Partnering to Improve Health Care Quality
for Mothers and Babies

PROVIDE Focus Areas

The two big ones: Induction and Labor Dystocia

Labor Induction

Partnering to Improve Health Care Quality
for Mothers and Babies

ACOG Standard Definitions

LABOR	Uterine contractions resulting in cervical change (dilation and/or effacement) Phases: • Latent phase – from the onset of labor to the onset of the active phase • Active phase – accelerated cervical dilation typically beginning at 6 cm
AUGMENTATION OF LABOR	The stimulation of uterine contractions using pharmacologic methods or artificial rupture of membranes to increase their frequency and/or strength following the onset of spontaneous labor or contractions following spontaneous rupture of membranes. If labor has been started using any method of induction described below (including cervical ripening agents), then the term, Augmentation of Labor, should not be used.
INDUCTION OF LABOR	The use of pharmacological and/or mechanical methods to initiate labor (Examples of methods include but are not limited to: artificial rupture of membranes, balloons, oxytocin, prostaglandin, Laminaria, or other cervical ripening agents) Still applies even if any of the following are performed: • Unsuccessful attempts at initiating labor • Initiation of labor following spontaneous ruptured membranes without contractions

Definitions of Failed Induction and Arrest Disorders

Failed induction of labor
- Failure to generate regular (eg, every 3 min) contractions and cervical change after at least 24 h of oxytocin administration, with artificial membrane rupture if feasible

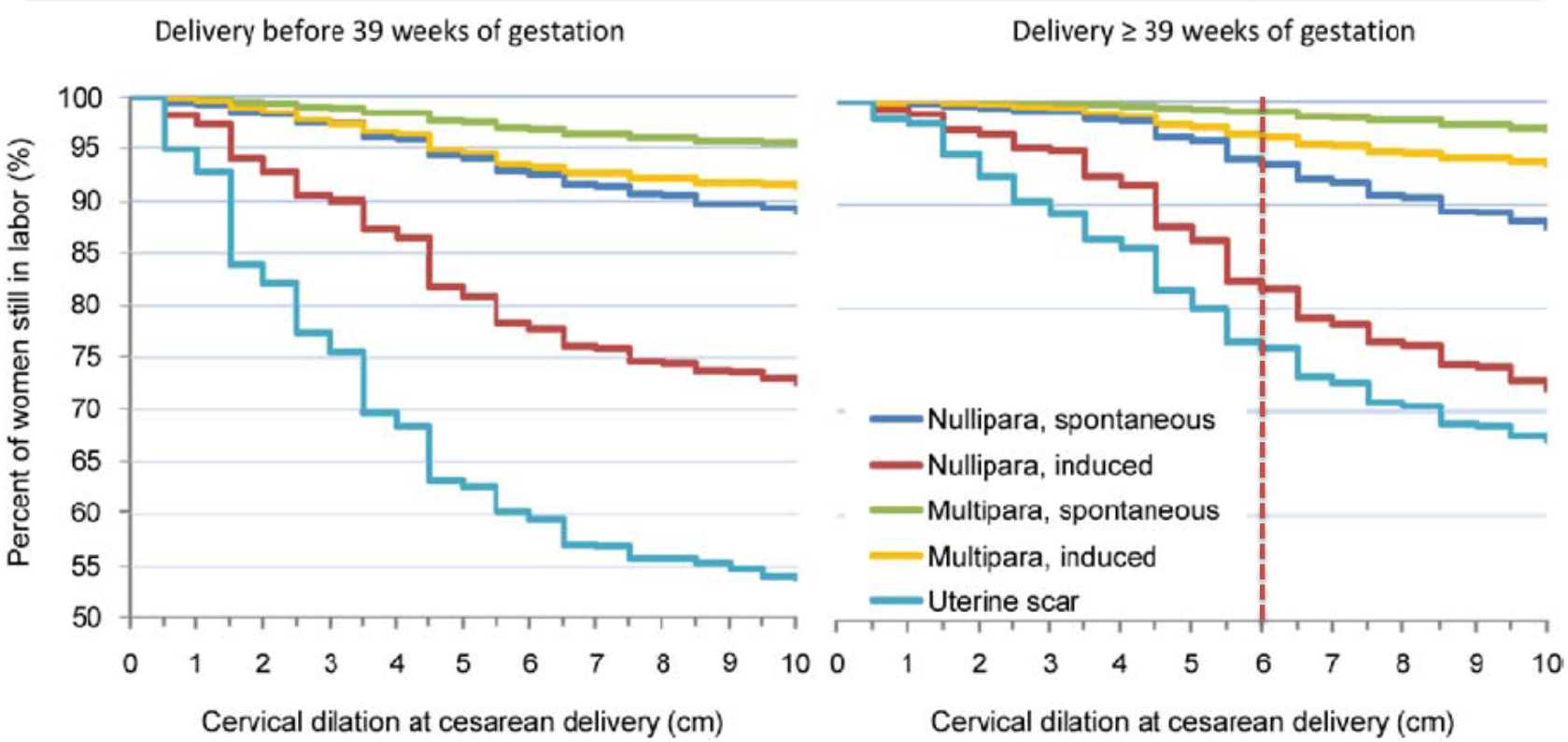
First-stage arrest
- 6 cm or greater dilation* with membrane rupture and no cervical change for
  - 4 h or more of adequate contractions (eg, >200 Montevideo units) or
  - 6 h or more if contractions inadequate

Second-stage arrest
- No progress (descent or rotation) for
  - 4 h or more in nulliparous women with an epidural
  - 3 h or more in nulliparous women without an epidural
  - 3 h or more in multiparous women with an epidural
  - 2 h or more in multiparous women without an epidural

Spong CY et al. Obstet Gynecol Nov 2012;120(5):1181–1193.

FIGURE 2

Cervical dilation at cesarean delivery



Cervical dilation at intrapartum cesarean delivery among women attempting vaginal delivery by parity, onset of labor (induced vs spontaneous onset), previous uterine scar in singleton gestations.

Zhang. Contemporary cesarean delivery practice in the US. Am J Obstet Gynecol 2010.

Finding: More than 50% of induced nullips are <6cm at CS

Labor Induction Checklist

For Obstetrical and Medically Necessary Induction of Labor:

- Confirm gestational age (The need to deliver at a gestational age less than 39 weeks is dependent on severity of condition)
- Confirm one of the following indications

☐41+0 weeks
☐Abruptio placentae
☐Preeclampsia
☐Gestational HTN
☐GDM
☐PROM
☐Fetal Demise
☐Coagulopathy/Thrombophilia
☐Pulmonary disease
☐Chorioamnionitis
☐Unstable Lie
☐Other Fetal compromise
☐IUGR
☐Isoimmunization
☐Fetal malformation
☐Multiples w/ complications
☐Twins w/o complication

☐Heart disease
☐ Liver disease (e.g. cholestasis of pregnancy.)
☐Chronic HTN
☐Diabetes (Type I or II)
☐Renal disease
☐Oligohydramnios

- If other indication, confirm necessity for induction with perinatology:

☐Other:_____
__ Perinatology consult obtained and agrees with plan:
_____
(consultant name)

Suspected Macrosomia

- Suspected fetal macrosomia is **not an indication for delivery** and rarely is an indication for cesarean delivery.
- To avoid potential birth trauma,**the College recommends that cesarean delivery be limited to estimated fetal weights of at least 5,000 g in women without diabetes and at least 4,500 g in women with diabetes.**
- The prevalence of birth weight of 5,000 g or more is rare, and **patients should be counseled that estimates of fetal weight, particularly late in gestation, are imprecise.**
- Screening ultrasonography performed late in pregnancy has been associated with the unintended consequence of increased cesarean delivery with no evidence of neonatal benefit. Thus, **ultrasonography for estimated fetal weight in the third trimester should be used sparingly and with clear indications**.

Safe prevention of the primary cesarean delivery. Obstetric Care Consensus No. 1. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:693–711.

Labor Induction Checklist

For Elective Induction of Labor

- Ensure patient will be 39 weeks gestation or greater at time of induction
- Confirm gravity and parity of patient
- Be aware of reason that elective induction is planned
  - ☐Patient or obstetrician choice
  - ☐Risk of rapid labor
  - ☐Distance from hospital
  - ☐Psychosocial indications

- Confirm favorable cervix by Bishops score (See table)
  - ☐Bishop's score >/= 8 for nullipara
  - ☐Bishop's score >/= 6 for multipara

Bishop's Score Calculation				
Parameter	0	1	2	3
Dilation (cm)	0	1 - 2	3 - 4	5 - 6
Effacement, %	0 - 30	40 - 50	60 - 70	≥80
Station (-3 to +3)	- 3	-2	-1, 0	≥+1
Consistency	Firm	Medium	Soft	
Position	Posterior	Middle	Anterior	
ACOG Patient Safety Checklist No. 5; December, 2011				

Labor Induction Checklist

For all Inductions:

- Provide patient with written educational material on induction of labor
- Obtain signed induction of labor education form
- Remind patient to call Labor and Delivery (or designee) prior to leaving home on the day of the induction

