Promoting Primary Vaginal Deliveries Initiative

Where We Are, Where We Are Going, and Managing the OP Baby

PROVIDE Collaborative Session Webinar

Partnering to Improve Health Care Quality
for Mothers and Babies

Welcome!

- **Please join by telephone to enter your Audio PIN on your phone or we will be unable to un-mute you for discussion.**
- If you have a question, please enter it in the Question box or Raise your hand to be un-muted.
- This webinar is being recorded.
- Please provide feedback on our post-webinar survey.

Agenda

February 14, 2019

- Announcements
- **Where we are Now** – FPQC Data Team
- **What PROVIDE hospitals need** – Guest panelists
- **Managing the OP Baby** – Julie DeCesare, MD and Jessica Brumley, CNM, PhD
- Q&A

Announcements: Upcoming Events

- Labor Support Trainings:
  - Sarasota, FL: February 27, 2019
  - Hollywood, FL: March 28, 2019

- FPQC 2019 Annual Conference: April 4-5!
  - Submit a poster!
  - Can be on a QI project in process or completed
  - Due Feb 28 – See FPQC.org conference site for info

New! Online Discussion Forums

- Join our Maternal Health Discussion Group!
  - Visit us @theFPQC on Facebook and find our "Groups"
  - Direct link: https://www.facebook.com/groups/618131375299397/

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Announcements: Data

- Your Structural Measures (collected every 6 months) are due!
- Link to the submission survey was sent via email to your data lead from data analyst Estefania Rubio

Recruiting New Hospitals!
NTSV Rates by Delivery Attendant

"Providing delivery attendant rates was the most important component in reducing our cesarean rates." Elliott Main, CMQCC

- Provides **quarterly NTSV cesarean** rate by delivery attendant.
- Successfully updated **12 months** of birth certificate data for **9 pilot hospitals**.
- Department of Health offered to assist **all PROVIDE hospitals**.
- **Stagger start** interested hospitals over time.

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Where We Are Now

PROVIDE Initiative-wide Data Report

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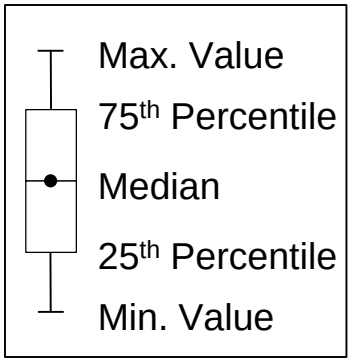
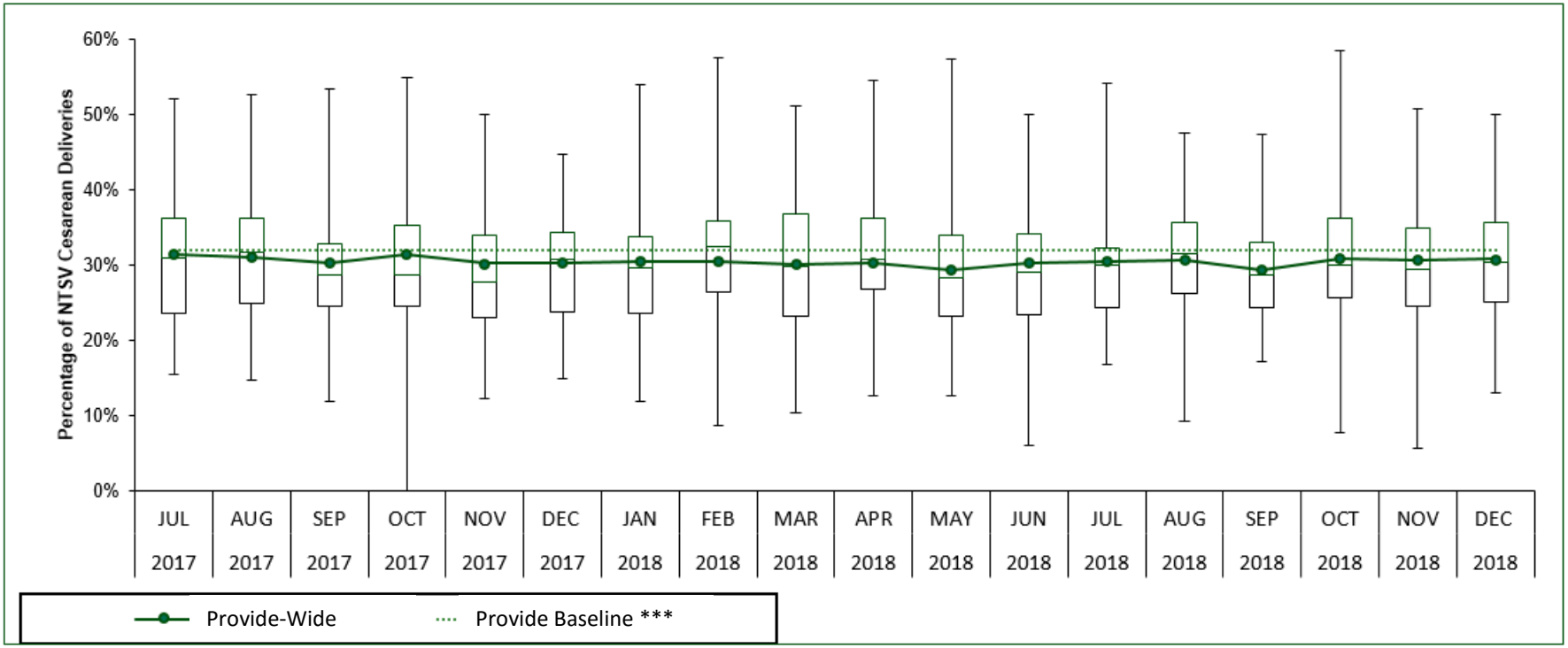
NTSV Cesarean Rates

