



INTRAPARTUM CARE

SECOND STAGE OF LABOUR

BIRTH MANAGEMENT

Keywords: labour management, second stage of labour, birth preparation, hands off technique, hands on technique, neonatal birth, episiotomy, birth notification, third stage, paediatric attendance

AIM

- To provide the woman with appropriate care during the second stage of labour.

BACKGROUND INFORMATION

Different techniques have been used to reduce perineal trauma during vaginal birth. A large study comparing “hands on” or “hands poised” birth techniques noted that the “hands poised” method was associated with lower rates of episiotomy, while the women who had the “hands on” birth technique indicated they experienced less pain in the first 24 hours after delivery, and at 10 days post birth. A smaller more recent study showed no difference in the two techniques.¹

KEY POINTS

1. Selection of the birthing technique using the “hands poised” or “hands on” method is determined by the woman and the accoucheur.
2. Episiotomy should be by restrictive use rather than routine use.
3. There are no randomised controlled trials testing the efficacy of suctioning of the pharynx during birth in preventing meconium aspiration syndrome. However an incidental finding in the study by Wiswell et al showed a three-fold increase in meconium aspiration syndrome in infants where oropharyngeal suction was not performed.² At KEMH gentle perineal suction of the baby’s mouth and nose shall be carried out providing this does not delay the birth. Upper airway suctioning shall occur if the baby has thick, tenacious meconium present in the oropharynx or / and when the baby shows any signs of compromise or has depressed vital signs.
4. When the nuchal cord is found to be tightly wrapped around the infant’s neck at birth it should be clamped and cut.
5. Delayed clamping of the umbilical cord in full-term infants may be beneficial.² In preterm infants delayed clamping is associated with decreased intraventricular haemorrhage and need for transfusions.

PREPARATION OF THE AREA AND EQUIPMENT

- Check the resuscitation cot to ensure:
 - The cot is switched on and warmed
 - Adequate functioning supply of oxygen, air and suction
 - Laryngoscope – check the function
 - Nasal/oral intubation tubes and introducers
 - 2 heparinised syringes and 21 gauge needles
 - Pre warmed towel – have available for the birth
- Place cord blood bottles within easy access.
- Check the oxytocic medication and ensure it is prepared for use.
- Check equipment to be used for birth:
 - Sterile bowl pack
 - Instrument pack – including x4 Howard Kelly forceps, x1 episiotomy scissors, x1 cord cutting scissors
 - Sterile trolley cover
 - Sterile gloves



- Plastic apron, protective glasses/face shield and mask
- Sterile cotton wool balls
- Sterile large combine pad
- Sterile abdominal sponges
- Ensure equipment is available if required to perform an episiotomy:
 - 1 x 20mL syringe
 - 1 x 19 gauge needle
 - 1 x 22 gauge needle
 - 10 – 15 mL 0.5% Lignocaine

	PROCEDURE	ADDITIONAL INFORMATION
1	Position of the women for birth Encourage the woman to position herself in the most comfortable position.	 Evidence remains inconclusive regarding the effectiveness of birth position in preventing perineal trauma. ^{3,4} The upright position has been shown to cause no adverse effects to the mother or infant; but it has been associated with increased blood loss. ⁵
2	Preparation for the birth	
2.1	The accoucheur washes his/her hands and dons: <ul style="list-style-type: none">• protective full face visor• plastic apron• mask• sterile gloves	Hand washing removes transient flora preventing transfer from the accoucheur to the woman which may introduce infection. ⁶ A protective full face visor must be worn to minimise the risk of infection from blood and body fluids to the eyes, nose and mouth. Prescription glasses do not provide adequate protection. ⁷
2.2	At the discretion of the accoucheur, clean the genital area using swabs soaked in warm tap water.	A wound caused by accidental or deliberate trauma to the skin breaks down the chemical and mechanical defence for preventing infection in the body. ⁶ There is no evidence that using tap water to cleanse acute wounds increases infection and there is some evidence to indicate it reduces it ⁸ .
2.2	Separate the labia majora with the non-dominant hand, and use the other hand to swab downward from the urethral orifice towards the anus.	
2.3	Consider placing a drape under the woman's buttocks if the situation permits.	The drape provides a clean area to place equipment that may be needed, and reduces the transmission of infectious organisms.
2.4	Consider placing a clean pad over the anal area.	May provide a barrier to prevent soiling by faecal material.
2.5	Assemble equipment for the birth and place within easy reach.	
2.6	Prepare a syringe with local anaesthesia when an episiotomy may be needed.	See Clinical Guidelines, O&M, Intrapartum Care, Second Stage of Labour: Episiotomy & Infiltration of the Perineum