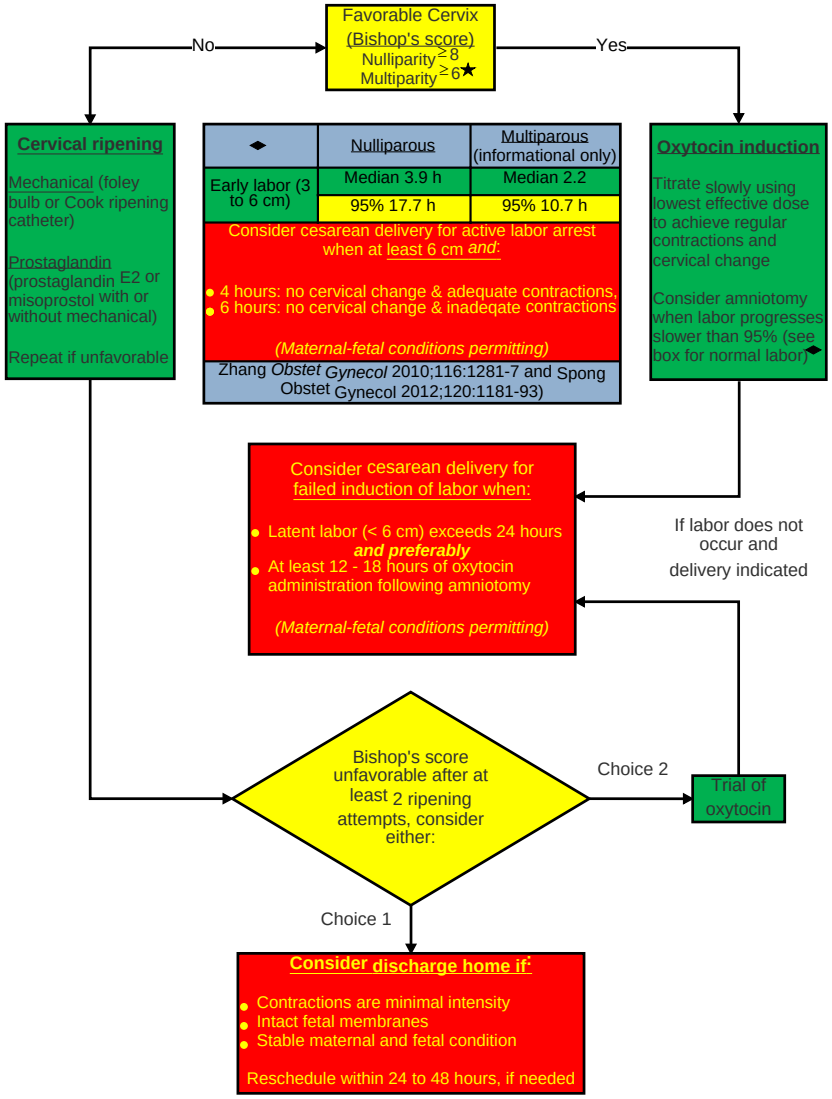
References:

ACOG Committee Opinion, No.560, 2013

ACOG Patient Safety Checklist No 2. Inpatient Induction of Labor December 2011, reaffirmed 2014

Induction of labor algorithm

(adapted from Obstetric Care Consensus. Safe Prevention of the Primary Cesarean Delivery. March, 2014. Number 1)



Bishop's Score Calculation				
Parameter	0	1	2	3
Dilation (cm)	0	1 - 2	3 - 4	5 - 6
Effacement, %	0 - 30	40 - 50	60 - 70	≥80
Station (-3 to +3)	- 3	-2	-1, 0	≥+1
Consistency	Firm	Medium	Soft	
Position	Posterior	Middle	Anterior	

ACOG Patient Safety Checklist No. 5; December, 2011

Maternal or fetal indications for delivery
(ACOG Committee Opinion, No. 560, 2013)

As per ACOG recommendations, perform induction of labor before 41 weeks when a maternal or fetal indication exists. When none exists, proceed with a favorable cervical exam.

Obstetric Issues
- Premature rupture of membranes
- Pregnancy at or beyond 41 weeks
- Pregnancy between 39 and 41 weeks with favorable cervix

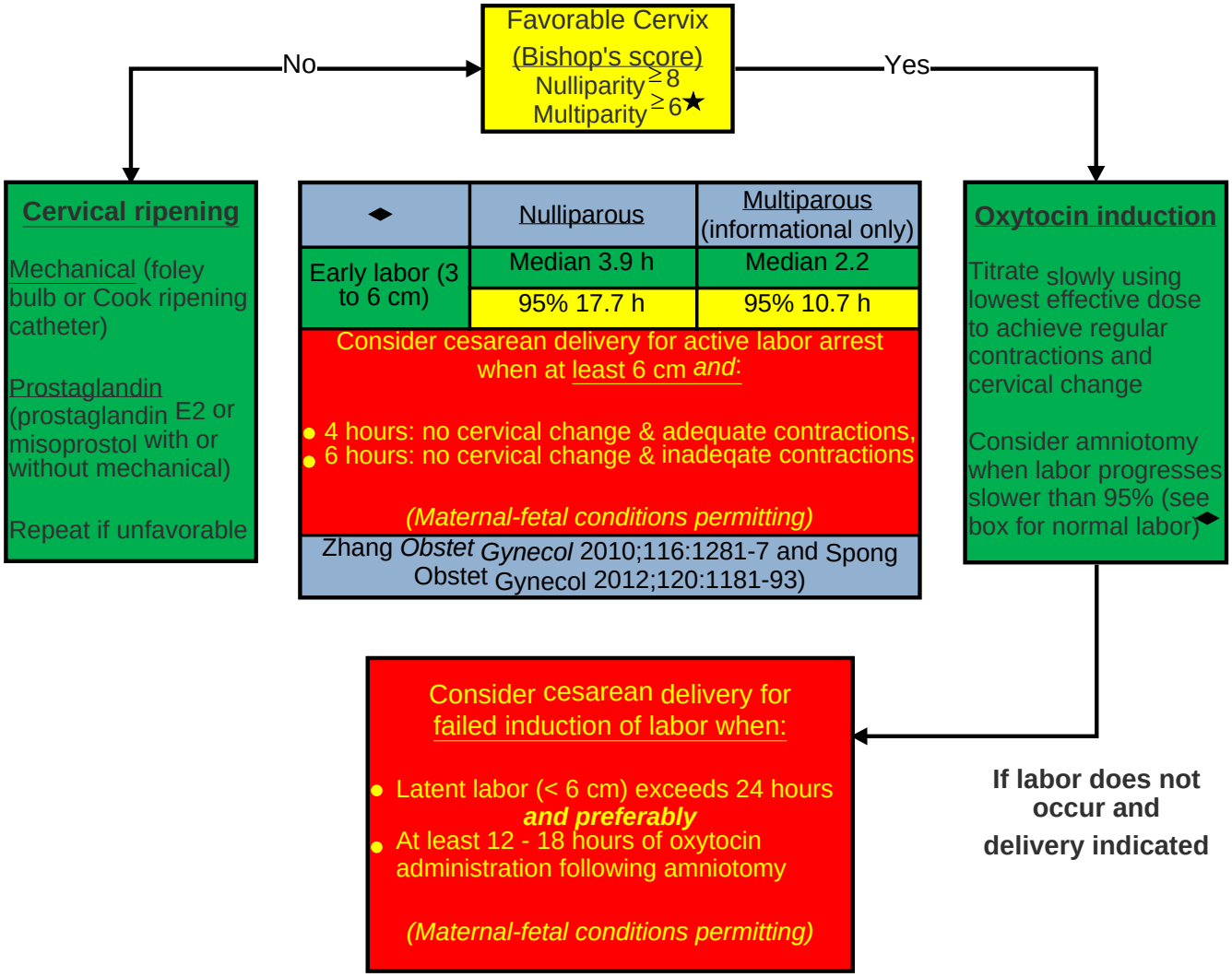
Maternal Issues
- Essential hypertension
- Diabetes mellitus
- Gestational Hypertension

Fetal Issues
- Growth restriction, singleton or multiple
- Multiple gestation
- Oligohydramnios

