



Promoting Primary Vaginal Deliveries Initiative

Second Stage of Labor

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

June 14, 2018

 Announcements

 Second Stage of Labor – Push it Real Good!

 Q&A

Quality Improvement Methods Training

July 30-31

More info at FPQC.org Events website

- 👶 FREE Training for Perinatal Professionals
- 👶 Jacksonville, FL
- 👶 This 1.5 day training is aimed at hospital-based QI teams in maternal or neonatal healthcare, but is open to all who can attend **as a team** with a small scope QI project already in mind.

Are Your Hospital's Birth Certificates Accurate?



Sign
Up
Now!

Did you know that inaccurate or incomplete birth certificate data significantly impacts the health and healthcare of Florida's mothers and babies?

 **Join the Birth Certificate Initiative (BCI)! - Deadline to apply is June 15th!**

 Please visit health.usf.edu/publichealth/chiles/fpqc/bci for more information.

Project Resources Website

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

or

FPQC.org → Current Projects → PROVIDE

Promoting Primary Vaginal Deliveries



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Promoting Primary Vaginal Deliveries (PROVIDE) Initiative

Stakeholders across the state and the U.S. have begun to take note of cesarean delivery rates, including their impact on morbidity, mortality, and health care costs.

A recent analysis of Florida birth certificates showed roughly one-fifth of the hospitals (21%) meet the Healthy People 2020 national goal for Nulliparous Term Singleton Vertex (NTSV) cesarean section deliveries of 23.9% or less. The primary cesarean delivery rate, which drives the overall cesarean rate, among low-risk first-birth deliveries in Florida ranges from 6.6% to 59.5%. This wide variation suggests clinical practice patterns may contribute and provides an opportunity for improvement.



Project Goal

The goal of the PROVIDE Initiative is to improve maternal and newborn outcomes by applying evidence-based interventions to promote primary vaginal deliveries at Florida delivery hospitals and ultimately reduce NTSV cesareans.

PROVIDE News & Announcements



PROVIDE Initiative Resources

[Online Tool Box for PROVIDE Hospitals](#) >

This Tool Box contains tool kit documents, algorithms, example policies and educational materials, and more. This resource is updated regularly throughout the project.

Newly Added Tool Box Resources:

- Mechanical Cervical Ripening resources (St Joseph Hoag Health)

Additional Resources:

- o Alliance for Innovation in Maternal Health (AIM) Program eModules on Safe Reduction of Primary Cesarean Birth



Archived Webinars



Participating Hospitals

PROVIDE Tool Box

Direct Link:

health.usf.edu/publichealth/chiles/fpqc/PROVIDE/toolbox

Promoting Primary Vaginal Deliveries (PROVIDE) Tool Box for Hospital Implementation



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This is the tool box of materials for hospital teams working on the PROVIDE Initiative.

New items are added regularly; We suggest bookmarking this page!

Please contact FPQC@health.usf.edu about any issues or questions about materials.



Tool Kit



Slide Sets



INDUCTION Resources



LABOR DYSTOCIA Resources



FETAL HEART RATE CONCERN Resources



Patient Education Resources



Shared Decision Making Tools

SAVE THE DATE

PROVIDE MID-PROJECT MEETING

SEPTEMBER 21, 2018

9 AM – 4 PM

SECOND HARVEST FOOD BANK

ORLANDO



Second Stage

Push It Real Good

Jessica Brumley CNM, PhD

Karen Bruder, MD

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Session Outline

- ACOG/SMFM/ACNM/AWHONN Recommendations/data on second stage and demonstrate relationship between fetal position/maternal pelvis and maternal pushing positions
- Evidence for second stage positions, open glottis pushing, laboring down, etc.
- Appropriate second stage positions for specific clinical presentations and review techniques for rotating a baby in second stage
- Patient and Family Education on 2nd stage



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ORGANIZATION RECOMMENDATIONS



OBSTETRIC CARE CONSENSUS

Second stage of labor

A specific absolute maximum length of time spent in the second stage of labor beyond which all women should undergo operative delivery has not been identified.

