



## CLINICAL PRACTICE GUIDELINE

# Second stage of labour and Birth

**This guideline is for the care of healthy women and babies.  
If the woman has a known medical and/or pregnancy complication staff are to refer to the appropriate guideline.**

### Key points

1. Ask the woman's consent before all procedures and observations.
2. Document escalation of care as clinically indicated.
3. Do not offer routine episiotomy. <sup>4</sup>

### Definitions <sup>1</sup>

- Cervix 10cm dilated to birth of the baby.
- Clinical signs of descent
  - anal dilatation when presenting part is at the level of the ischial spines
  - perineal bulging during the height of contractions as presenting part begins to descend
  - perineal bulging persisting after the contraction when the bi-parietal diameters have passed through the ischial spines
- Passive second stage of labour – a period of time, not necessarily continuous, when:
  - The finding of full dilatation of the cervix before or in the absence of involuntary expulsive contractions.
- Active second stage of labour – when:
  - Presenting part is visible OR
  - Expulsive contractions with a finding of full dilation of the cervix or other signs of clinical descent OR
  - Active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions.

### Normal ranges <sup>1</sup>

#### Nulliparous woman

- Birth would be expected to take place within 3 hours of the start of the active second stage.
- Diagnose delay in the active second stage at 2 hours and arrange medical review.

**Multiparous women**

- Birth would be expected to take place within 2 hours of the start of the active second stage.
- Diagnose delay in the active second stage at 1 hour and arrange medical review

**Note** – if the woman has an urge to push and there are no clinical signs of descent full dilation should be confirmed. Premature pushing before full dilation can lead to maternal exhaustion and / or oedema of the cervix

**Care in second stage**

- Do not perform manual stretching of perineum or perineal massage<sup>1</sup> in the second stage of labour.
- Encourage and help the woman to move and adopt whatever positions she finds most comfortable.
- Ensure perineum is visualised by primary accoucheur.
- If pushing is ineffective or if requested by the woman, offer strategies to assist birth such as change in maternal position, emptying bladder and encouragement.
- For women birthing in water refer to [Waterbirth guideline](#)
- Apply warm perineal compresses at the commencement of perineal stretching<sup>6</sup>
  - Water to be between 38 – 44 Degrees Celsius which can be attained by either:
    - Adding 300mL boiling water to 300mL cold tap water (cold water should be added to container first for safety).
    - Use of metered tap water with controlled water temperature.
  - Prior to application of warm perineal compress test water temperature as follows:
    - No spinal/epidural analgesia – test on woman’s inner thigh.
    - Spinal/epidural analgesia – test on woman’s fore arm
  - Replace water entirely every 15 minutes.
  - Do not “top up” or add hot water as correct temperature cannot be assured.
  - Monitor the colour of the perineum after application for signs of excessive heat.

**Observations****Maternal**

1. Temperature – 4 hourly
2. Respiratory rate 4 hourly
3. Heart rate – 15 minutely and when assessing FHR
4. Blood pressure (BP) – 1 hourly
5. Contractions – 30 minutely

6. Vaginal examination – 1 hourly
7. Abdominal palpation – prior to vaginal examination
8. Vaginal loss – ongoing. \*\* If meconium present with CMP at home consultation and transfer to the supporting hospital must occur.
9. Bladder – document frequency of void

**Fetal**

FHR – after each contraction OR at least 5 minutely, for at least 1 minute.

- The maternal heart rate should be palpated and documented to differentiate between maternal and fetal heart rates.

If an intrapartum CTG has been started because of concerns arising from IA, but the trace is normal after 20 minutes, you may after consultation with medical team return to IA unless the woman asks to stay on continuous CTG.

\*\* If intrapartum CTG needed for CMP at home consultation and transfer to the supporting hospital must occur.

