Hospital labor and delivery process step by step

Step 1: Calling ahead and arriving at maternity triage

Many hospital births begin before you enter the building: with a phone call to the maternity triage desk, labor floor, midwife, or obstetric practice. You may be asked about contraction frequency and duration, fluid leakage, vaginal bleeding, fetal movement, gestational age, Group B streptococcus status if known, pain level, prior cesarean section, medical conditions, and how far you live from the hospital. If there is heavy bleeding, severe pain, decreased fetal movement, fever, a seizure, or concern for umbilical cord prolapse after rupture of membranes, do not wait at home; seek emergency care.

On arrival, triage is designed to answer two questions: are you in labor, and are you or the fetus showing signs that require immediate care? A nurse or clinician usually checks maternal vital signs, reviews your prenatal record, confirms allergies and medications, and places external fetal monitoring to assess fetal heart rate and uterine contraction pattern. A sterile speculum exam may be used if rupture of membranes is uncertain. A cervical exam may assess dilation, effacement, station, position, and presenting part, unless there is a reason to avoid it, such as unexplained bleeding or placenta previa.

Step 2: Admission, consent, baseline assessment, and care planning

If active labor is suspected or there is another medical reason to stay, you are admitted to the labor and delivery unit. The team confirms identification, obtains consents, reviews your birth plan review with obstetrician or midwife if one exists, and clarifies preferences such as mobility, labor positions, analgesia, immediate skin-to-skin contact, delayed cord clamping, newborn medications, and feeding plans. A birth plan is not a contract; it is a communication tool that helps the team align care with your priorities while preserving safety.

Admission commonly includes laboratory tests such as blood type and antibody screen, complete blood count, and any condition-specific studies. IV access may be placed, especially if antibiotics, oxytocin, epidural fluids, or emergency medications could be needed. Some low-risk patients may have intermittent auscultation rather than continuous monitoring, while others require continuous electronic fetal monitoring because of induction, oxytocin use, epidural analgesia, meconium-stained fluid, fetal concerns, hypertension, diabetes, prior uterine surgery, or other risk factors. The plan should be explained in clear language, and you can ask what is necessary now versus optional or situational.

Step 3: Early labor and active first stage labor

The first stage of labor begins with regular contractions that cause cervical effacement and dilation and ends at complete dilation, usually 10 centimeters. Early labor often includes mild to moderate contractions, cervical softening, and gradual dilation. Some people remain at home during early labor if maternal and fetal status are reassuring, but hospital observation may be appropriate for medical conditions, long travel distance, significant pain, ruptured membranes, or anxiety.

Active first stage labor is typically associated with stronger, more regular contractions and faster cervical change. Many references describe active labor as beginning around 6 centimeters, though clinical judgment matters more than a single number. During this phase, nurses frequently reassess pain, coping, fetal heart patterns, contraction adequacy, hydration, temperature, and bladder fullness. An overly full bladder can impede fetal descent, so you may be encouraged to urinate regularly; if you have an epidural and cannot void, a

catheter may be used according to hospital protocol.

Supportive measures include position changes, walking if safe, birthing balls, breathing strategies, hydrotherapy where available, massage, counterpressure, warm packs, and continuous emotional support. Medical options may include nitrous oxide in some hospitals, systemic opioids, or epidural analgesia. If progress slows, clinicians may discuss artificial rupture of membranes, also called amniotomy, or oxytocin augmentation. These choices depend on cervical findings, fetal position, contraction pattern, membrane status, infection risk, and fetal tolerance.

Step 4: Transition and preparation for the second stage of labor

Transition is the intense late portion of the first stage, when the cervix approaches complete dilation. Contractions may feel very close together, pressure may increase, nausea or shaking can occur, and emotional focus may narrow. These signs can be normal, but the team still evaluates fetal heart rate and maternal wellbeing. If you feel an urge to push, tell the nurse or clinician; pushing before complete dilation may sometimes cause cervical swelling, though there are individualized exceptions.

When a cervical exam confirms complete dilation, the team assesses fetal station, position, and maternal sensation. If you have an epidural and both you and the fetus are stable, some teams allow a passive second stage of labor, sometimes called laboring down, so contractions can bring the baby lower before active pushing begins. Others start pushing sooner if the head is low or there is a clinical reason. The bed may be adjusted, sterile supplies opened, and neonatal equipment checked. This preparation can look dramatic, but much of it is routine safety readiness.

Your support person may be guided on where to stand, how to help with leg support, and when to offer fluids or encouragement. The clinical team should explain who is in the room and why, especially if additional staff enter for fetal heart concerns, anticipated shoulder dystocia, preterm birth, meconium, or operative vaginal delivery planning.

