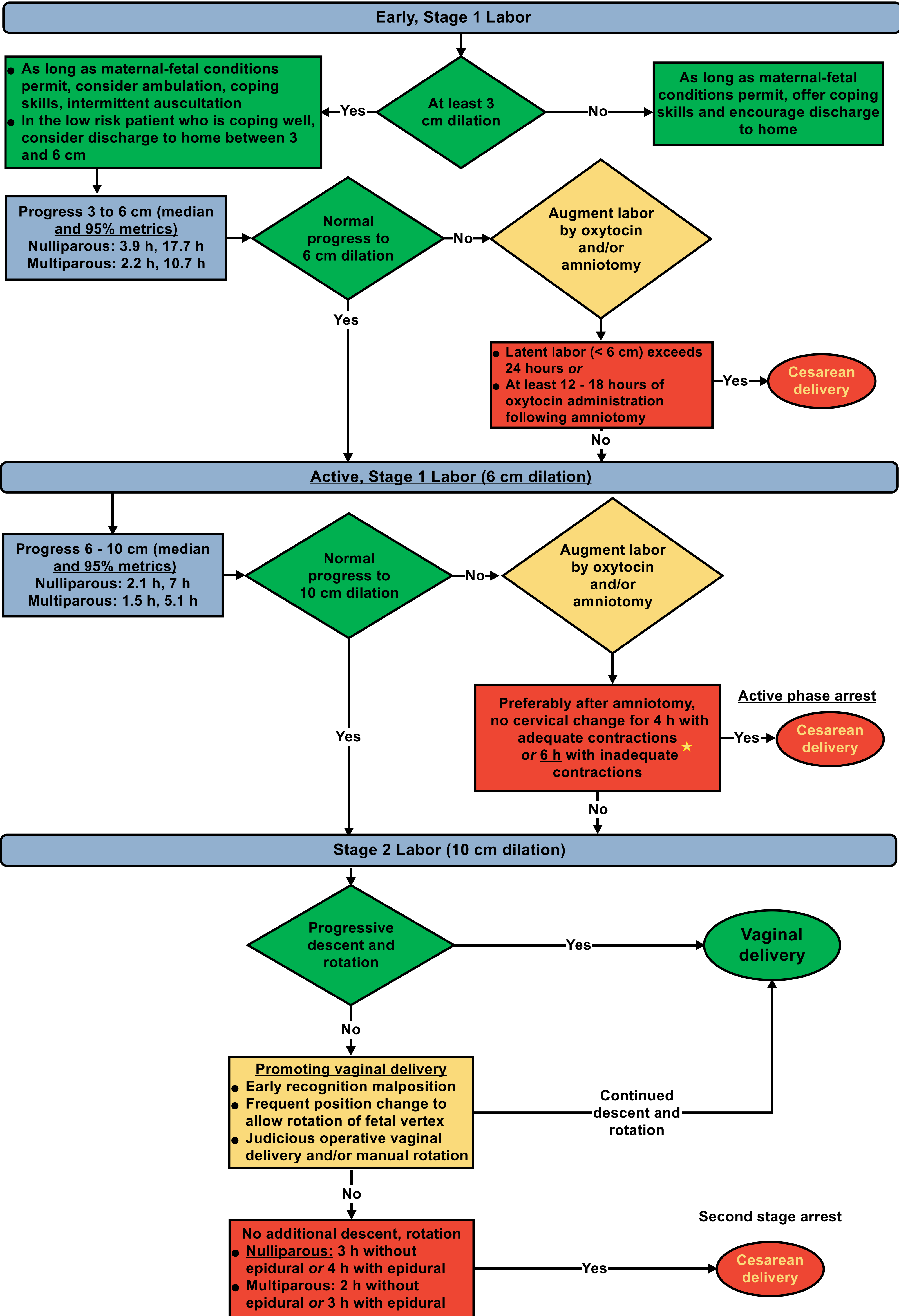

Adapted from Zhang *Obstet Gynecol* 2010;116:1281–7 *and* Spong *Obstet Gynecol* 2012;120:1181–93

FPQC
Florida Perinatal Quality Collaborative

Definition of Abnormal Labor:		
	Nulliparous	Multiparous (informational only)
Early labor (3 to 6 cm)	Median 3.9 h	Median 2.2
	95% 17.7 h	95% 10.7 h
	Consider cesarean delivery when: • Less than 6 cm, preferably with ruptured membranes ***and*** • Length of latent labor exceeds 24 hours ***or*** • At least 12 - 18 hours of oxytocin administration following amniotomy	
Active labor (6 to 10 cm)	Median 2.1 h	Median 1.5 h
	95% 7 h	95% 5.1 h
	Active phase arrest • At least 6 cm, preferably with ruptured membranes *and* • 4 hours: no cervical change and adequate contractions★ (greater than 200 Montevideo Units (MVU) or strong intensity contractions occurring every 3 minutes) *or* • 6 hours with Pitocin: no cervical change and inadeqate contractions	
	Nulliparous	Multiparous (informational only)
Second stage arrest, no descent or rotation for at least:	3 h without epidural	2 h without epidural
	4 with epidural	3 with epidural
Zhang, *Obstet Gynecol* 2010;116:1281-7 and Spong, Obstet Gynecol 2012;120:1181-93)		

Promoting Vaginal Delivery in the First Stage of Labor

- Encourage ambulation, frequent position change, use of birthing ball, coping with labor pain, and delaying admission until at least 6 or more cm dilation
- Some methods to promote coping in labor include: hot and cold packs, sterile water injections, massage or pressure, hypnosis, TENS unit
- In the stable patient who is coping well and has cervical dilation between 3 and 6 cm, consider discharging this patient to home after a thorough discussion about the risks and benefits of early admission using the shared decision model discussed elsewhere in this tool kit
- In low-risk patients, consider IA (intermittent auscultation) for those patients without fetal heart rate abnormalities
- Unless medically required, allow adequate time for labor to progress in the first stage and defer diagnosis of active labor until 6 cm dilation
- As long as maternal-fetal conditions permit, cesarean delivery for a prolonged latent phase is not indicated when slow, progressive cervical change occurs
- The presence of moderate variability and accelerations (either spontaneous or stimulated) has little association with acidosis or neurological injury

Promoting Vaginal Delivery in the Second Stage of Labor

- If maternal-fetal conditions permit, allow passive descent and physiologic rest for the mother who does not have an urge to valsalva.
- Allow longer pushing times if neuraxial anesthesia present
- Use of maternal squat bar, side lying with an open pelvis, peanut ball, and frequent position change facilitates fetal rotation
- For slow progress, ask for bedside evaluation to diagnose possible fetal malposition; if present, consider rotation
- Consider judicious operative vaginal delivery in appropriate candidates
- Consider 3 to 4 open glottis pushing efforts for 6 - 8 seconds per contraction or pushing efforts with every other contraction when a category 2 electronic fetal monitoring tracing exists