**Preparation for birth of the baby**

1. PPE – accoucheur wears:
  - protective full face visor
  - plastic apron
  - sterile gloves
2. Assemble equipment for birth, placing it within easy reach of the accoucheur
3. Consider:
  - Swabbing downward from urethral orifice to anal area
  - Placing drape under woman's buttocks
  - Clean pad over anal area

**Birth of the baby**

1. Encourage the woman to minimise active pushing using gentle verbal guidance. The use of controlled slowed or shallow maternal breathing should be used to birth the baby slowly.
2. Support the perineum with the dominant hand.
3. Apply gentle counter pressure to the fetal head with the non-dominant hand to control the fetal head, allowing progress whilst preventing uncontrolled expulsion.
4. Once the head has birthed, wait for restitution to occur. Note the time the head has birthed.

5. Continue to support the perineum as you provide gentle verbal guidance to the woman to push gently to birth the shoulders. In the event that the shoulders do not deliver spontaneously, remove the dominant hand and apply **gentle** traction to release the anterior shoulder.
6. Allow the posterior shoulder to be released following the curve of Carus, continuing to protect the perineum.
7. Provide support to the baby's body by moving both hands.
8. Support the baby's body and assist placing the baby on the woman's abdomen/chest (skin-to-skin) if she wishes.
9. Note time of birth.

**Note:** Although access to the perineum is necessary for the achievement of perineal support at crowning, this should not restrict a woman's movement during the second stage of labour and at time of birth.

The clinician may need to adjust their position in order to allow visualisation and support of the perineum. Perineal support can be provided in most positions including semi-recumbent, lateral and 'all fours' (hands and knees). Unless the baby's condition is critical, once the head is born, the clinician should encourage the women to refrain from pushing until restitution occurs (external rotation of the baby's head and internal rotation of the shoulders).

### Documentation

1. Document all maternal and fetal observations on Partogram contemporaneously.
2. If documenting in retrospect date and time entry.
3. Document all VE's on Partogram.
4. Document woman's consent to procedures.
5. Escalate any delay in second stage and/or deviations from the normal progress of labour to medical team.
6. Enter birth details into MR250 (or CMP MR08) clinical notes, including time of:
  - Birth of head
  - Birth of body
  - Clamping cord
  - IM oxytocic and injection site (if administered)
  - Placenta delivered
  - Blood loss volume
7. Complete STORK entry.

**Note:** All documentation must have date, time, legible signature and staff position

**\*\*Note** – If transfer required for CMP clients in the home setting refer to the following guideline: <https://healthpoint.hdwa.health.wa.gov.au/policies/Policies/NMAHS/WNHS/WNHS.OG.TransferHomeToHospital.pdf>



## References

1. National Institute for Clinical Excellence. Intrapartum care for healthy women and babies. **NICE Clinical Guidelines**,. 2014 CG190.
2. Provision of routine intrapartum care in the absence of pregnancy complications. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. July 2017.
3. Albers L, Borders N. Minimising genital tract trauma and related pain following spontaneous vaginal birth. *Journal of Midwifery Womens Health*. 2007; 52:246-253
4. Basu M, Smith D, Edwards R. Can the incidence of obstetric anal sphincter injury be reduced? The STOMP experience. *European Journal of Obstetrics & Gynecology and Reproductive Biology*. 2016 Jul 31;202:55-9. Jiang H, Qian X, Carroli G, Garner P. Selective versus routine use of episiotomy for vaginal birth. *The Cochrane Library*. 2017.
5. Albers L, Borders N. Minimising genital tract trauma and related pain following spontaneous vaginal birth. *Journal of Midwifery Womens Health*. 2007; 52:246-253 ;
6. Dahlen H, Homer C, Cooke M, Upton A, Nunn R, Brodrick B. 'Soothing the ring of fire': Australian women's and midwives' experience of using perineal warm packs in the second stage of labour. *Midwifery*. 2009; 25:e39-e48.)

## Related WNHS policies, procedures and guidelines

O&G: Waterbirth

O&G: Labour guidelines including Second stage of labour

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