical officer:
  - Progress of labour
  - Risk factors (antenatal or intrapartum)
  - CEFM/CTG review and interpretation. Co-sign the EFM sticker and CTG print out

No maternal or fetal concerns:

- maternal observations 'between the flags'
- EFM normal limits
- progress with pushing noted, and woman motivated for normal vaginal birth
- no need for medical officer to remain in room till birth

Ongoing management plan with woman, support people and midwife:

- agree upon an additional time frame for pushing
- review earlier if indicated
- document plan in medical record

Maternal or fetal concerns present:

- maternal observations 'outside the flags'
- EFM abnormal
- minimal progress with pushing
- maternal exhaustion or requesting assistance

Ongoing management plan with woman, support people and midwife:

- consider lactate, and/or
- expedite birth:
  - episiotomy
  - instrumental birth
  - caesarean section
- document plan in medical record

Birth of neonate