Data Source: Birth Certificate





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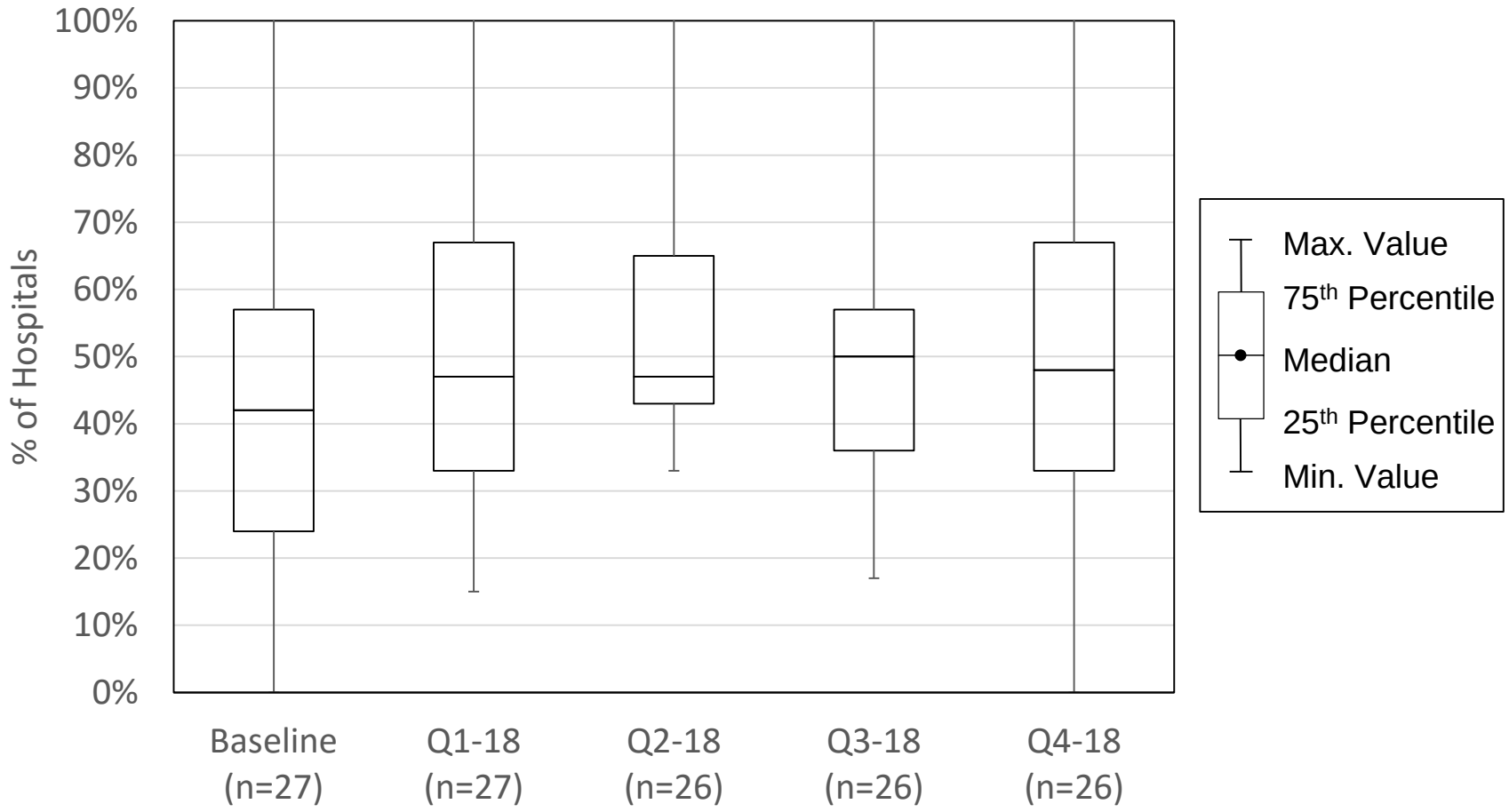
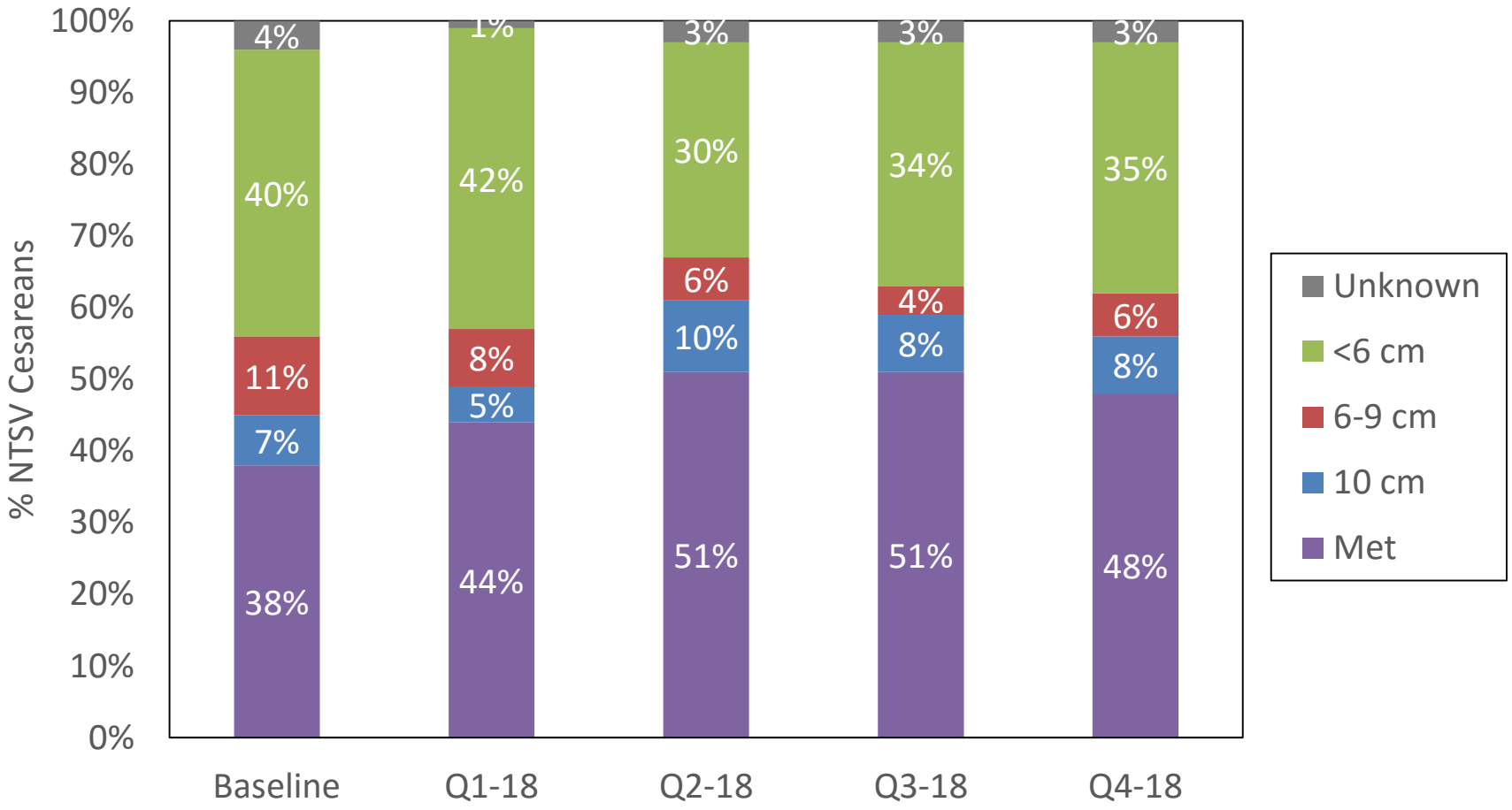
INDUCTION CASE AUDIT

Data Source: NTSV Cesarean Audits

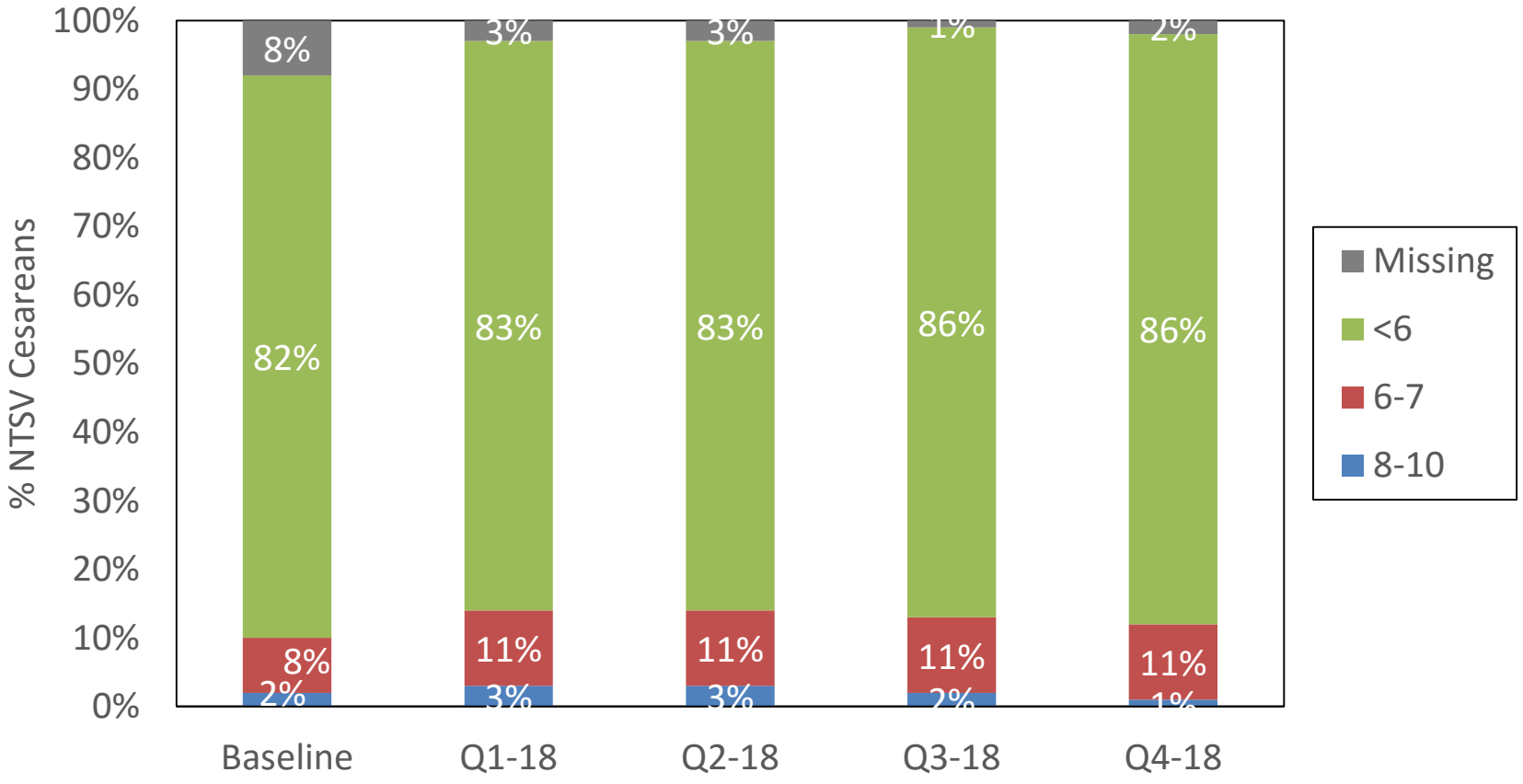
I-2: Percent of NTSV Cesarean Deliveries by Hospital with Induction that Met ACOG/SMFM Criteria



I-4: Percent of Cesarean Deliveries with Induction that Did Not Meet ACOG/SMFM Criteria by Cervical Dilatation