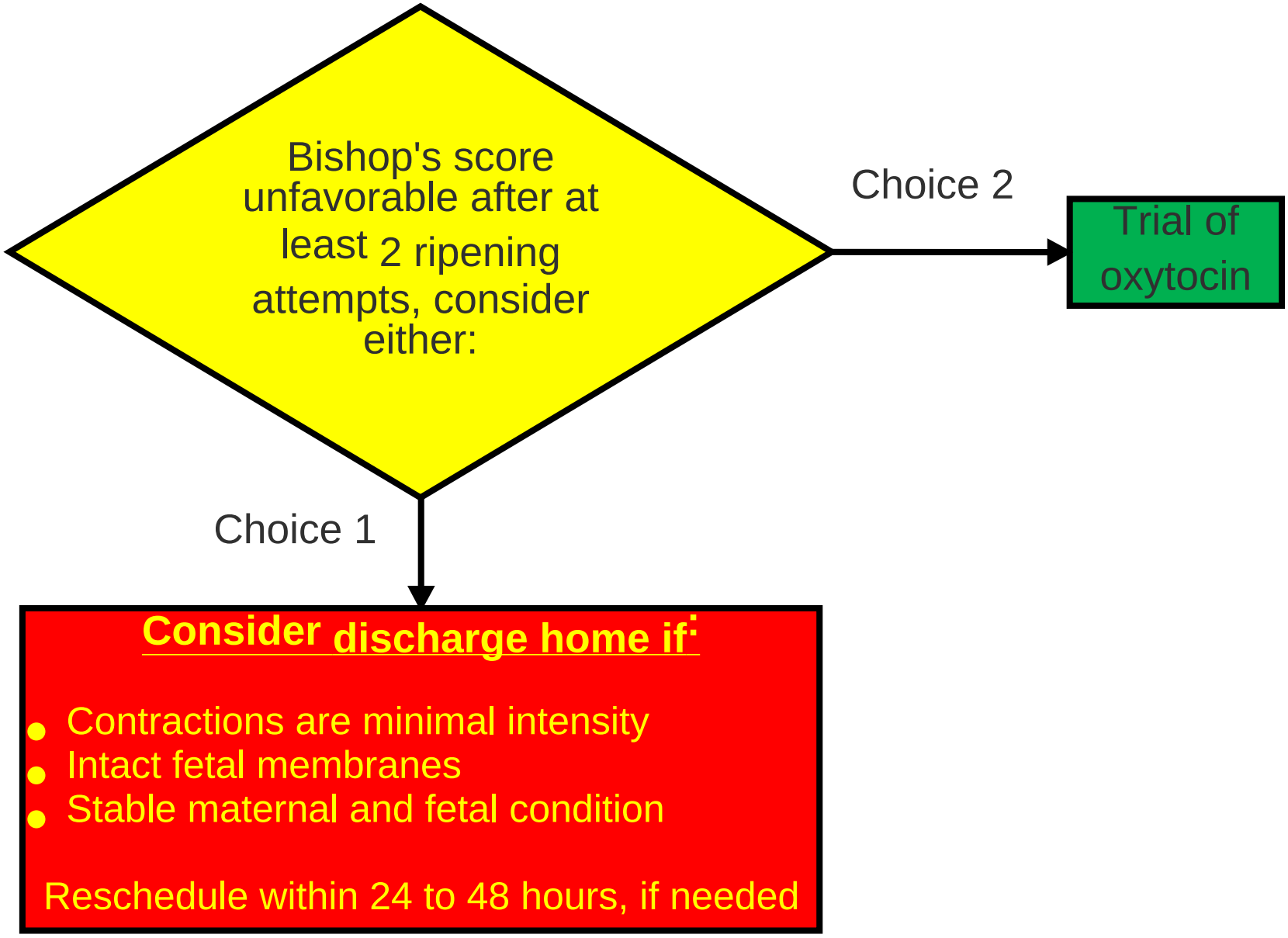
This is a simplified table adapted for this algorithm. Please see accompanying companion checklist for additional indications for delivery.

★ Informational only, focus is nulliparous patient

According to the ACOG, induce labor prior to 41 weeks when a maternal-fetal indication exists. When none exists, proceed with a favorable cervical exam.



Bishop's Score Calculation				
Parameter	0	1	2	3
Dilation (cm)	0	1 - 2	3 - 4	5 - 6
Effacement, %	0 - 30	40 - 50	60 - 70	≥80
Station (-3 to +3)	- 3	-2	-1, 0	≥+1
Consistency	Firm	Medium	Soft	
Position	Posterior	Middle	Anterior	
ACOG Patient Safety Checklist No. 5; December, 2011				

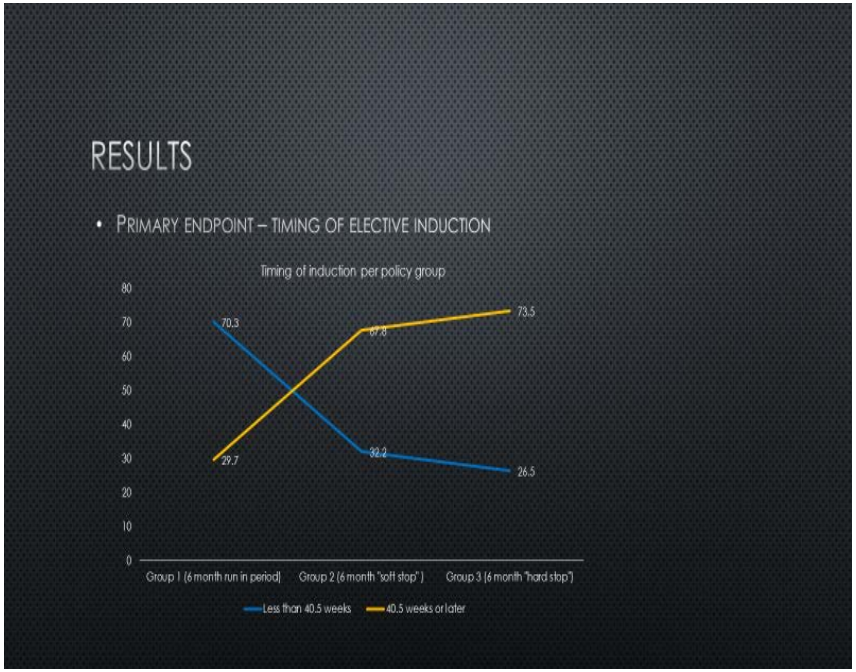

Bishop's score unfavorable after at least 2 ripening attempts, consider either:
Choice 2
Trial of oxytocin
Choice 1
Consider discharge home if:
Contractions are minimal intensity
Intact fetal membranes
Stable maternal and fetal condition
Reschedule within 24 to 48 hours, if needed

ARRIVE Trial

- RCT
- 3000 patients
- Primary outcome- Composite Neonatal Outcomes
  - No difference in groups
- Secondary outcome- CD
  - CD rate 18.5% Induction Group
  - CD rate 22% Expectant Management Group

Exampleof Hospital QA on Induction Focus Area

Sacred Heart Hospital, Pensacola eliminated nonmedical IOL until 40 w 5 days thru department policy change



Sample Policies, Booking Forms, etc.

CMQCC
California Maternal
Quality Care Collaborative

Appendix T
Model Policies

Hoag Hospital. Induction of Labor Scheduling Policy. Includes Induction of Labor Scheduling Request and patient education materials. Used with permission.

Category:	**Patient Care Services**	**Effective Date:**	**See footer**
Owner:	**Labor and Delivery OR Manager**		
Title:	**Cesarean Delivery / Induction of Labor Scheduling**		

PURPOSE: To eliminate non-medically indicated (elective) deliveries prior to 39 weeks. Non-medically indicated cesarean delivery or induction of labor prior to 39 completed weeks gestation requires approval of the Hoag Physician Leader or designee.

SCOPE: Labor and Delivery

NNE PQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

The following guidelines are intended only as a general educational resource for hospitals and clinicians, and are not intended to reflect or establish a standard of care or to replace individual clinician judgment and medical decision making for specific healthcare environments and patient situations.

Guideline for Non-Medically Indicated Delivery (NMID)
Approved 5/1/2015
(Replaces Elective Labor Induction)

Please note NNEPQIN has separately published "Guideline for Medically Indicated Delivery and Induction of Labor".

Scope: Women undergoing non-medically indicated delivery (NMID). This guideline does not apply to women presenting with spontaneous rupture of membranes or spontaneous onset of labor.

Baptist Hospital of Miami
BAPTIST HEALTH SOUTH FLORIDA

LABOR AND DELIVERY
STANDBY INDUCTION SCHEDULING

Desired Induction Date: _____ Obstetrician: _____

Standby Inductions will not be called in without scheduling form.

Patients Name: _____ Phone: _____

Age: _____ Gravida: _____ Para: _____ EDC: _____ GA: _____wks GBS: _____

Type of Induction: _____Cytotec _____Pitocin _____ Cervidil

Indications:

_____ Favorable Cervix: _____cms _____% effacement

*Circle all that apply below:

Cervix	Score				Bishop Score Modifiers
	0	1	2	3	
Position	Posterior	Mid-position	Anterior		
Consistency	Firm	Medium	Soft		
Effacement	0 - 30%	40 – 50%	60 – 70%	>80%	***Add 1 point for each previous vaginal delivery***
Dilation	Closed	1 – 2 cm	3 -4 cm	>5 cm	
Station	-3	-2	-1, 0	+1, +2	

Per policy, a Bishop score of 6 or greater required for elective induction.

TOTAL BISHOP SCORE: _____ Date: _____

TGH Tampa General Hospital

Induction of Labor Booking Form

Patient Name: _____ DOB: _____

Pt. Phone: _____

Provider: _____

Provider office CONTACT number: _____

Provider office FAX number: _____

Requested date/week for induction: _____ Gestational age now: _____

EDC: _____

☐ Patient has received written material on Induction of Labor
☐ Patient has signed consent for Induction of Labor

Indication for induction

Medical
(May book up to 4 wks prior to requested date)
☐ Abruptio placentae
☐ Chorioamnionitis
☐ Fetal demise
☐ Gestational Hypertension

Elective *(May book up to 7 days prior to requested date)*
39 weeks or more at time of induction
AND
☐ Bishop Score 10 or greater for a Primipara
☐ Bishop Score 8 or greater for a Multipara

Form 5: Tallahassee Consent (Permission to use is granted)

Tallahassee Memorial
Women's Pavilion
Tallahassee Memorial HealthCare

YOUR LABOR INDUCTION

Labor induction is usually done with a medication called Oxytocin or Pitocin®. With your practitioners order, our staff will start the medication at a standard dose and increase it over time to achieve labor progress. While you are getting the medication, we will closely monitor the baby's heart rate and your contractions. The length of labor depends on how dilated or "ripe" your cervix is at the start of the induction. In general the more dilated you are, the quicker your labor. Also, if this is not your first birth, labor may be faster for you.

If your cervix is already fairly dilated, your practitioner may start your induction by breaking the bag of water. If your cervix is closed and not shortening, we may schedule cervical ripening the day before your induction. This procedure will soften and begin to dilate your cervix. Ripening will make the Oxytocin more effective when it is begun. Sometimes, the ripening process will trigger the onset of your labor.

WHY ARE LABOR INDUCTIONS PERFORMED?