Before diagnosing arrest of labor in the second stage, if the maternal and fetal conditions permit, allow for the following:

- At least 2 hours of pushing in multiparous women (1B)
- At least 3 hours of pushing in nulliparous women (1B)

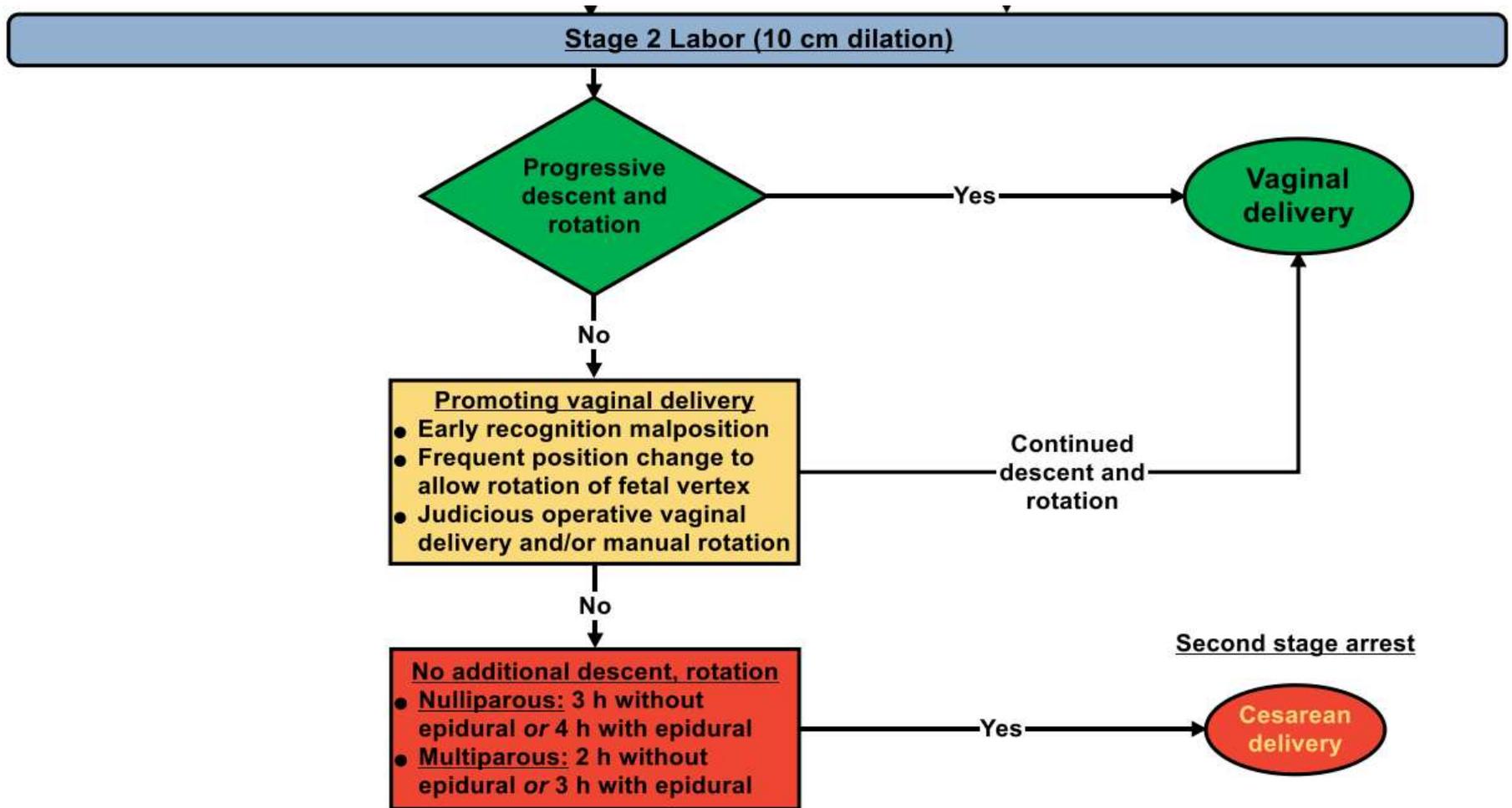
Longer durations may be appropriate on an individualized basis (eg, with the use of epidural analgesia or with fetal malposition) as long as progress is being documented. (1B)

CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

- Allow for longer durations of the second stage for women with regional anesthesia (e.g. at least 4 hours in nulliparous women, at least 3 hours in multiparous women), as long as maternal and fetal statuses remain reassuring
- Allow for passive descent when there is no urge to push (delayed pushing until there is a stronger urge to push, generally 1-2 hours after complete dilation). Passive descent is correlated with shorter overall pushing time and greater chance of spontaneous vaginal birth

- Adverse neonatal outcomes have not been associated with duration of the second stage of labor.
- Instrument delivery can reduce the need for cesarean.

FPQC Algorithm



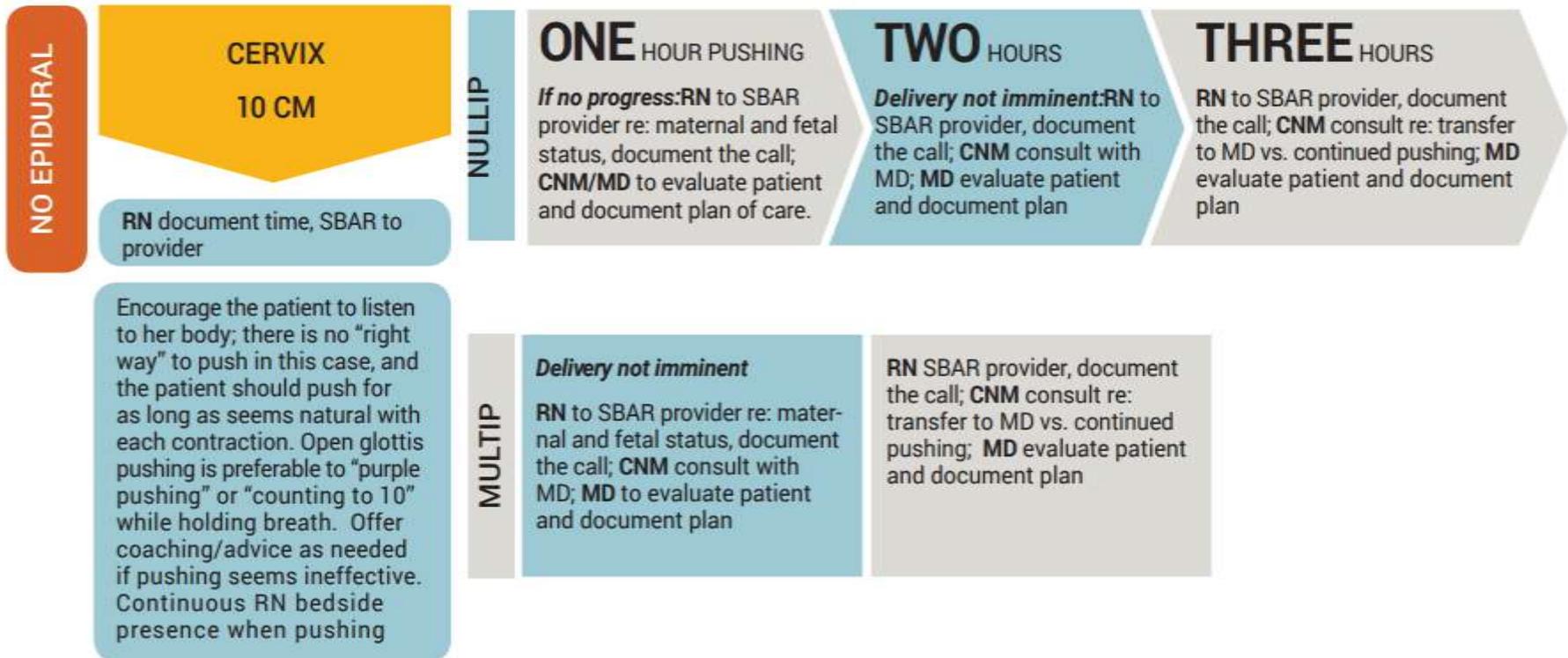


OBSTETRIC CARE CONSENSUS

Operative vaginal delivery in the second stage of labor by experienced and well trained physicians should be considered a safe, acceptable alternative to cesarean delivery. Training in, and ongoing maintenance of, practical skills related to operative vaginal delivery should be encouraged.