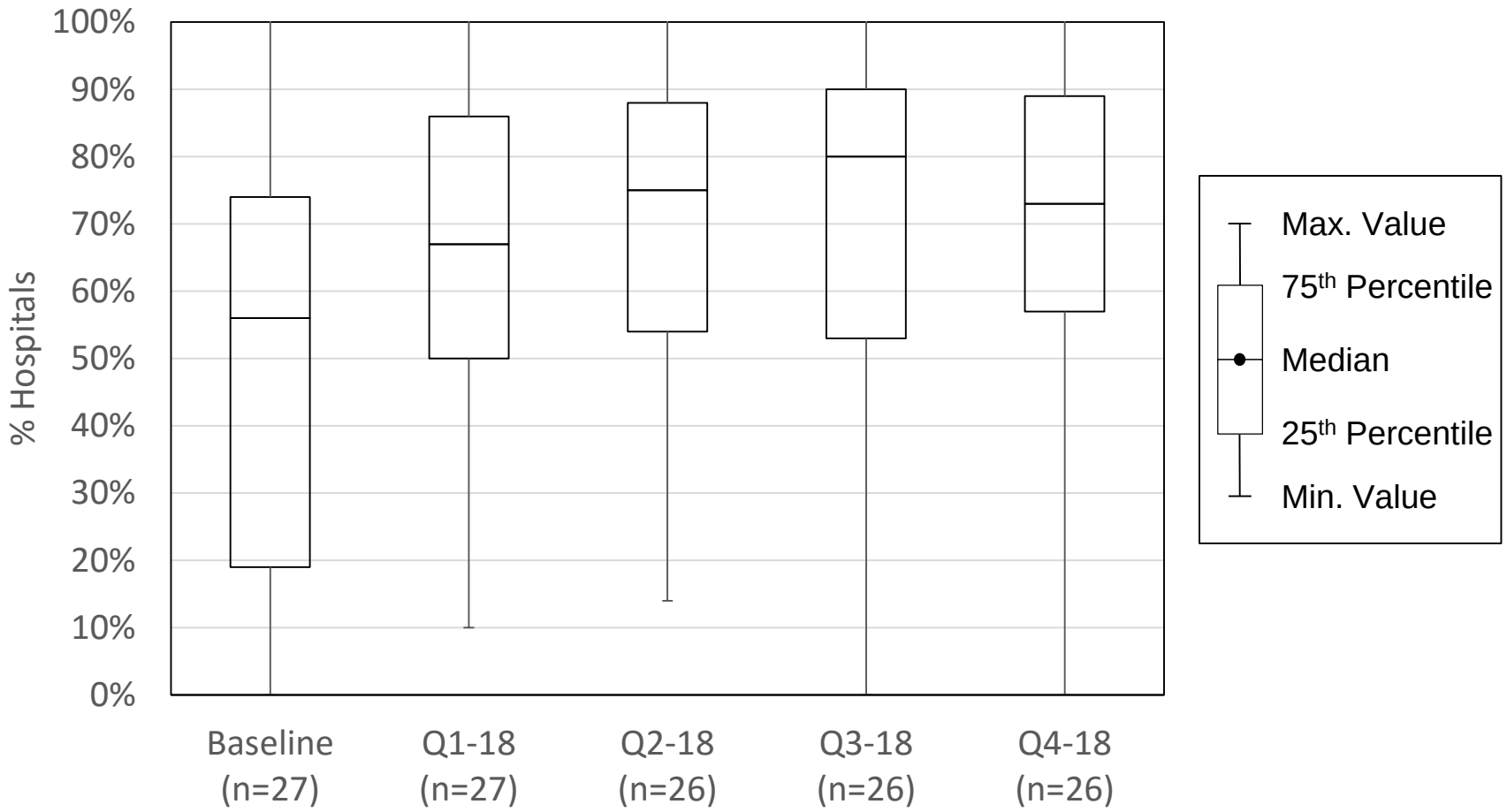


I-9: Percent of NTSV Cesarean Deliveries with Induction by Bishop Score at Time of Induction



NOTE: the reported bishop score is only used when data to calculate the bishop score was not entered

I-10: Percent of All NTSV Cesarean Deliveries by Hospital with Induction and a Bishop Score <8 with Cervical Ripening Agent Used



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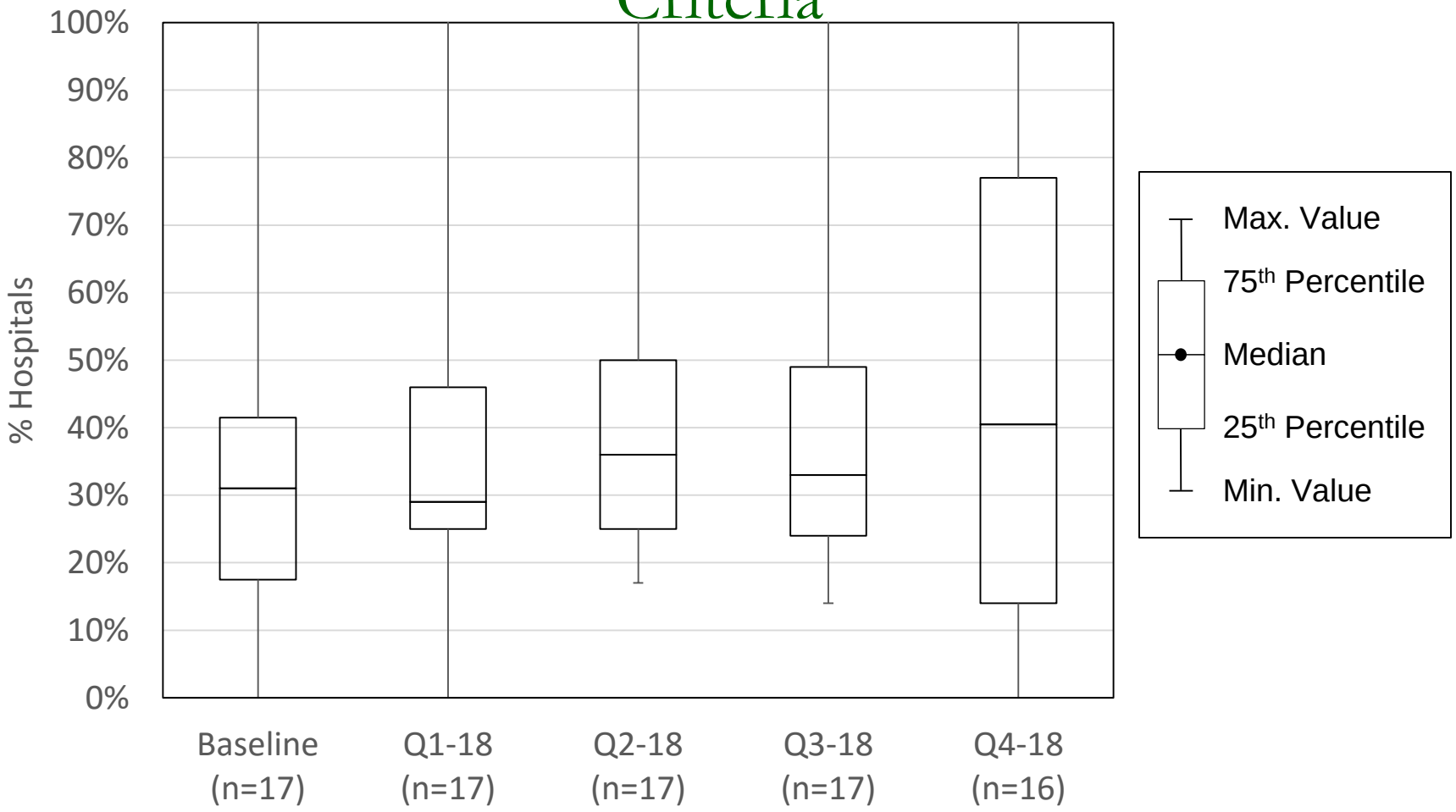
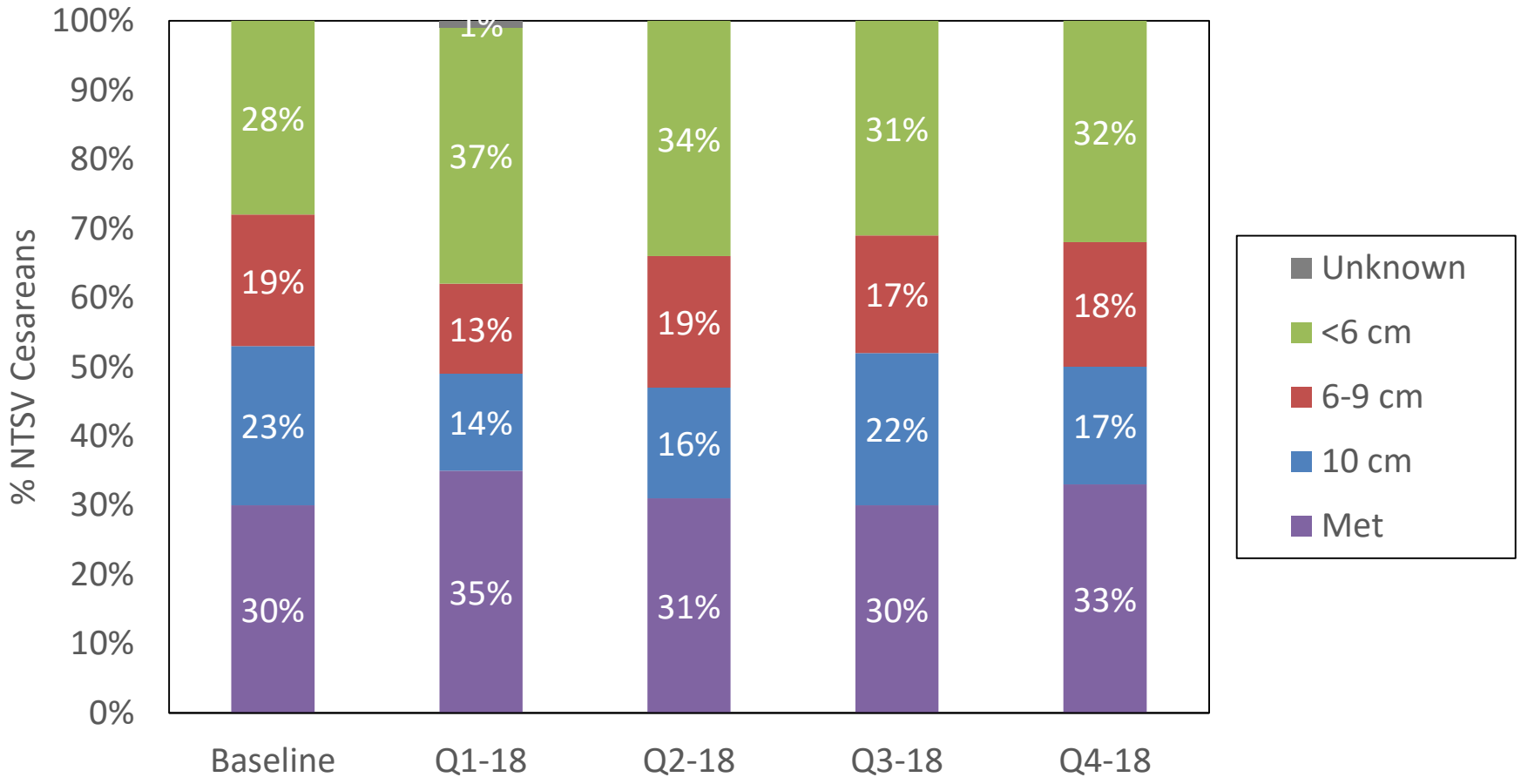
LABOR DYSTOCIA/FAILURE TO PROGRESS AUDIT