Labor inductions are performed for many reasons. Clearly, some reasons are more urgent than others. Here are just a few examples:

- A woman is well past her due date
- A woman is experiencing medical problems that place her or her baby at risk, such as high blood pressure, diabetes, rupture of the bag of water, etc.
- The baby or babies may be small or the amniotic fluid too low
- Though less common elective labor induction may be done for convenience or discomfort of the mother after 39 weeks

WHAT ARE THE POTENTIAL RISKS AND BENEFITS OF LABOR INDUCTION?

It is always important to consider the potential benefits and risks of any procedure. The risks include, but are not limited to, the following:

- Labor inductions may carry a greater risk of cesarean birth delivery than do labors that start on their own, especially with an "unripe" cervix..
- Induction usually results in longer labors and may lead to a higher chance of a vacuum or forceps delivery.
- All medications have possible side effects or unintended adverse reactions. For example, it is possible to cause contractions that are too frequent and may affect the baby's heart rate. This is why careful monitoring of your baby's heart rate is necessary during labor induction.

If you are considering an elective induction, the risks may outweigh the possible benefits especially, if this is a first time labor.

CONSENT FOR INDUCTION OF LABOR

Indication for Induction: _____

_____

I have read the above information and I have had the chance to ask my practitioner questions. All of my questions have been answered to my satisfaction. I wish to proceed with the induction.

_____ _____

Patient Signature Date

Labor Dystocia

Partnering to Improve Health Care Quality
for Mothers and Babies

Did you know?

6 is the new 4!

FIRST STAGE OF LABOR

- A prolonged latent phase (>20 hours in nulliparous women and >14 hours in multiparous women) should not be an indication for cesarean delivery.
- Slow but progressive labor in the first stage should not be an indication for cesarean delivery.
- Cervical dilation of 6 cm should be considered the threshold for the active phase of most women in labor. Thus, <6 cm dilation, standards of active phase progress should not be applied.

Safe prevention of the primary cesarean delivery. Obstetric Care Consensus No. 1. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:693–711.

Active Labor Dx

3 or more painful ctx in 10 min

AND

More than 75% effacement

AND

4-5 cm immediately preceded by more than 1 cm cervical change in less than 2 hours

OR

6 or more cm dilation

Neal JL, Lowe NK, Schorn MN, et al. Labor dystocia: A common approach to diagnosis. *J Midwifery Womens Health*. 2015;60(5):499-509. doi: 10.1111/jmwh.12360 [doi].

Toolkit contains weblinks to resources that support early labor and establish criteria for active labor admission

Safe Deliveries Roadmap

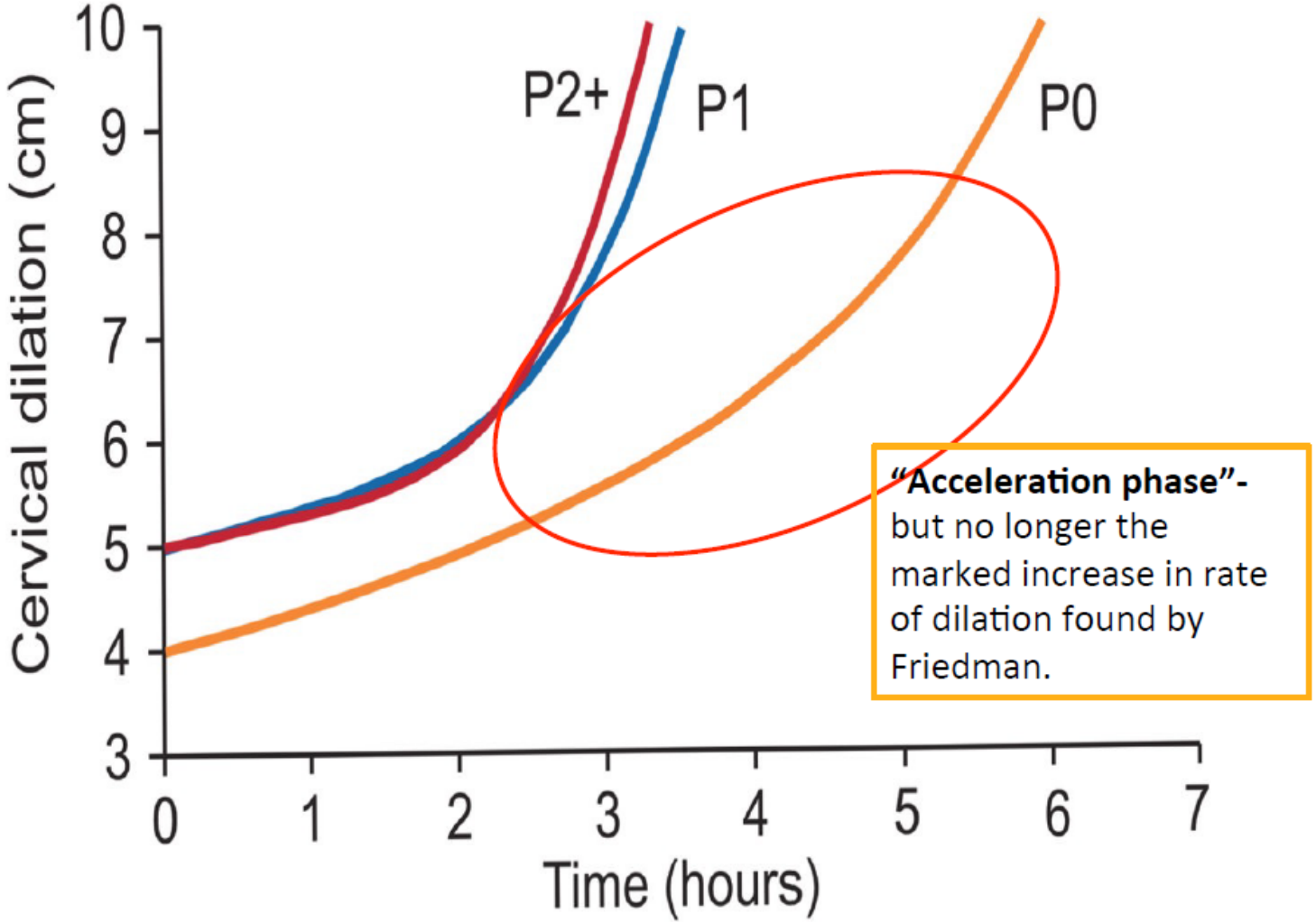
Advancing Safety for Mothers and Babies
A Roadmap from Pre-pregnancy to Postpartum

Topic 3b: Labor- First Stage: Consider Discharge Home or Further Observation

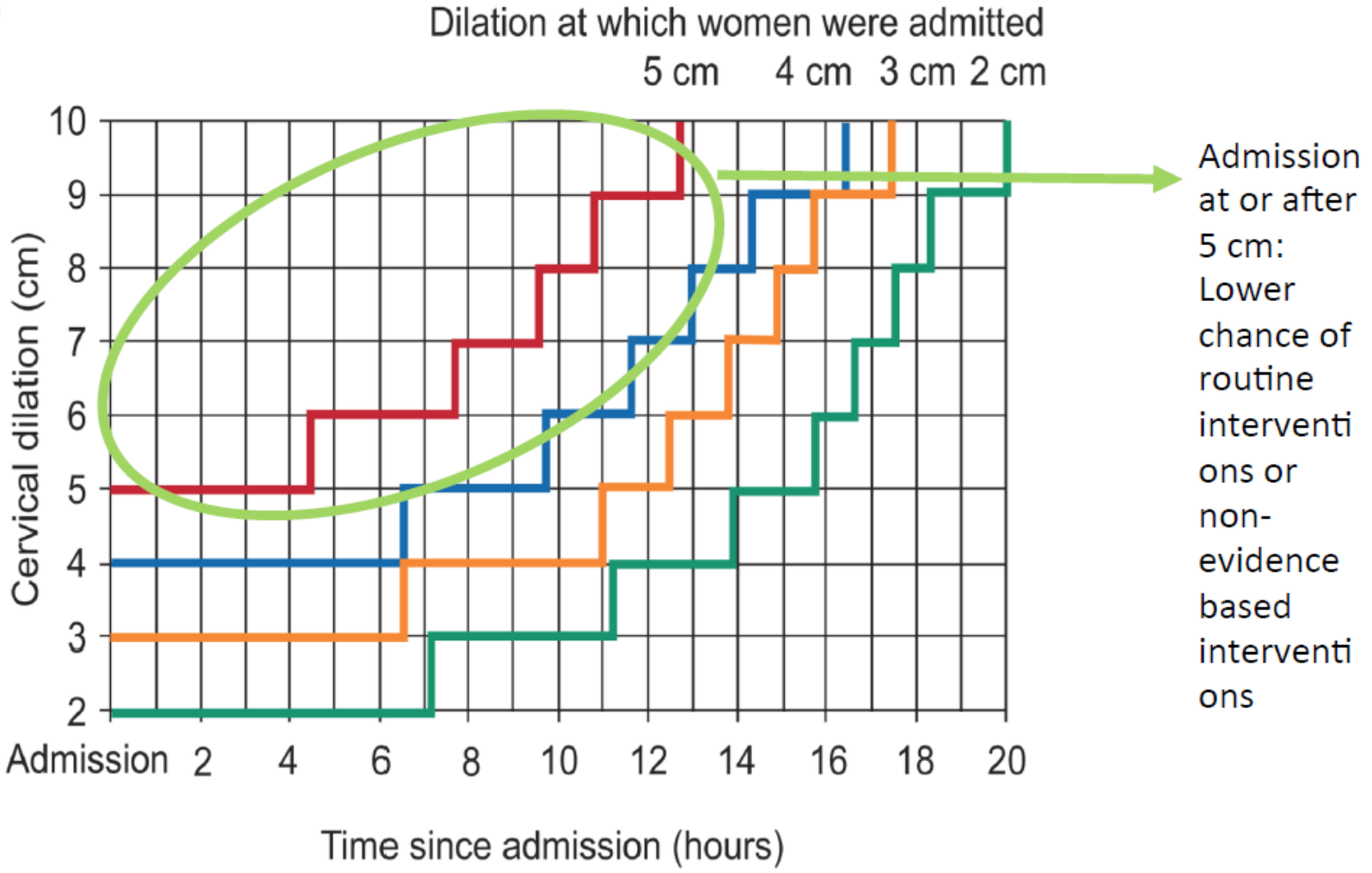
Note: For spontaneous labor only.