Step 5: Pushing, birth of the baby, and immediate newborn care

The second stage of labor begins at complete dilation and ends with birth. Pushing may last minutes or several hours, depending on whether this is a first birth, fetal position, epidural use, contraction strength, maternal energy, and pelvic anatomy. Some people use coached pushing with breath-holding for short intervals; others use open-glottis pushing guided by their own urge. Positions may include semi-reclined, side-lying, hands-and-knees, squatting with support, or using a squat bar, depending on monitoring, epidural density, fetal status, and hospital resources.

As the fetal head crowns, the clinician may support the perineum and guide controlled delivery of the head to reduce sudden stretching. Routine episiotomy is not standard in many settings, but it may be recommended for specific urgent indications. After the head is born, the team checks for a nuchal cord and supports delivery of the shoulders and body. If shoulder dystocia occurs, staff may use well-rehearsed maneuvers such as maternal position changes and suprapubic pressure; the room may become very focused, but the goal is rapid, coordinated care.

If the newborn is vigorous, many hospitals place the baby directly on the parent’s chest for immediate skin-to-skin contact while drying and stimulation occur. Delayed cord clamping may be offered when clinically appropriate. If the baby needs help breathing, has poor tone, is very preterm, or there are other concerns, neonatal clinicians may move the baby to a warmer for assessment and resuscitation. Apgar scores, temperature support, identification bands, and feeding support are part of early newborn care.

Step 6: Delivery of the placenta and management of bleeding

The third stage of labor begins after the baby is born and ends with delivery of the placenta. It is usually shorter than the first two stages. You may feel mild contractions or pressure again. Clinicians watch for signs of placental separation, such as a lengthening cord, a gush of blood, and a change in uterine shape. Gentle cord traction may be used when appropriate, and uterotonic medication such as oxytocin is commonly given to help the uterus contract and reduce postpartum hemorrhage risk.

After delivery of the placenta, the clinician inspects it to confirm it appears complete, because retained placental tissue can contribute to bleeding or

infection. The uterus is massaged or assessed through the abdomen to ensure it is firm. This can be uncomfortable, but uterine tone is a key safety marker. The birth canal is examined for lacerations involving the perineum, vagina, labia, cervix, or deeper tissues. Repairs, when needed, are performed with local anesthesia, existing epidural anesthesia, or additional pain control.

Bleeding is monitored closely. A normal amount of lochia is expected, but heavy bleeding, a boggy uterus, falling blood pressure, dizziness, or persistent tachycardia prompts urgent evaluation. Protocols may include additional uterotonics, IV fluids, laboratory tests, tranexamic acid in some cases, uterine tamponade, or surgical escalation. Your team should narrate what is happening whenever possible, because rapid postpartum interventions can feel frightening.

Step 7: The first hours after birth on labor and delivery

The first one to two hours after birth are often called the recovery period, even before transfer to the postpartum unit. Nurses check maternal blood pressure, pulse, temperature, uterine firmness, bleeding, bladder status, pain level, and perineal or incision status if applicable. If you had an epidural, leg strength and sensation are monitored until it is safe to stand. You may be offered food and fluids if there are no restrictions. Assistance with the first trip to the bathroom is important because dizziness and temporary leg weakness can occur.

Newborn care during this window may include weight, measurements, vitamin K injection, eye prophylaxis where standard, glucose checks if indicated, temperature monitoring, and the first feeding. Skin-to-skin contact helps thermoregulation, bonding, and early feeding cues when both parent and baby are stable. If breastfeeding is planned, nurses or lactation staff can help with latch, positioning, and recognizing swallowing. If formula feeding or expressed milk is planned, staff can support safe feeding volumes and technique.

Before transfer, the team usually reviews what happened during birth, medications given, laceration degree if any, estimated or quantified blood loss, newborn status, and the plan for postpartum observation. Ask questions while events are fresh: why an intervention was recommended, whether follow-up is needed, and what symptoms should be reported immediately.

Step 8: When the plan changes: induction, assisted birth, or cesarean section

Hospital labor is dynamic. Sometimes the step-by-step pathway changes because labor stalls, membranes have been ruptured for a prolonged period, infection is suspected, blood pressure becomes concerning, fetal heart patterns are nonreassuring, or the baby's position prevents descent. The team may discuss induction or augmentation with oxytocin, amniotomy, intrauterine pressure catheter placement in selected cases, or closer fetal monitoring. These decisions require individualized risk-benefit discussion.

Operative vaginal delivery with vacuum or forceps may be considered when the cervix is fully dilated, the head is low enough, position is known, and vaginal birth is judged safer or faster than cesarean in that moment. If criteria are not met, or if maternal or fetal status requires surgical delivery, cesarean section may be recommended. A cesarean section involves anesthesia, sterile abdominal preparation, surgical delivery through uterine and abdominal incisions, placental removal, and postoperative monitoring.

Even when urgent decisions arise, you deserve respectful communication: what is happening, how urgent it is, what alternatives exist, and what consent is needed. In true emergencies, explanations may be brief until stabilization occurs, but debriefing afterward is part of compassionate care.