D-2: Percent of NTSV Cesarean Deliveries by Hospital with Dystocia that Met ACOG/SMFM Criteria



D-3: Percent of NTSV Cesarean Deliveries with Dystocia that Did Not Meet ACOG/SMFM Criteria by Cervical Dilatation



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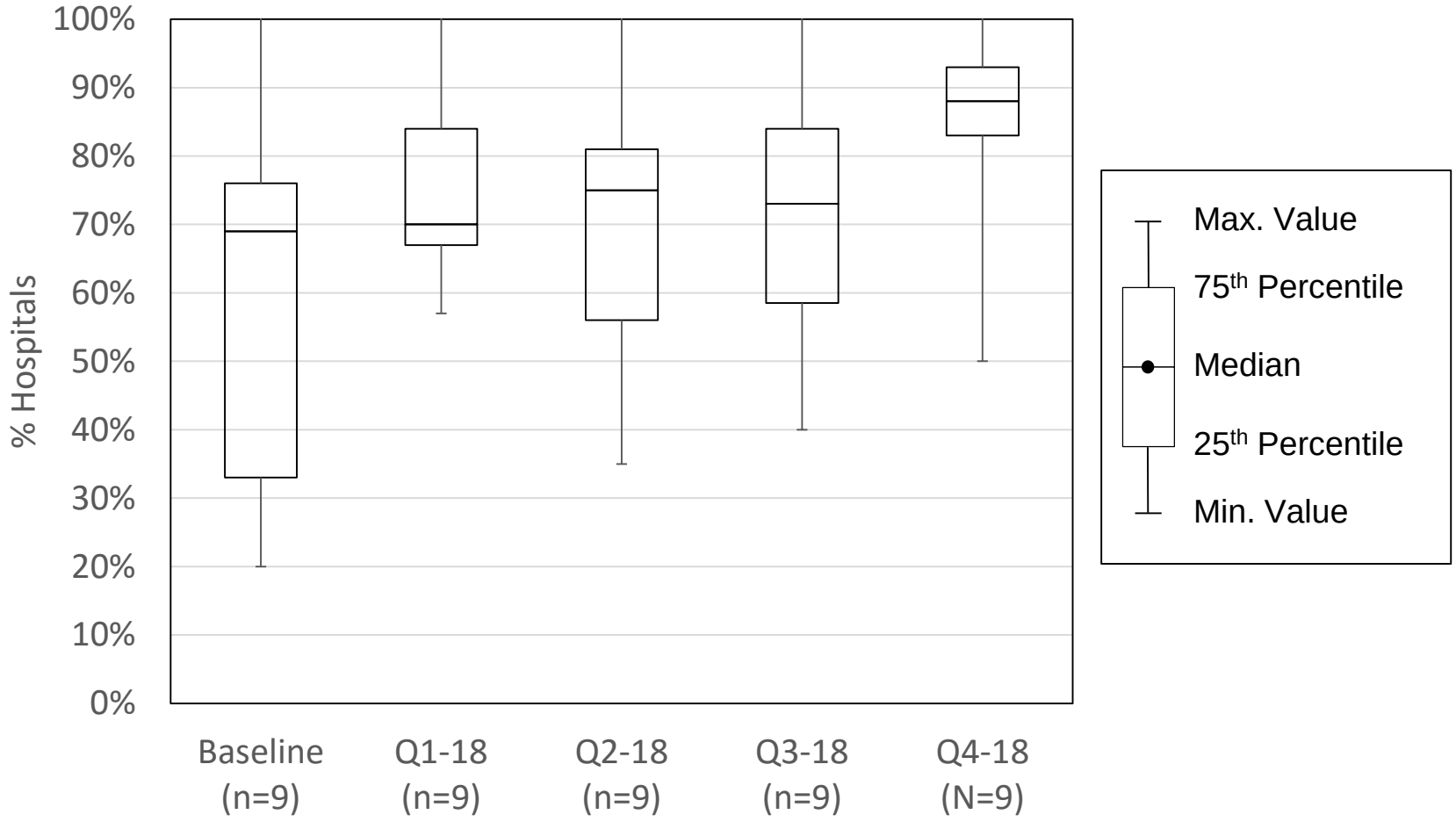
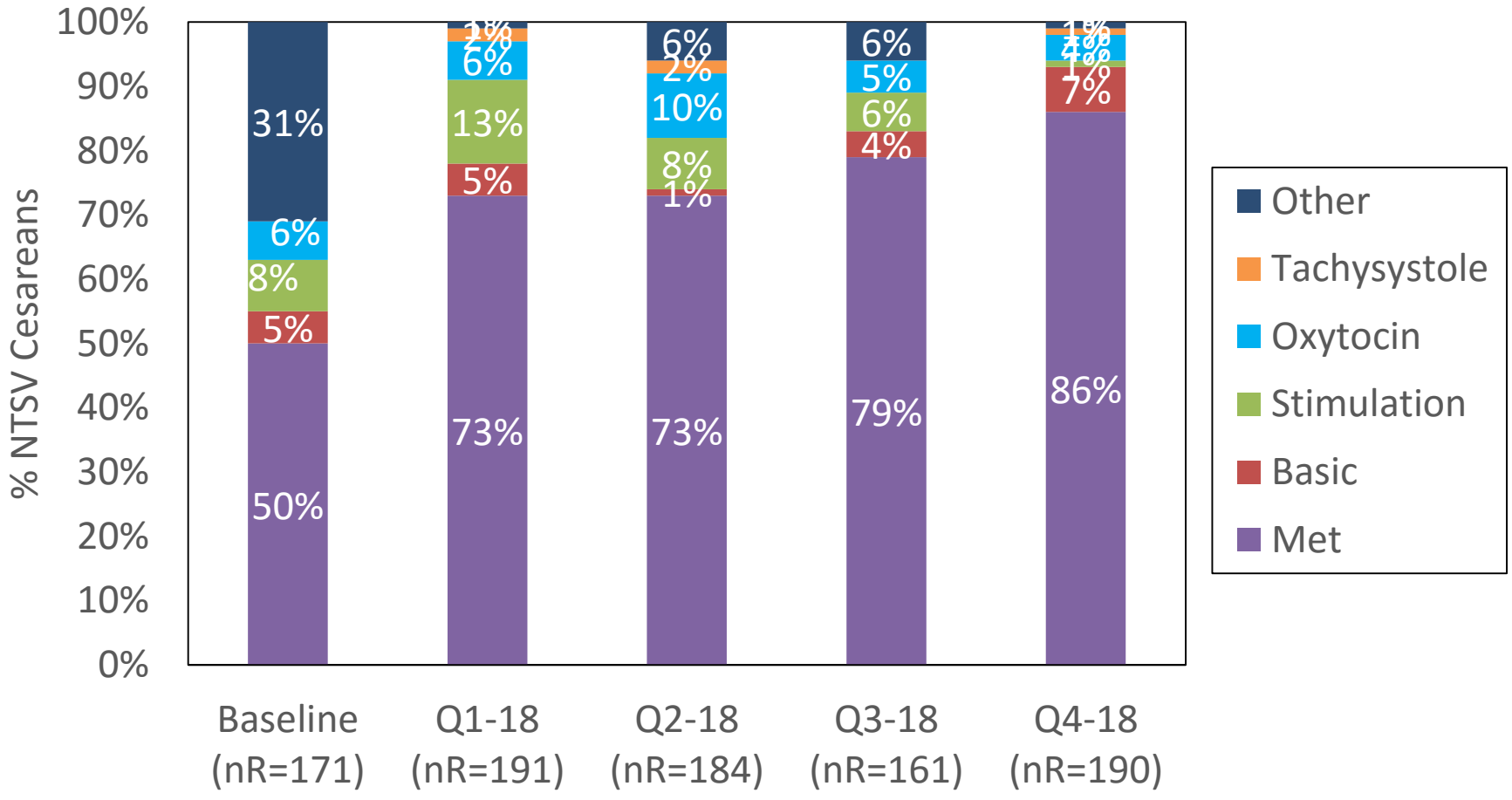
FETAL HEART RATE CONCERN AUDIT