Recommendations

- Cervix 4-5 cm without change x 2 - 4 hours
- Less than 80% effacement
- Membranes intact
- Reactive NST/FHR category I (if uterine contractions present)
- Contractions less than 3/10 minutes



Zhang, 2010: **Figure 2.** Average labor curves by parity in singleton, term pregnancies with spontaneous onset of labor, vaginal delivery and normal neonatal outcomes. P0: nulliparas; P1: women of parity 1; P2+: women of parity 2 or higher.

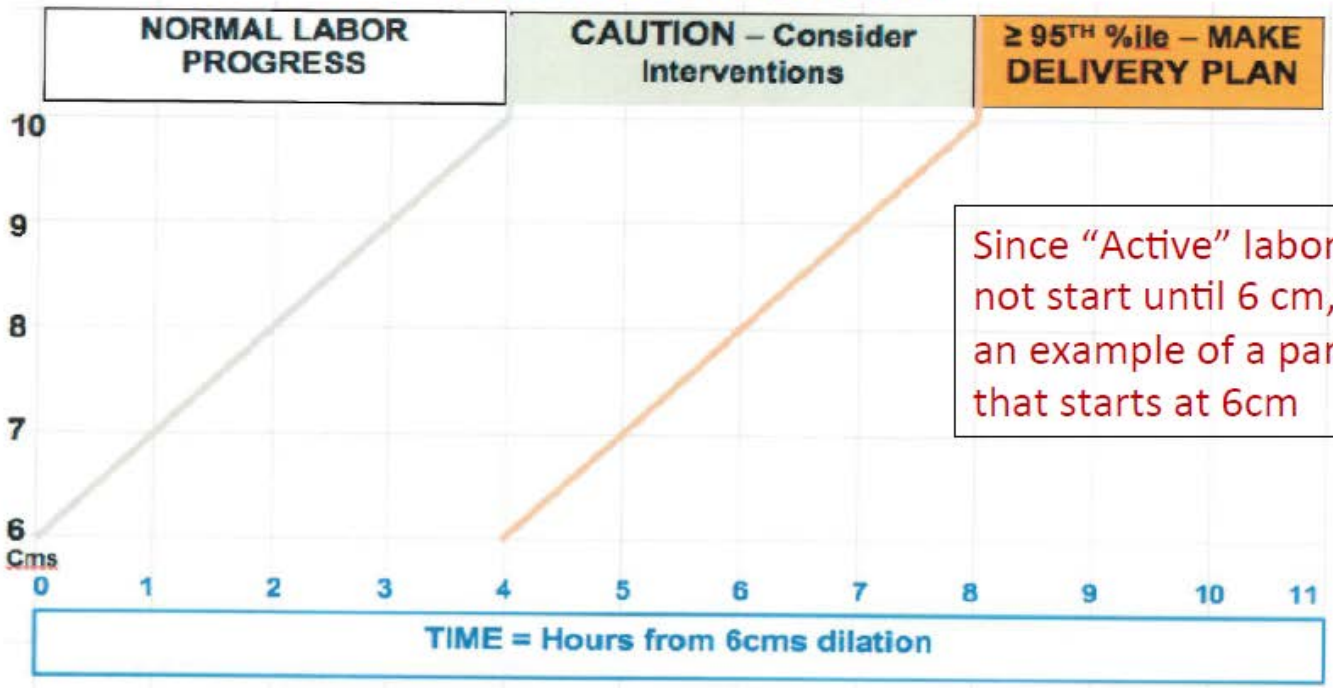


Zhang 201 Figure 3. The 95th percentiles of cumulative duration of labor from admission among singleton, term nulliparas with spontaneous onset of labor, vaginal delivery, and normal neonatal outcomes.

CMQCC

ACTIVE LABOR PARTOGRAM

Term ≥ 37 Weeks Gestation



Since "Active" labor does not start until 6 cm, this is an example of a partogram that starts at 6cm

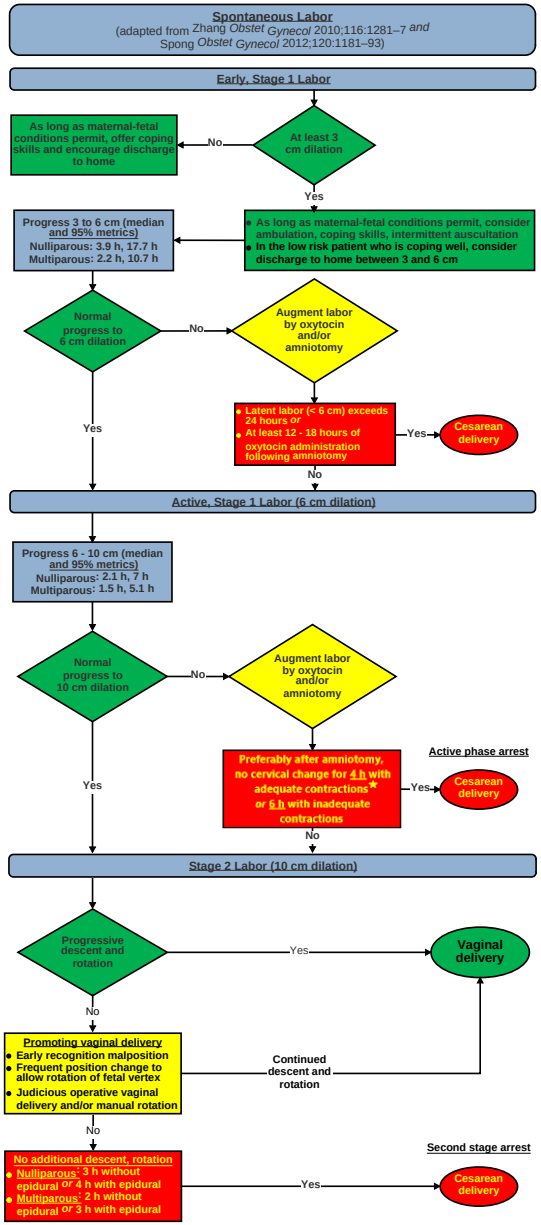
CAUTION ZONE: **Consider AROM, Augmentation if not already done and no contraindication**

At 6cms or more, 4 hours without cervical change is ≥ 95%ile. Successful vaginal delivery is less likely and maternal & neonatal complications increase.

Refs: Zhang J. et al. Obstet Gynecol.2010;116(6):1281-87 & Neal JL and Lowe NK. Med Hypotheses.2012;78(2):319-26

SWEDISH

FPQC's Spontaneous Labor Algorithm



Definition of abnormal labor:

	Nulliparous	Multiparous (informational only)
Early labor (3 to 6 cm)	Median 3.9 h 95% 17.7 h	Median 2.2 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 95% 7 h	Median 1.5 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 inadequate contractions	
	Nulliparous	Multiparous (informational only)
Second stage arrest, no descent or rotation for at least:	3 h without epidural 4 with epidural	2 h without epidural 3 without 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