PROCEDURE	ADDITIONAL INFORMATION
<p>2.7 Organise for a RMO and /or Paediatric Registrar to be present at the birth as required. See Clinical Guidelines, O&M, Intrapartum Care, Second Stage, Birth: Paediatrician Attendance for 'At Risk' Births: LBS QRG</p>	
<p>3 Birth of the head</p>	
<p>3.1 Hands on Approach</p> <ul style="list-style-type: none"> • Place fingers on the advancing head to maintain flexion and control. • Support the perineum with the fingers • Check for cord around the infant's neck. If tightly wound around the neck, apply 2 Howard Kelly clamps approximately 3cm apart and cut the cord between the clamps. Unwind the cord. 	<p>Allows monitoring of descent and prevents rapid descent with crowning and extension which could cause perineal trauma.⁷</p> <p>Assists prevention of perineal trauma⁷, and may reduce puerperal perineal pain.⁹</p>
<p>3.2 Hands off Approach</p> <p>The accoucheur shall have his/her hands poised ready to touch the head of the baby and guard the perineum if necessary</p>	<p>If rapid expulsion of the head is occurring then the accoucheur will be able to apply light pressure to the head.</p>
<p>4 Birth of the shoulders and body</p>	
<p>4.1 Hands on approach</p> <ul style="list-style-type: none"> • Allow internal rotation of the shoulders and trunk and restitution of the head. • Place a hand on each side of the infant's head, then apply gentle downward traction to deliver the anterior shoulder.⁷ • As the auxiliary crease is seen, guide the head and trunk in an upward curve.⁷ • Support the infant's body and assist placing the infant on the mother's abdomen (skin-to-skin) if she wishes. • Note the time of birth. • Ensure a warm cover is placed over the infant. 	<p>Allows the anterior shoulder to slip beneath the symphysis pubis.⁷</p> <p>Allows the posterior shoulder to escape over the perineum.⁷</p> <p>Permits the mother immediate sighting of her baby.⁷</p> <p>Prevents cooling of the infant.⁷ Hypothermia causes a worsening of hypoxia by diverting oxygen and glucose from vital centres in order to create heat for survival.¹⁰</p>
<p>4.2 Hands off approach</p> <p>Allow the shoulders to birth spontaneously.</p>	
<p>5 Clamping and cutting the cord</p>	
<p>Clamp and cut the cord after birth of the baby Decision for early or delayed clamping and cutting of the cord is determined by:</p> <ul style="list-style-type: none"> • Fetal condition • Maternal condition • Requirement for early blood collection <p>See Clinical Guideline O&M, Intrapartum Care, Specimen Collection Post Birth:</p>	<p>Applying a swab over the cord prior to cutting may prevent blood spraying.¹⁰</p> <p>Delay in umbilical cord clamping in full term infants for a minimum of 2 minutes following birth improves the long and short term haematological and iron status for the newborn and extends into infancy. The associated increase in polycythaemia appears to be benign^{2, 11}. Delayed clamping may increase the risk for jaundice requiring</p>

PROCEDURE	ADDITIONAL INFORMATION
<p>Umbilical Cord Collection / Analysis See Clinical Guideline, O&M, Intrapartum, Specimen Collection Post Birth: Cord Blood for Stem Cell Harvest: Collection of.</p>	<p>phototherapy.¹² Early cord clamping is performed in situations requiring prompt treatment of the infant or harvesting of stem cells.¹³ It may increase Rh-sensitization.¹⁴ Trials have not shown any difference in post-partum haemorrhage rates when comparing early or delayed cord clamping.¹² Umbilical cord blood gas and lactate results have been shown to be sensitive to delayed sampling procedures.¹³ Pre term infants with delayed cord clamping for 30 to 120 seconds appear to be associated with less need for transfusions and experience less intraventricular haemorrhages.^{14, 15}</p>
<p>6 Suction Nasopharyngeal suction can be administered in the presence of meconium stained amniotic fluid or excessive mucus.⁷</p>	<p>Most infants do not require airway clearance at birth. If suction is required it is recommended that suction of the oropharynx is done prior to the nasopharynx. This prevents mucus and other material being drawn into the respiratory tract should the infant gasp with nasal suction.¹⁰ Excessive suction can cause vagal stimulation resulting in laryngospasm and bradycardia.¹⁰</p>
<p>7 Apgar Scores The Apgar score should be done at one (1) minute, and five (5) minutes after the birth.</p>	<p>The 1 minute Apgar score guides management of resuscitation, while the 5 minute Apgar score is more reliable for predicting risk of death within the first 28 days of life, and for neurological outcomes and risk of disability at the infants first year of age.¹⁰</p>
<p>8 Administering an oxytocic See Clinical Guideline, O&M, Intrapartum, Third Stage of Labour: Active Management</p>	<p>See Clinical Guideline, O&M, Intrapartum, Third Stage: Syntometrine; Guidelines</p>
<p>9 Episiotomy See Clinical Guideline, O&M Intrapartum, Episiotomy & Infiltration of the Perineum</p>	<p>Evidence supports the use of restrictive rather than routine use of episiotomy.¹⁶ Indications for use include fetal heart rate anomalies, maternal exhaustion or distress, or if the perineum is restricting progress.¹⁷</p>
<p>10 Third Stage See: Clinical Guidelines, O&M: Intrapartum: Third Stage of Labour:</p> <ul style="list-style-type: none"> • Active Management • Expectant (Physiological) Management • Retained placenta 	
<p>11 Documentation Document the birth details. Document additional information on the MR 250 Integrated progress notes.</p>	<p>See Clinical Guidelines, O&M, Intrapartum: Birth Notification</p>

REFERENCES (STANDARDS)

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National Standards – 1 Care is Guided by Current Best Practice
Legislation - Nil

Related Policies – KEMH Clinical Guidelines, O&M, Intrapartum Care;

- Second Stage of Labour: [Episiotomy & Infiltration of the Perineum](#); [Birth: Paediatrician Attendance for 'At Risk' Births: LBS QRG](#)
- Third Stage of Labour: [Active Management](#); [Syntometrine: Guidelines for Use of](#); [Expectant \(Physiological\) Management](#); [Retained placenta](#)
- Specimen Collection Post Birth: [Umbilical Cord Collection / Analysis](#); [Cord Blood for Stem Cell Harvest: Collection of](#).
- [Birth Notification](#)

Other related documents – Nil

RESPONSIBILITY

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