FHRC-1: Percent of NTSV Cesarean Deliveries by Hospital with Fetal Heart Rate Concerns that Met FPQC Criteria for Corrective Measures

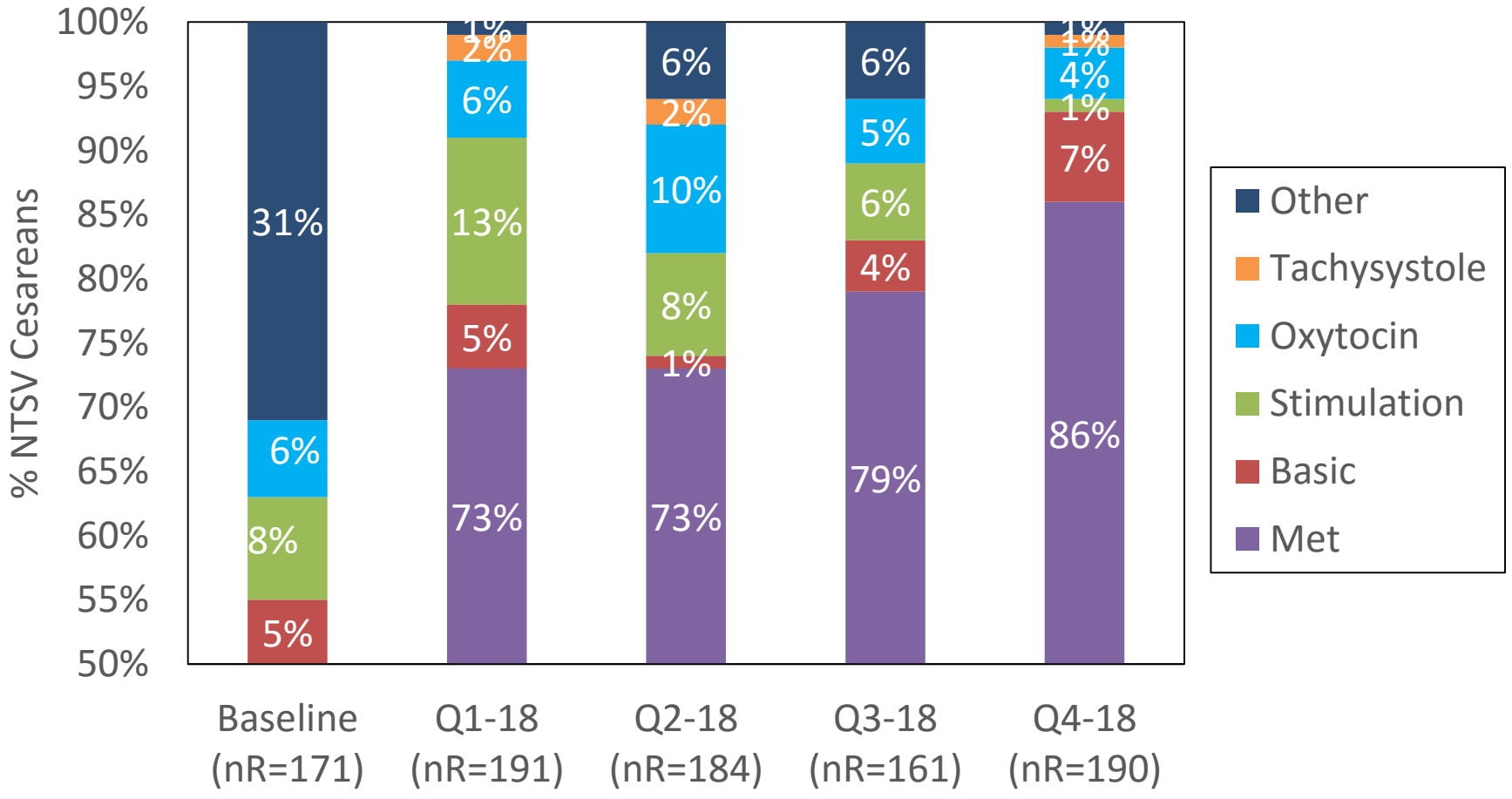


FHRC-2: Percent of Cesarean Deliveries with Fetal Heart Rate Concerns that Did Not Meet FPQC Criteria by Corrective Measure



Note: All other corrective measures require that basic measures be used

FHRC-2: Percent of Cesarean Deliveries with Fetal Heart Rate Concerns that Did Not Meet FPQC Criteria by Corrective Measure



Note: All other corrective measures require that basic measures be used

Structural Measures

27 hospital have submitted structural measures
We need them from all!

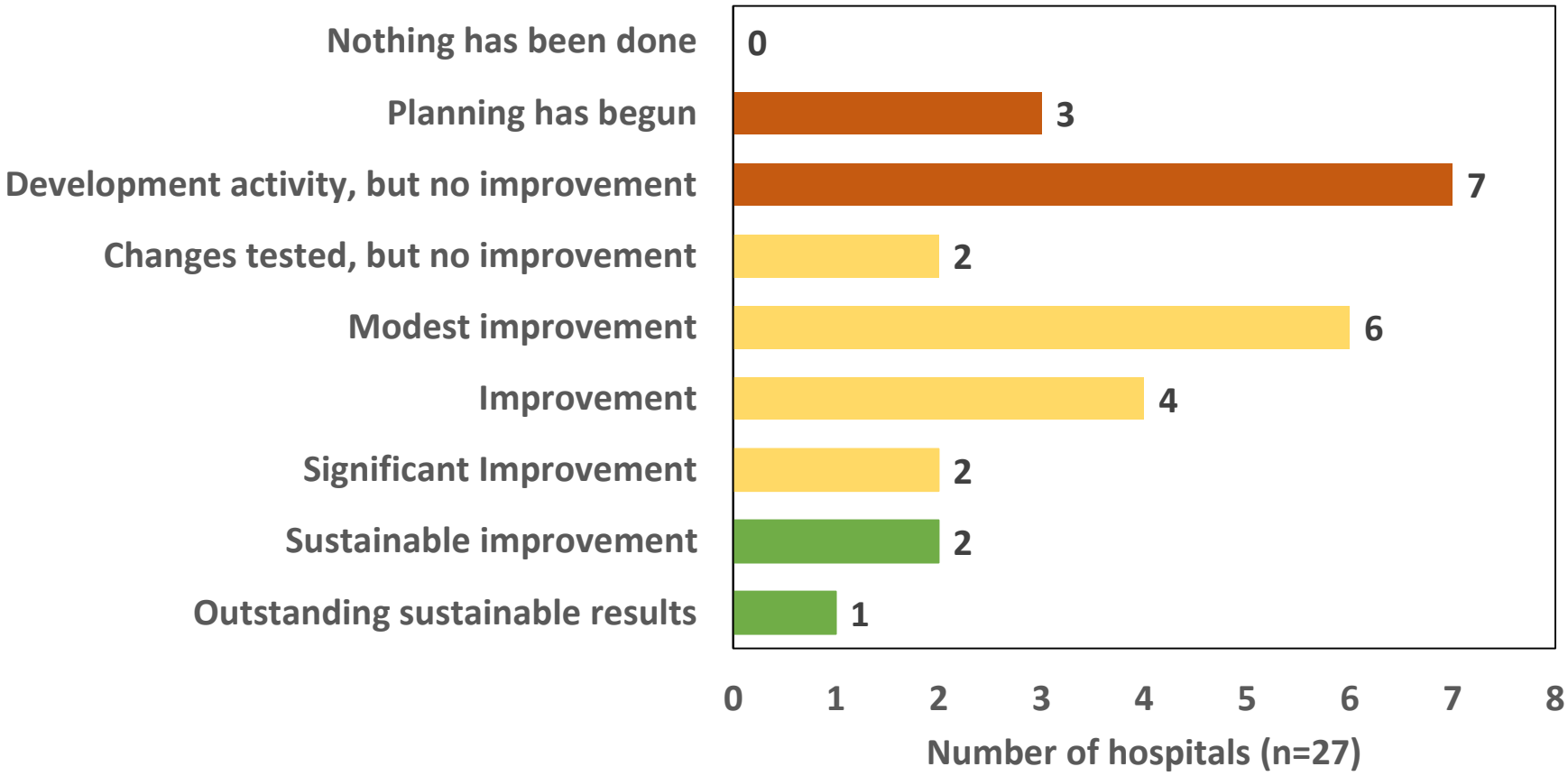
- Patient, Family & Staff Support
- Unit Policy and Procedure
- EHR Integration
- Multidisciplinary Case Reviews
- Staff Education

Submitted by hospital every 6 months

Structural Measures

- Data collected through Qualtrix
- Link to submit your data was sent to project and data leads
- Please complete by February 28, 2018