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine

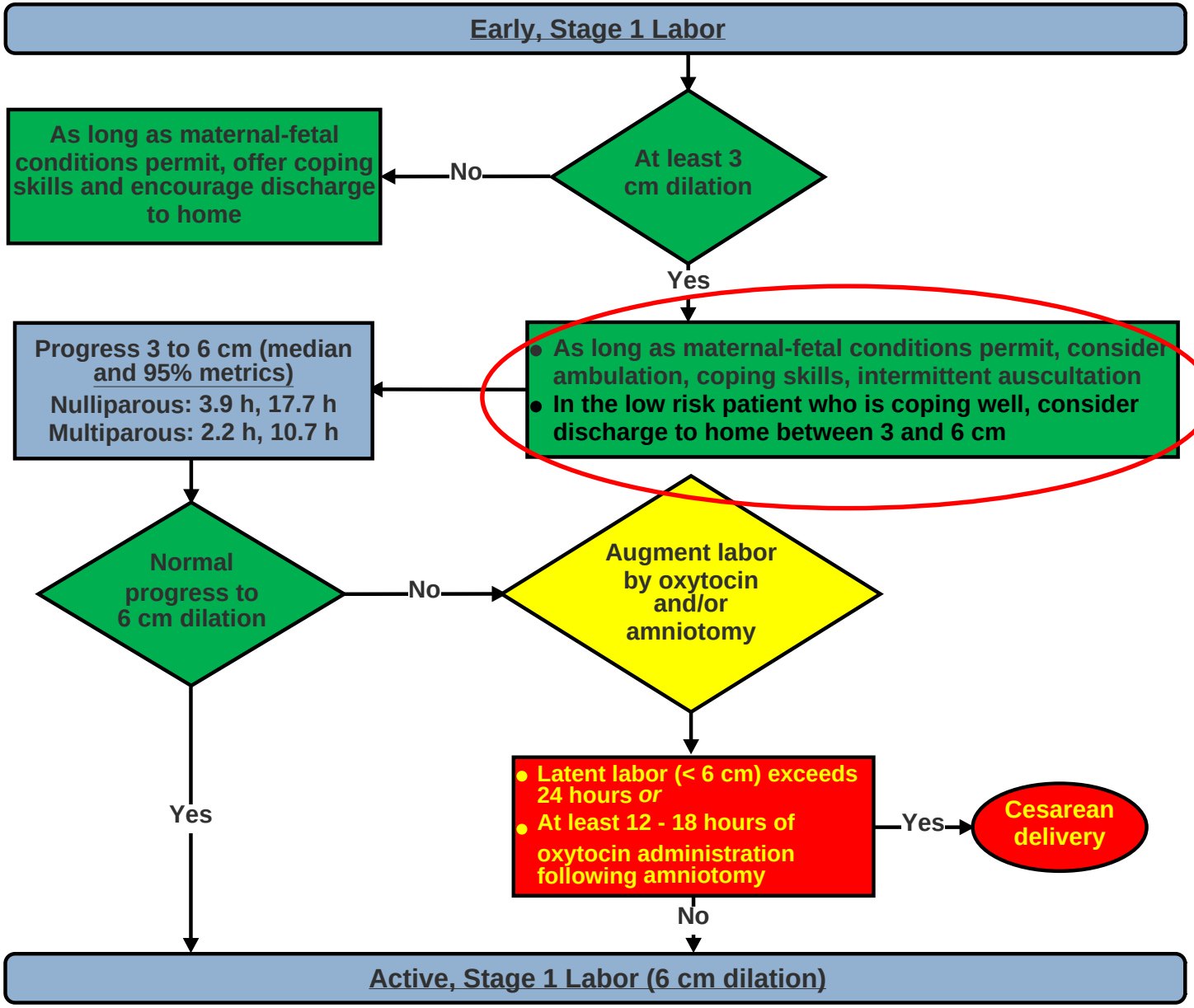
OBSTETRIC CARE CONSENSUS

Box 1. Definition of Arrest of Labor in the First Stage

Spontaneous labor: More than or equal to 6 cm dilation with membrane rupture and one of the following:

- 4 hours or more of adequate contractions (eg, more than 200 Montevideo units)
- 6 hours or more of inadequate contractions and no cervical change

Safe prevention of the primary cesarean delivery. Obstetric Care Consensus No. 1. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:693–711.


Early, Stage 1 Labor
At least 3 cm dilation
No
As long as maternal-fetal conditions permit, offer coping skills and encourage discharge to home
Yes
As long as maternal-fetal conditions permit, consider ambulation, coping skills, intermittent auscultation
In the low risk patient who is coping well, consider discharge to home between 3 and 6 cm
Progress 3 to 6 cm (median and 95% metrics)
Nulliparous: 3.9 h, 17.7 h
Multiparous: 2.2 h, 10.7 h
Normal progress to 6 cm dilation
No
Augment labor by oxytocin and/or amniotomy
Yes
Latent labor (< 6 cm) exceeds 24 hours or
At least 12 - 18 hours of oxytocin administration following amniotomy
Yes
Cesarean delivery
No
Active, Stage 1 Labor (6 cm dilation)

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Approaches to Limit Intervention During Labor and Birth

Latent Labor

Obstetrician–gynecologists, in collaboration with midwives, nurses, patients, and those who support them in labor, can help women meet their goals for labor and birth by using techniques that are associated with minimal interventions and high rates of patient satisfaction. **Many common obstetric practices are of limited or uncertain benefit for low-risk women in spontaneous labor.**

- For women who are in latent labor and are not admitted, a process of shared decision making is recommended.
- Admission during the latent phase of labor may be necessary for a variety of reasons.
- Admission to labor and delivery may be delayed for women in the latent phase of labor when their status and their fetuses' status are reassuring. The women can be offered frequent contact and support, as well as non-pharmacologic pain management measures.
- When women are observed or admitted for pain or fatigue in latent labor, techniques such as education and support, oral hydration, positions of comfort, and non-pharmacologic pain management techniques such as massage or water immersion may be beneficial.

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 without epidural
Zhang' *Obstet Gynecol* 2010;116:1281-7 and Spong' Obstet Gynecol 2012;120:1181-93)		

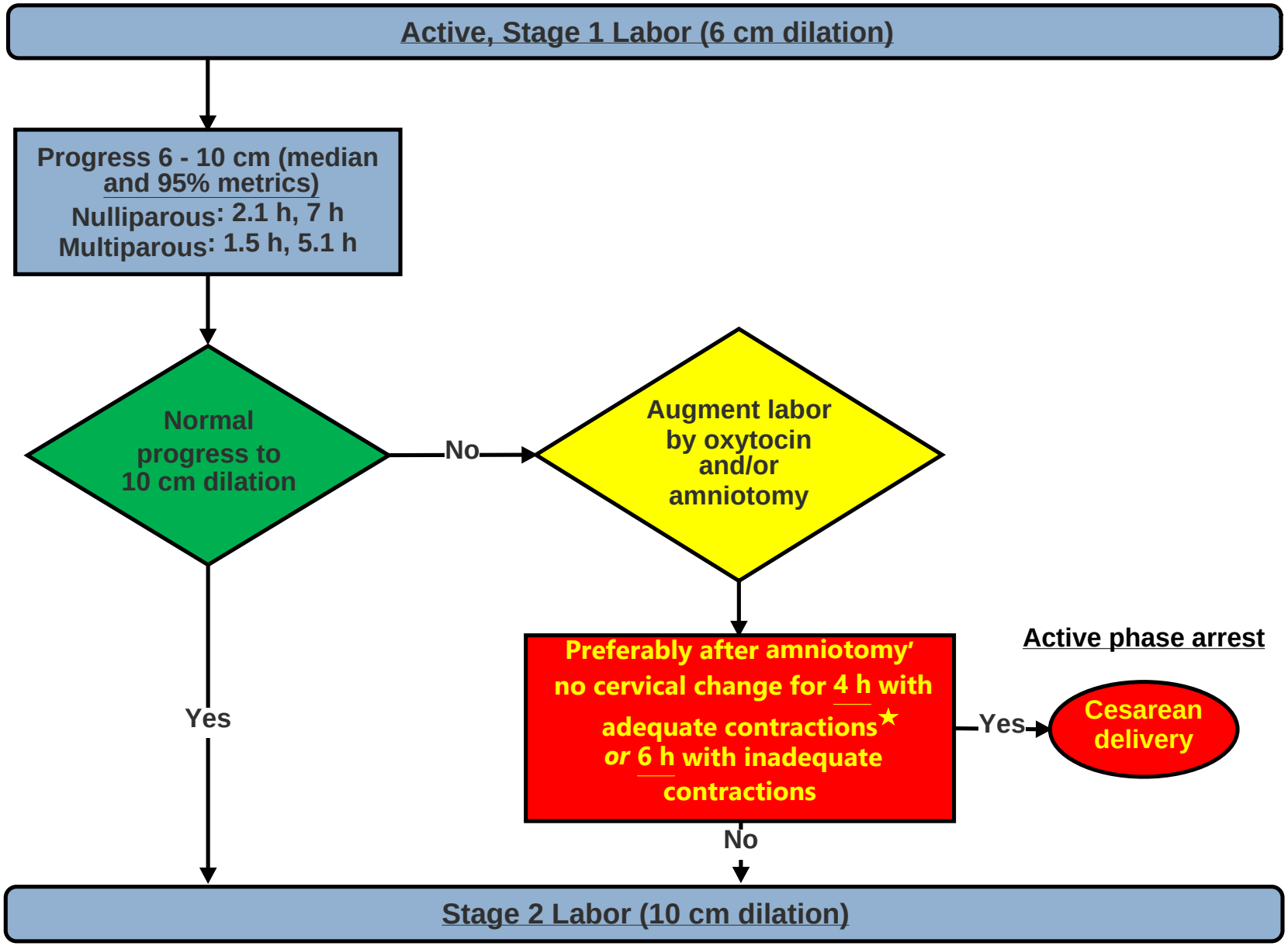
Promoting vaginal delivery in the first stage of labor:

- Encourage ambulation, frequent position change, use of birthing ball, coping with labor pain, and delaying admission until 6 or more cm dilation
- Methods to promote coping in labor include: hydrotherapy, hot & cold packs, sterile water injections, massage or pressure, hypnosis, TENS unit, oral nutrition.
- In the stable patient who is coping well and has cervical dilation between 3 to 6 cm, consider discharging the patient to home after a thorough discussion about risks and benefits of early admission using the shared decision model discussed elsewhere in this tool kit

Continued…

(Cont.) Promoting vaginal delivery in the first stage of labor:

- 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


Active, Stage 1 Labor (6 cm dilation)
Progress 6 - 10 cm (median and 95% metrics)
Nulliparous: 2.1 h, 7 h
Multiparous: 1.5 h, 5.1 h
Normal progress to 10 cm dilation
No
Augment labor by oxytocin and/or amniotomy
Yes
Preferably after amniotomy' no cervical change for 4 h with adequate contractions★ or 6 h with inadequate contractions
Yes
Active phase arrest
Cesarean delivery
No
Stage 2 Labor (10 cm dilation)

Hormonal Physiology of Childbearing

- In environments where women feel stressed and fearful, stress hormones can increase, reducing oxytocin and slowing the process of the first stage labor
- Continuous support, pain coping techniques, can reduce stress hormones