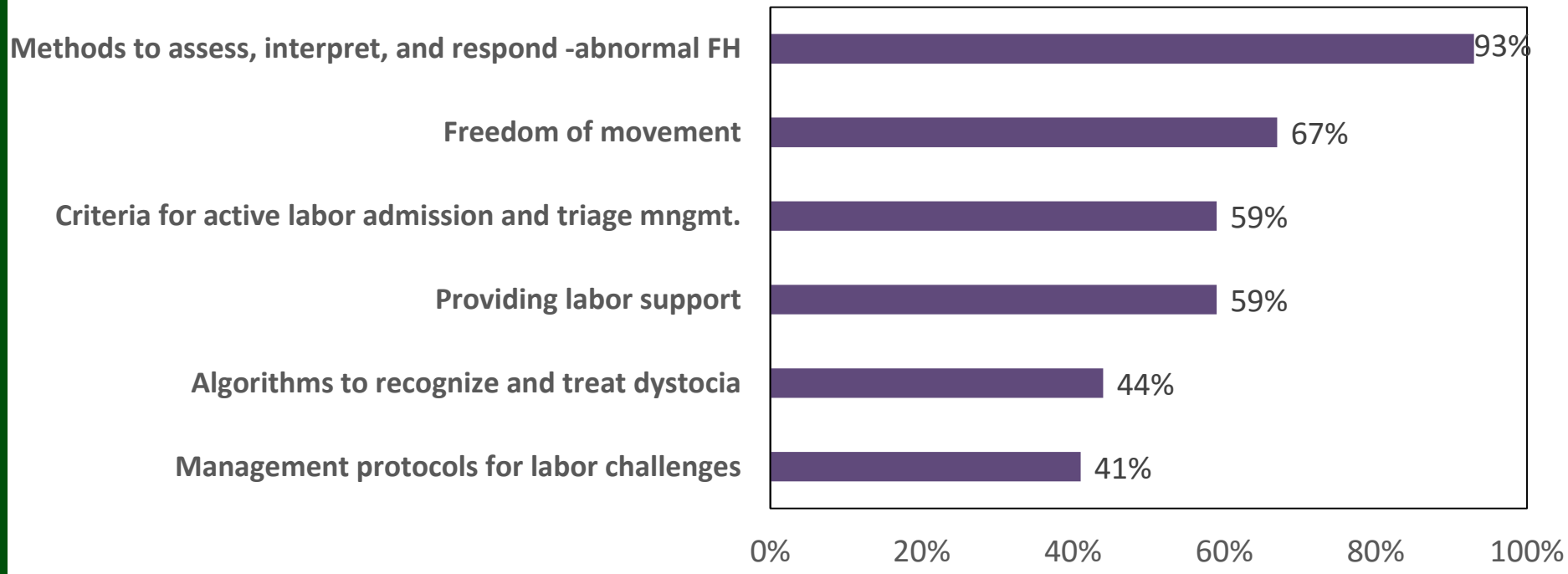
Hospital progress assessment*



*Preliminary results

Structural Measures

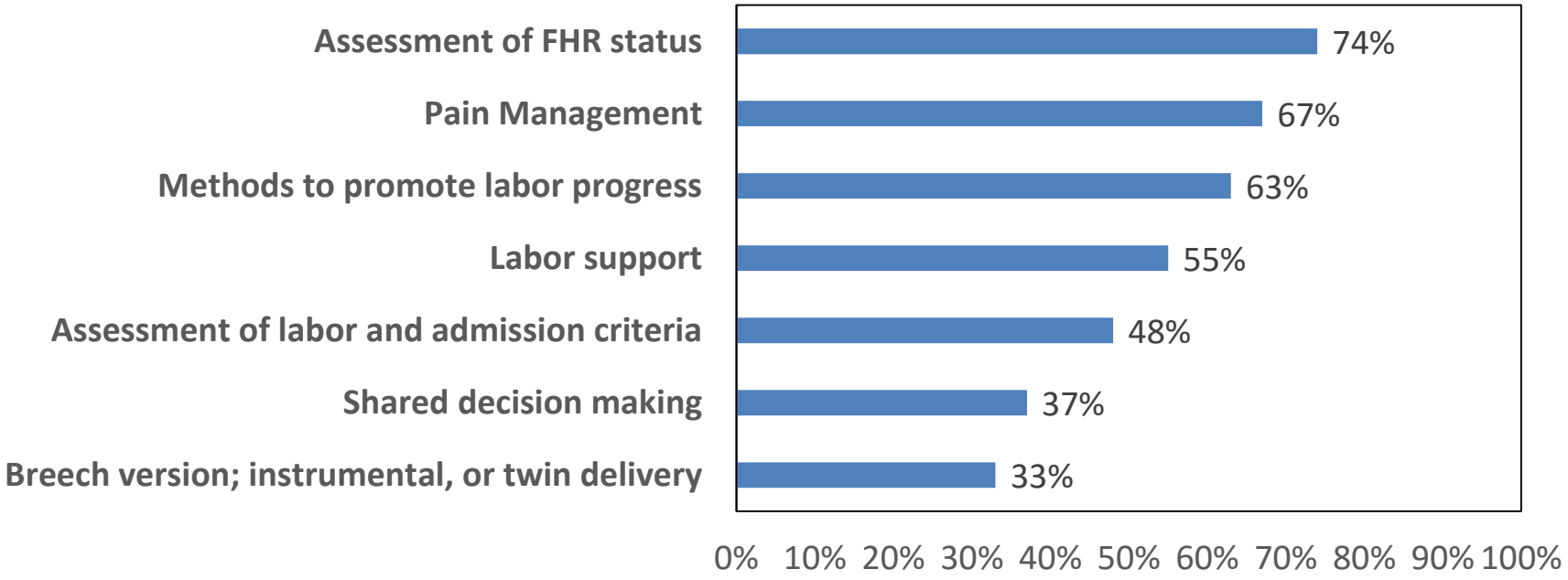
- Up-to-date labor guidelines, policies and procedures that includes a unit-standard approach for:



*Preliminary results

Structural Measures

Provider education and training techniques that develop knowledge and skills on approaches which maximize the likelihood of vaginal birth, including:



***Preliminary results**

Structural Measures

- **37%** of hospitals have OB specific resources and protocols to support patients, family, and staff through an unexpected/traumatic
- **51%** of hospitals have established process to perform **multidisciplinary case reviews**
- **41% have met** in the last 6 months and conducted multidisciplinary case reviews
- Only 15% of providers and 30% of nurses have completed an education program on the ACOG/SMFM labor management guidelines

Moving Forward

- Decreasing cesarean rates requires multiple pressure points
- Data help inform where to allocate resources and efforts

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Panelists:

- Carol Lawrence, Lee Health
- Mary Holloway, AdventHealth Orlando
- Laura Daly, Jackson Memorial Hospital

What Hospitals Need

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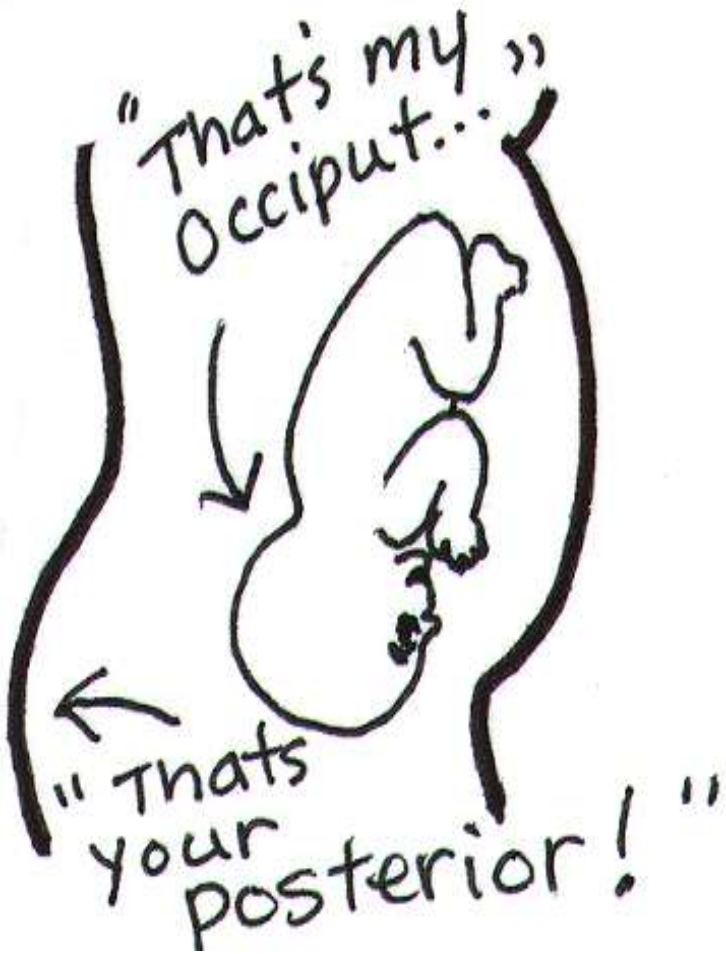
Management of the Occiput Posterior Fetus in Labor

Jessica Brumley CNM, PhD
Julie DeCesare MD

Risks of Occiput Posterior

- Longer labor
- Maternal fatigue
- Increased need for psychological support
- Surgical deliveries
- Perineal lacerations



Signs of Malposition:

- Mother might have back labor (but she might not)
- First stage may be prolonged/stalled
- Internal check indicates fetal head position such as swollen cervix especially if more on one side
- Visual inspection of the abdomen may reveal a dip in the front instead of a rounded gravid abdomen.
- Ultrasound if available is the gold standard in diagnosis of Occiput Posterior

Incidence of OP

- At onset of labor 15-32%
- OP at birth: 5.5% overall
  - 7% for primips; 4% for multips
  - 13% with epidural; 3.3% without epidural

Epidurals and Malposition

While there is no evidence that epidurals cause malposition, women with epidurals are up to 4 times more likely to have an OP fetus than women without an epidural.

Women with OP fetus are 2 - 6 times more likely to have a cesarean.

Avoid malposition:

- avoid routine early amniotomy
- position changes in 1st and 2nd stage every 20 minutes

Epidurals Have Pros and Cons

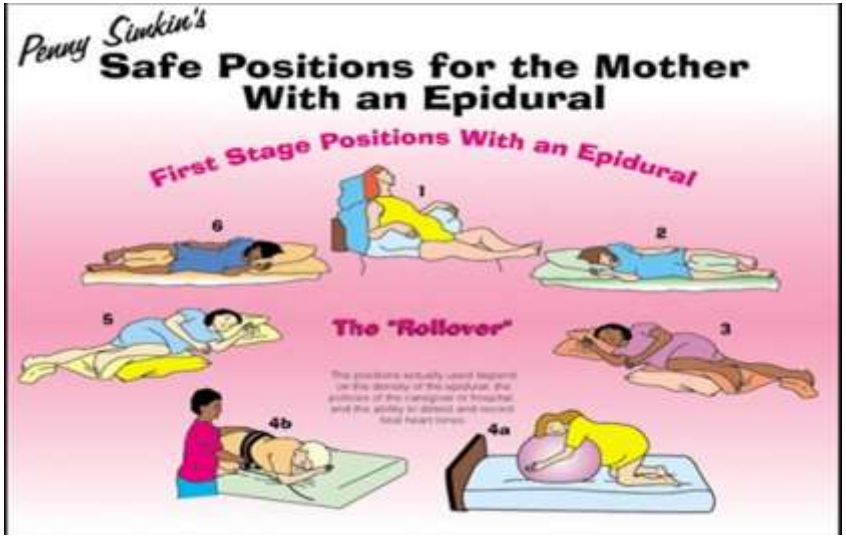
- If she doesn't move, can her pelvis rotate? Can baby descend?
- How is it affecting labor hormones?

- Epidurals may lead to:
  - Increased Pitocin usage
  - Prolonged 1st and 2nd stage
  - Increased vacuum, forceps, cesarean section

Using Epidural Wisely

1. Wait until true Active Labor
    a. Use other comfort techniques until 5-6 cm

1. Change position every half hour or so
    a. Use the “Rollover” and/or Peanut Ball



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

COMMITTEE OPINION

Number 687, February 2017

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).
- When you walk or move around in labor, your uterus, a muscle, works more efficiently (Roberts, Mendez-Bauer, & Wodell, 1983).

Why Movement Helps Promote Labor Progress

- Changing position frequently moves the bones of the pelvis to help the baby find the best fit through your birth canal, while upright positions use gravity to help bring the baby down (Simkin & Ancheta, 2005).
- When labor slows, a change in position often will help you "find your rhythm" again.
- If your baby is in a posterior position (with the back of the baby's head toward your spine), getting on your hands and knees helps the baby rotate and decreases back pain (Stremler et al., 2005).

Positions that Promote Physiologic Labor/Descent

- Hands and knees or child's pose
- Standing/walking
- Leaning over
- Swaying the hips (labor dance, figure 8's)
- Open-pelvis positions on birth ball or toilet
- Lunging
- Exaggerated SIMS
- Using a peanut ball

Walking

Squatting with a partner

Birth Ball

- Birth balls are a nice comfort for laboring mothers and can be used sitting or leaning.

- The traditional round ball allows the mother more pelvis rotation and moving the hips in a figure-eight position is helpful for comfort and fetal rotation.

Evidence on Birth Balls

- Promotes spinal flexion
- Increases the utero-spinal angle
- Allows for upright movement without exhausting the legs
- Reduces pain and pain perception
- Increases pelvic inlet and outlet
- Facilitates OP rotation
- Shorter 1st and 2nd stage duration

(Gizzo et al.2014) (Gau, 2011) (Lawrence et al. 2013) (Makvandi et al. 2015) (Thies et al. 2012)

Sizing for Birth Balls

Ideally, your knees should be lower than your hips or at a 90 degree angle, *not higher* than your hips.

As a general rule: If you're up to 5ft 8in in height, it's best to get a 65cm **ball**. If you're 5ft 9in or taller then it's best to get a 75cm **ball**.

Peanut Ball

- 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

Heard of the CUB?

Evidence on Upright Birth

- Available space in the pelvis can be increased by **28-30%**.
- **Contractions** can be more **effective**.
- **23%** less likely to need medical assistance.
- Baby is **54%** less likely to become distressed.
- **Shorter labour** & **29%** reduction in emergency C-section.
- **21%** reduction in episiotomy rates.
- **Reduced** need for **epidural.**

www.the-cub-usa.com

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Rotating a Suspected Malposition Baby

Malpositioned Baby Rotation

- *The "Miles Circuit" is a series of three positions (Child's Pose, Exaggerated Simms (usually on left side), & Lunge) that are done in 30 minute intervals for a 90 minute sequence.*
- *This can be done carefully with an epidural. The Miles Circuit can be utilized to alleviate back pain and to help facilitate turning a malpositioned baby.*

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Rotating a Baby in Second Stage

CMQCC

Rotation of ROP to OA

Mother is supine & Baby is ROP

Position changed to right sidelying for 30 mins

CMQCC

Pushing Positions (*without* epidural)

5. Sidelying (Sims Lateral) with Open Pelvis

Good position to encourage rest between pushing when needed. Also facilitates rotation when **malposition** is diagnosed. If ROP, woman should lay on right side. If LOP, woman should lay on left side.

CMQCC

Rotation of ROP to OA

Baby turns to ROT

Position changed to Hands & Knees for final rotation to OA

Education Resources for Nurses

- Labor Progress Handbook (Penny Simkin)
- SpinningBabies.com
- FPQC.org → Current Projects → PROVIDE → Tool Box Resources
  - See *Labor Dystocia* and *Patient Education*

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WHAT ELSE IS CAN A CLINICAN DO?

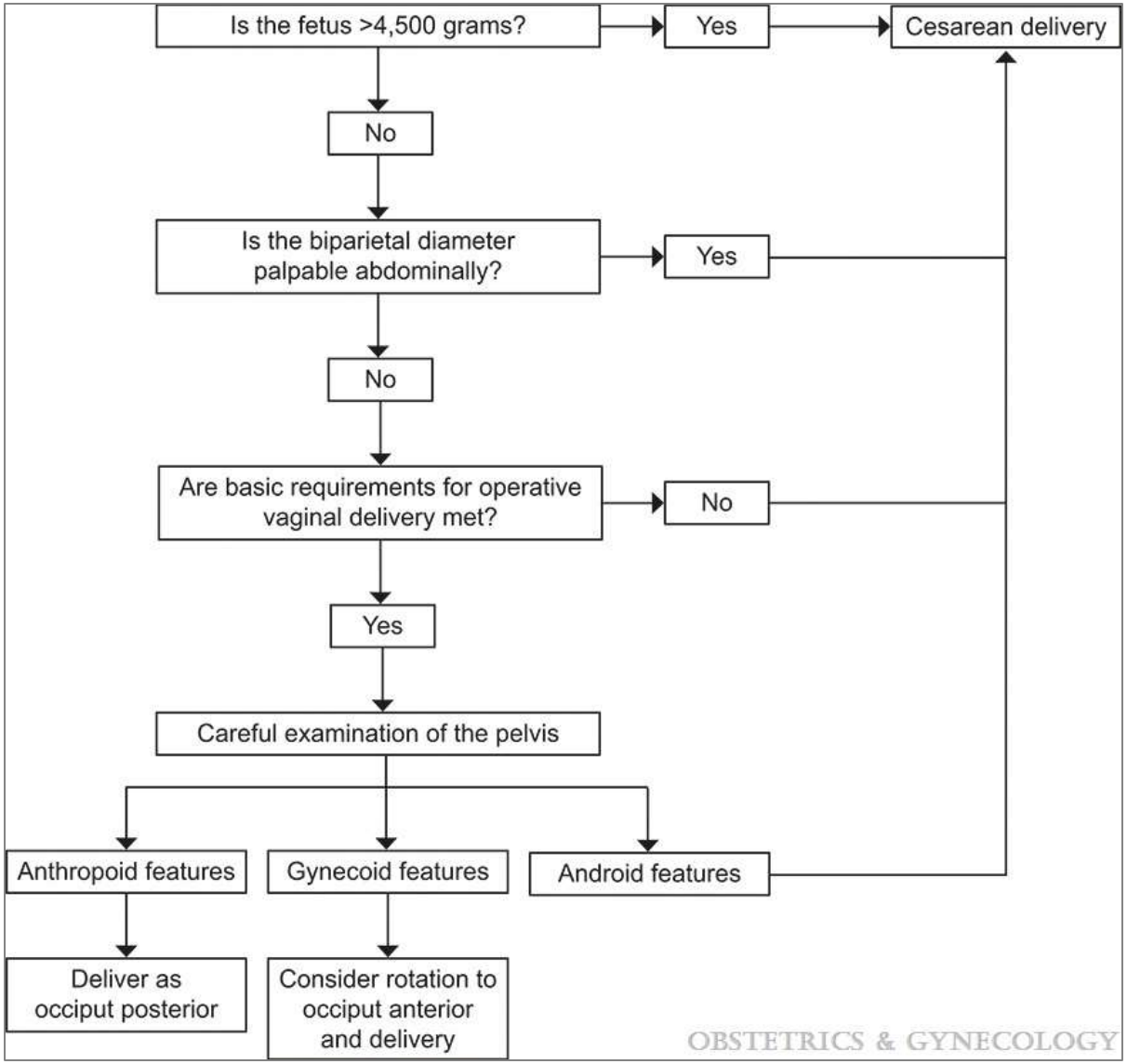
What to do with Persistent OP?