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

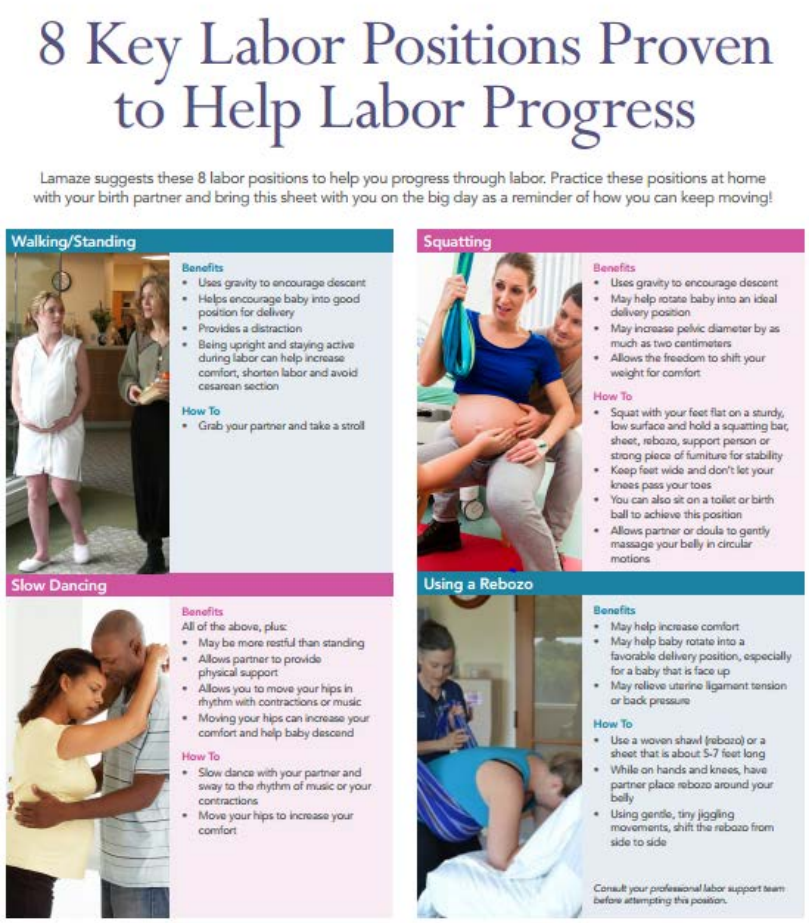
COMMITTEE OPINION

Approaches to Limit Intervention During Labor and Birth
(Things to avoid)

- Data suggest that in women with normally progressing labor and no evidence of fetal compromise, routine amniotomy is not necessary.
- The widespread use of continuous electronic fetal heart-rate monitoring has not improved outcomes when used for women with low-risk pregnancies.
- Women in spontaneously progressing labor may not require routine continuous infusion of intravenous fluids. For most women, no one position needs to be mandated nor proscribed.
- Obstetrician–gynecologists and other obstetric care providers should be familiar with and consider using low-interventional approaches for the intrapartum management of low-risk women in spontaneous labor.

Movement in Labor

- Women who are upright during first stage have shorter labors, and are less likely to have an epidural, less likely to have a cesarean (Cochrane Review: Lawrence et al 2013).
- Women report less severe pain, more satisfaction, fewer interventions (Priddis et al 2011).



8 Key Labor Positions Proven to Help Labor Progress

Lamaze suggests these 8 labor positions to help you progress through labor. Practice these positions at home with your birth partner and bring this sheet with you on the big day as a reminder of how you can keep moving!

Walking/Standing

Benefits
- Uses gravity to encourage descent
- Helps encourage baby into good position for delivery
- Provides a distraction
- Being upright and staying active during labor can help increase comfort, shorten labor and avoid cesarean section

How To
- Grab your partner and take a stroll

Squatting

Benefits
- Uses gravity to encourage descent
- May help rotate baby into an ideal delivery position
- May increase pelvic diameter by as much as two centimeters
- Allows the freedom to shift your weight for comfort

How To
- Squat with your feet flat on a sturdy, low surface and hold a squatting bar, sheet, rebozo, support person or strong piece of furniture for stability
- Keep feet wide and don't let your knees pass your toes
- You can also sit on a toilet or birth ball to achieve this position
- Allows partner or doula to gently massage your belly in circular motions

Slow Dancing

Benefits
All of the above, plus:
- May be more restful than standing
- Allows partner to provide physical support
- Allows you to move your hips in rhythm with contractions or music
- Moving your hips can increase your comfort and help baby descend

How To
- Slow dance with your partner and sway to the rhythm of music or your contractions
- Move your hips to increase your comfort

Using a Rebozo

Benefits
- May help increase comfort
- May help baby rotate into a favorable delivery position, especially for a baby that is face up
- May relieve uterine ligament tension or back pressure

How To
- Use a woven shawl (rebozo) or a sheet that is about 5-7 feet long
- While on hands and knees, have partner place rebozo around your belly
- Using gentle, tiny jiggling movements, shift the rebozo from side to side

Consult your professional labor support team before attempting this position.

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Approaches to Limit Intervention During Labor and Birth

- Although many have encouraged a supine position during labor, this position has known adverse effects, including supine hypotension and more frequent fetal heart rate decelerations

Peanut Ball

Recog/Prevent

- Decreased length of labor
- Decreased CS rate in patients with epidurals

Tussey, C. M., Botsios, E., Gerkin, R. D., Kelly, L. A., Gamez, J., & Mensik, J. (2015). Reducing length of labor and cesarean surgery rate using a peanut ball for women laboring with an epidural. *The Journal of Perinatal Education*, *24*(1), 16-24. http://dx.doi.org/10.1891/1058-1243.24.L16

Implement Intermittent Monitoring for Low-risk Patients

Continuous monitoring:

- Increases the likelihood of cesarean
- Has not been shown to improve neonatal outcomes (e.g. reduce rates of CP)
- Restricts movement (and normal physiologic processes and coping)

- Potentially reduces nursing interaction/ labor support

IA Evidence

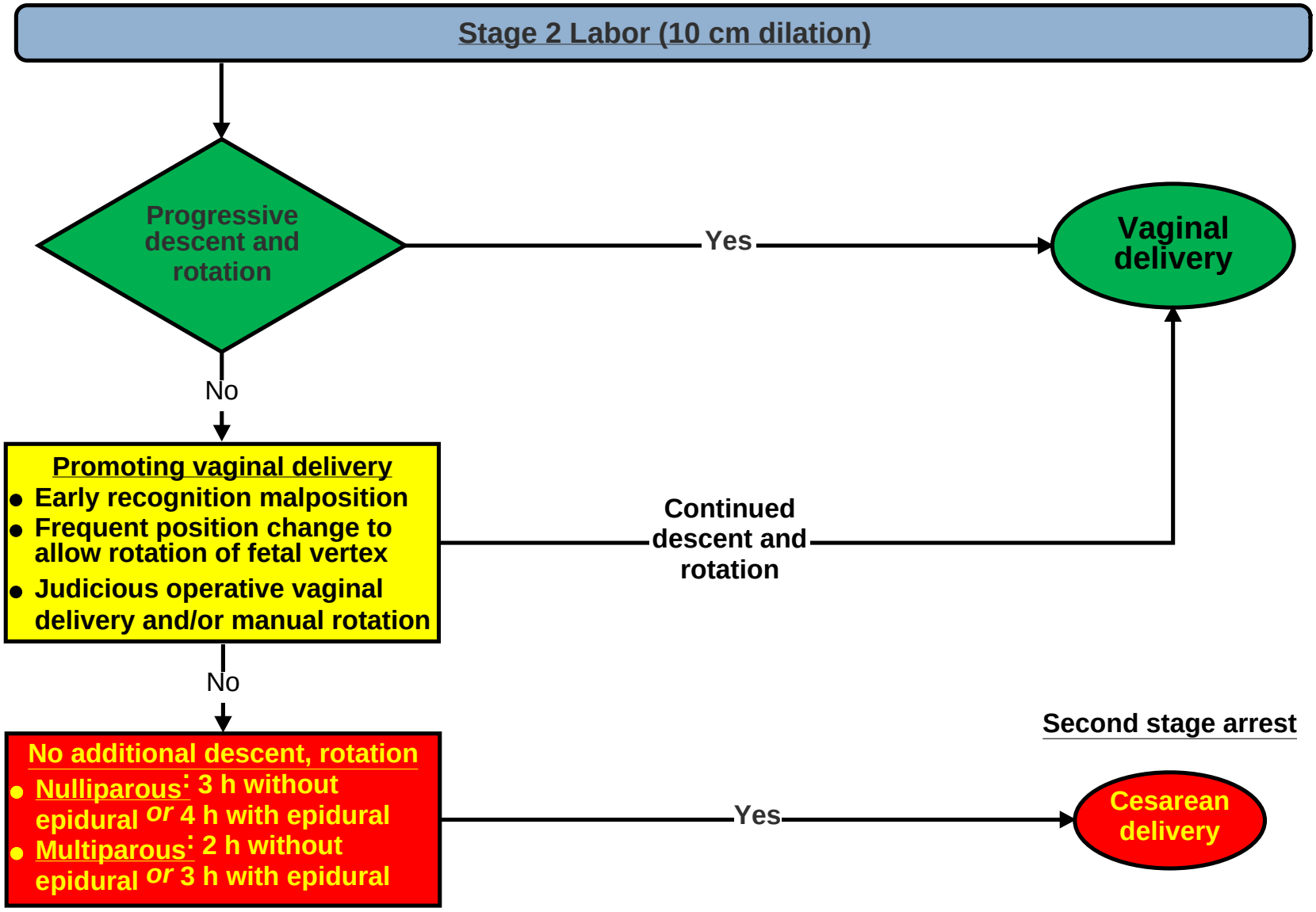
- Cochrane Review (13 RCTs, n>37,000)
  - Increased risk of C-S, V/FAVD
  - No difference in perinatal mortality, CP or Apgars <7 @ 5 mins.
  - Neonatal seizures rare, but slightly more in IA group.
- "Given that available data do not clearly support EFM over IA, either option is acceptable in a patient without complications." ACOG, 2009
- "IA is the preferred method of fetal surveillance for healthy low risk women in labor" SOGC

IA… When and Where?

- **Per ACOG and AWHONN**
  - Latent labor q 1 hour
  - Active labor q 30 minutes
  - Second stage q 15 minutes
- **Listen Before**
  - Administration of Narcotics
  - AROM
  - Transfer or discharge
- **Listen After**
  - Vaginal Exam
  - SROM/AROM
  - Abnormal uterine activity
  - Abnormal vaginal bleed
- **Where?**
  - Walking / Standing
  - In the shower/tub
  - On the ball
  - In the bed
  - With a mouse, in a house, on chair…Anywhere!

Second Stage

- Adverse neonatal outcomes have not been associated with duration of the second stage of labor.
- Instrument delivery can reduce the need for cesarean.
- Recommended longer pushing time than previously practiced
- Try open glottis pushing, especially with non-epidural patients
- All patients can change position while pushing to help with fetal descent and rotation


Stage 2 Labor (10 cm dilation)
Progressive descent and rotation
Yes
Vaginal delivery
No
Promoting vaginal delivery
Early recognition malposition
Frequent position change to allow rotation of fetal vertex
Judicious operative vaginal delivery and/or manual rotation
Continued descent and rotation
No
Second stage arrest
No additional descent, rotation
Nulliparous: 3 h without epidural or 4 h with epidural
Multiparous: 2 h without epidural or 3 h with epidural
Yes
Cesarean delivery

Promoting vaginal delivery in the Second Stage of labor:

- If maternal-fetal conditions permit, then 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

CMQCC
California Maternal
Quality Care Collaborative

Appendix N

Algorithm for the Management of Second Stage of Labor

NO EPIDURAL

CERVIX
10 CM

RN document time, SBAR to provider

Encourage the patient to listen to her body; there is no "right way" to push in this case, and the patient should push for as long as seems natural with each contraction. Open glottis pushing is preferable to "purple pushing" or "counting to 10" while holding breath. Offer coaching/advice as needed if pushing seems ineffective. Continuous RN bedside presence when pushing

NULLIP

ONE HOUR PUSHING

***If no progress*:RN** to SBAR provider re: maternal and fetal status, document the call; **CNM/MD** to evaluate patient and document plan of care.

TWO HOURS

***Delivery not imminent*:RN** to SBAR provider, document the call; **CNM** consult with MD; **MD** evaluate patient and document plan

THREE HOURS

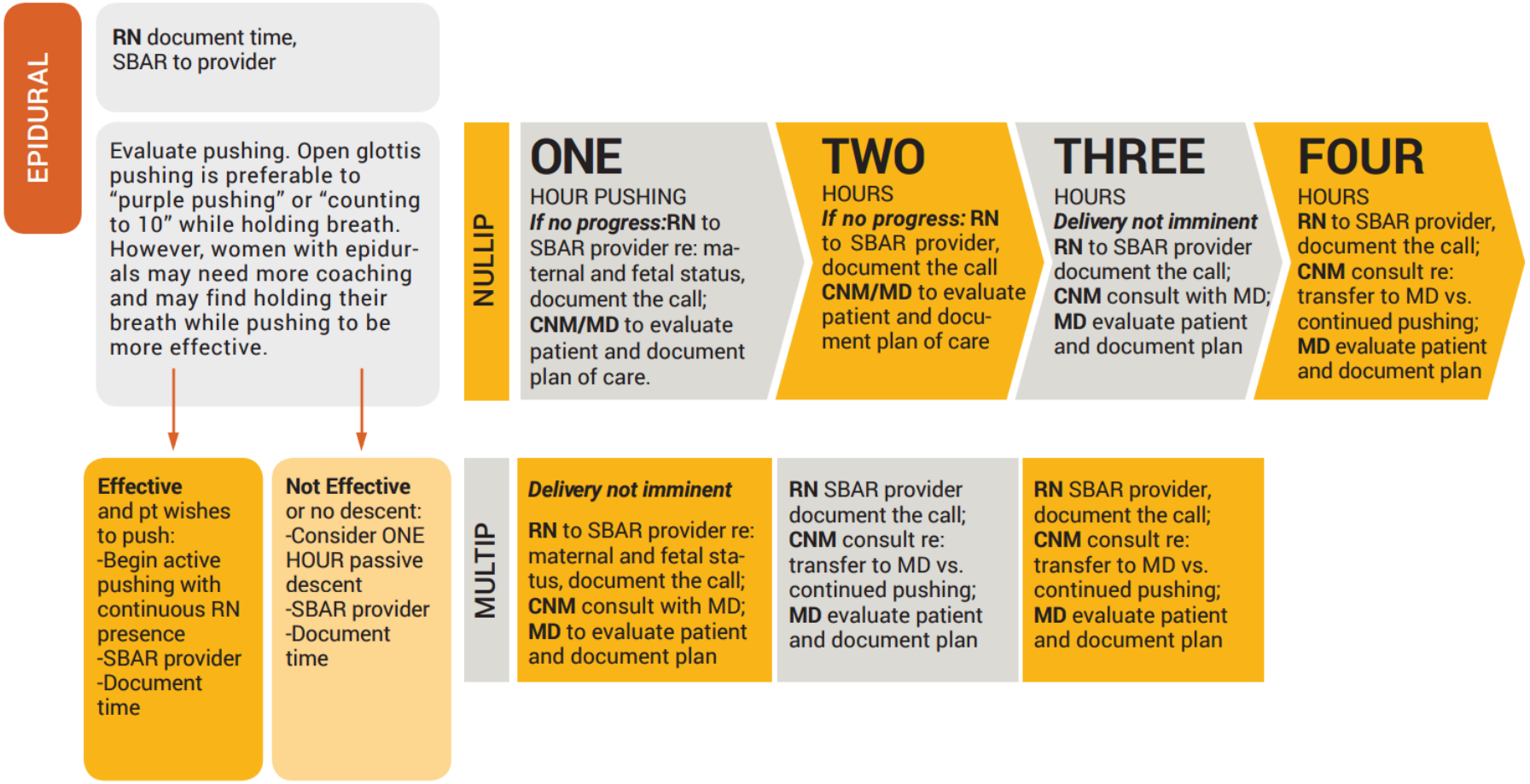
RN to SBAR provider, document the call; **CNM** consult re: transfer to MD vs. continued pushing; **MD** evaluate patient and document plan

MULTIP

Delivery not imminent

RN to SBAR provider re: maternal and fetal status, document the call; **CNM** consult with MD; **MD** to evaluate patient and document plan

RN SBAR provider, document the call; **CNM** consult re: transfer to MD vs. continued pushing; **MD** evaluate patient and document plan


EPIDURAL
RN document time, SBAR to provider
Evaluate pushing. Open glottis pushing is preferable to "purple pushing" or "counting to 10" while holding breath. However, women with epidurals may need more coaching and may find holding their breath while pushing to be more effective.
Effective and pt wishes to push: -Begin active pushing with continuous RN presence -SBAR provider -Document time
Not Effective or no descent: -Consider ONE HOUR passive descent -SBAR provider -Document time
NULLIP
ONE HOUR PUSHING
If no progress:RN to SBAR provider re: maternal and fetal status, document the call; CNM/MD to evaluate patient and document plan of care.
TWO HOURS
If no progress: RN to SBAR provider, document the call CNM/MD to evaluate patient and document plan of care
THREE HOURS
Delivery not imminent RN to SBAR provider document the call; CNM consult with MD; MD evaluate patient and document plan
FOUR HOURS
RN to SBAR provider, document the call; CNM consult re: transfer to MD vs. continued pushing; MD evaluate patient and document plan
MULTIP
Delivery not imminent
RN to SBAR provider re: maternal and fetal status, document the call; CNM consult with MD; MD to evaluate patient and document plan
RN SBAR provider document the call; CNM consult re: transfer to MD vs. continued pushing; MD evaluate patient and document plan
RN SBAR provider, document the call; CNM consult re: transfer to MD vs. continued pushing; MD evaluate patient and document plan

What about Cahill et al October 2018?

- Immediate Vs delayed pushing (60”)- no diff in vaginal birth rate.
- Stopped early due to PPH/EBL concerns (no diff in severe PPH >2000 CS, >1000 vaginal)
- ACOG released a Practice Advisory that recommends that women begin pushing once cervical dilation is complete.
- ACNM endorses this Practice Advisory but acknowledges that more research is needed and that this is not a recommendation for a new standard of care and cannot replace individual clinical judgment.

Immediate	Delayed
Shorter 2nd stage	Shorter pushing time
Lower risk of PPH based on EBL, defined > 500 mL vaginal or > 1000 CS	Fever variable decels
Lower risk chorioamnionitis (dx by MD during 2nd stage and tx w/atb).	Lower risk of neg effect on fetal O2 status
	Decreased risk 3rd & 4th degree lacerations
	Less maternal fatigue

(Simpson, 2019; Tuuli, 2012 MA)

Partnering to Improve Health Care Quality
for Mothers and Babies

QUESTIONS?