1. Is delivery indicated at this time?
2. Is vaginal delivery contraindicated?
3. What is the true position of the fetal head?
4. Should rotation be considered before vaginal

delivery?

5. If rotating, which method is preferred?

Fig. 4



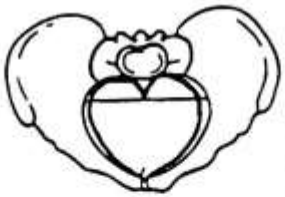
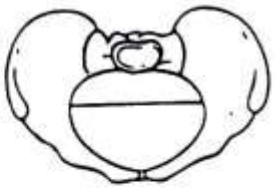
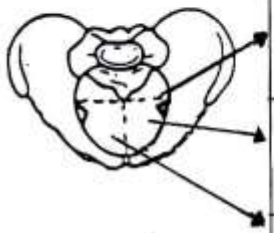
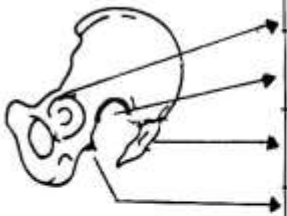
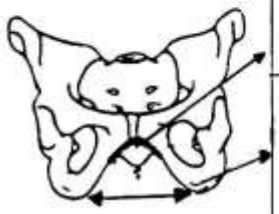
Persistent Occiput Posterior

Barth, William H.

Obstetrics & Gynecology125(3):695-709, March 2015.

doi: 10.1097/AOG.0000000000000647

Suggested approach to arrest of descent in the second stage with persistent occiput posterior.Barth. Persistent Occiput Posterior. Obstet Gynecol 2015.

		 Gynecoid	 Anthropoid	 Android	 Platypelloid
Pelvic inlet 	Widest transverse diameter of inlet	12 cm	< 12 cm	12 cm	12 cm
	Anteroposterior diameter of inlet	11 cm	> 12 cm	11 cm	10 cm
	Forepelvis	Wide	Divergent	Narrow	Straight
Pelvic midcavity 	Side walls	Straight	Narrow	Convergent	Wide
	Sacrosciatic notch	Medium	Backward	Narrow	Forward
	Inclination of sacrum	Medium	Wide	Forward (lower third)	Narrow
	Ischial spines	Not prominent	Not prominent	Not prominent	Not prominent
Pelvic outlet 	Subpubic arch	Wide	Medium	Narrow	Wide
	Transverse diameter of outlet	10 cm	10 cm	< 10 cm	10 cm

Points to consider…

- Successful rotation after the onset of the second stage of labor is more likely to be successful if it is performed before arrest occurs. Manual rotation can convert 90% of OP or transverse arrest situations to OA.

- Manual rotation is more successful in multiparous women and young women.

- Rotation is important if there is a need for a fast delivery and/or if there is minimal or slow descent after a trial of pushing

Techniques to Rotate the Vertex

- 3 finger approach
- Whole hand
- Operative approach

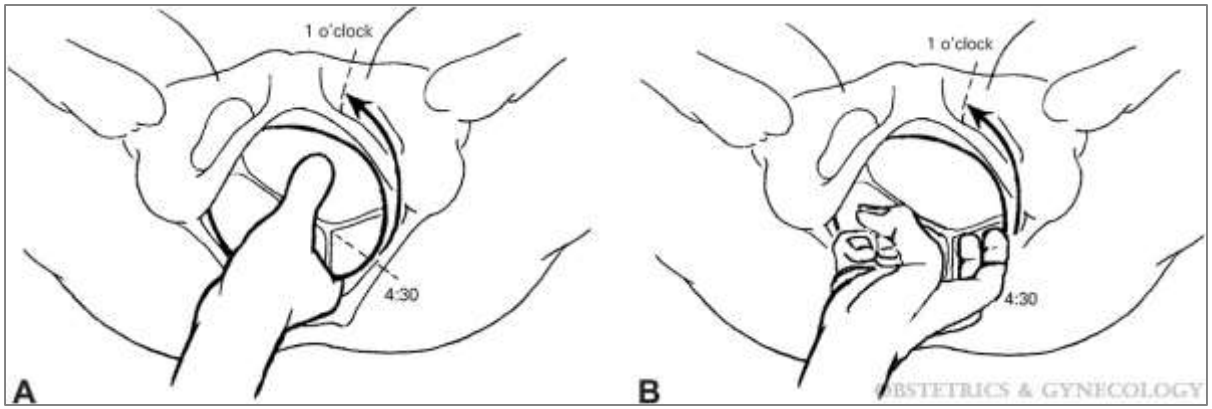
3 Finger Method of Rotation

Persistent Occiput Posterior

Barth, William H.

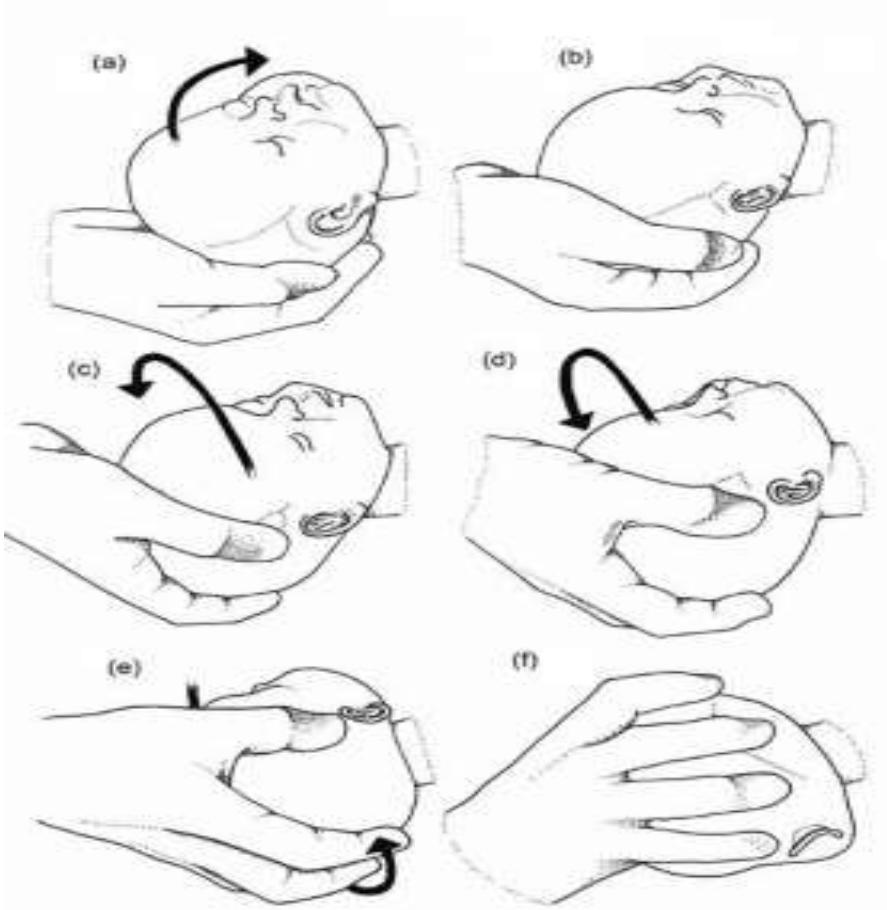
Obstetrics & Gynecology125(3):695-709, March 2015.

doi: 10.1097/AOG.0000000000000647



A

Whole Hand Method of Rotation



Risks to Rotation

- Manual rotation performed prior to instrumental birth is associated with little or no increase in risk to the pregnant woman or to the fetus.
- Gentle traction is key- Don’t force it!

What about Operative Vaginal Delivery?

- Rotational forceps generally not done
- OP Vacuum and Forceps can be performed
  - Some advocate placement of forceps upside down to facilitate delivery
  - Traction angle must be straight down with robust perineal support
  - Increased incidence of higher order lacerations (3rd and 4th)

Additional Reading

Persistent Occiput Posterior

Barth, William H. Jr MD

Obstetrics & Gynecology: March 2015 - Volume 125 - Issue 3 - p 695–709

doi: 10.1097/AOG.0000000000000647

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Q & A

If you have a question, please enter it in the Question box or Raise your hand to be un-muted.

We can only unmute you if you have dialed your Audio PIN (shown on the GoToWebinar side bar).

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THANK YOU!

Archived webinars, Resources, and Tools can be found online at

https://health.usf.edu/publichealth/chiles/fpqc/provide

Technical Assistance:

FPQC@health.usf.edu

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