Manual rotation of the fetal occiput in the setting of fetal malposition in the second stage of labor is a reasonable intervention to consider before moving to operative vaginal delivery or cesarean delivery. In order to safely prevent cesarean deliveries in the setting of malposition, it is important to assess the fetal position in the second stage of labor, particularly in the setting of abnormal fetal descent.

Algorithm for the Management of Second Stage of Labor



Epidural

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

FPQC Recommendations

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



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DELAYED PUSHING / LABORING DOWN / PASSIVE DESCENT



Delayed Pushing

- Definition: A period of rest between full dilation and the active urge to bear down; facilitates passive fetal descent and rotation⁸
 - With epidural: generally 1 hour for multips, 2 hours for nullips
 - Without epidural: generally 5-30 minutes
- Recommended by ACNM and AWHONN when contraindications (such as chorio, clinically significant decelerations) are not present^{9,10}



Delayed Pushing (continued)

Delayed pushing is especially useful when:

- An epidural diminishes the urge to push
- The fetal vertex is above +2 station at onset of 2nd stage
- Malposition (OP/OT) is present
- The woman is significantly fatigued or lacks motivation to push



A Recent Meta-Analysis¹² Comparing Immediate vs. Delayed Pushing Showed:

- 1. No difference** in cesarean or op vag delivery rates
- 2. A slight increase in the length of 2nd stage** (56 min)
- 3. A decrease in active pushing time** (by >20 minutes)
- 4. No significant difference in maternal outcomes**
- 5. No significant difference in neonatal outcomes** except the higher risk of arterial cord pH less than 7.1 (but no difference in the rate of arterial cord pH <7.0, NICU admission, or lower Apgar scores^{9,13})

But I heard Laboring Down isn't safe!

A recent large retrospective analysis found that delaying pushing by 60 minutes or more was associated with modest increases in cesarean (adjusted odds ratio [AOR], 1.86; 95% CI, 1.63–2.12) and operative vaginal (AOR, 1.26; 95% CI, 1.14–1.40) delivery, postpartum hemorrhage (AOR, 1.43; 95% CI, 1.05–1.95), and transfusion (AOR, 1.51; 95% CI, 1.04–2.17), but no increase in adverse neonatal out-comes (Yee et al., 2016).

- **The study design does not determine causation and did not account for important confounders such as the indications for delayed pushing or fetal station at the onset of the second stage of labor.**
- **Laboring Down is still an appropriate practice.**



Delayed Pushing (continued)

In summary, delayed pushing:

- Is safe
- Mimics the natural physiologic “lull” between full dilation and the active 2nd stage for women with an epidural
- Allows for passive fetal descent and rotation, and may be critical for descent of the malpositioned fetus
- Is an opportunity for maternal/ fetal rest, and for gathering strength for pushing.



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THE EVIDENCE

Changing Positions is Best Practice

- For women without an epidural, pushing in an upright position is associated with a decrease in the risk of episiotomies, vacuum and forceps-assisted deliveries, and fetal heart rate abnormalities, an increase in the risk of second-degree tears, and a possible increase in the risk of having blood loss more than 500 mL
- Women with *epidurals* who push in upright positions may experience a shortened labor and pushing phase. More evidence is needed to evaluate pushing positions in women with traditional (non-walking) epidurals

Non-Supine Positions

- Standing, kneeling, and squatting take advantage of gravity to help the baby move down into the pelvis.
- Additionally, squatting increases the size of the pelvis (Johnson, 1991; Ancheta, 2011), providing more room for the baby to maneuver and descend.
- Birthing in the side-lying position has been shown to reduce perineal tearing by allowing the presenting part to descend more slowly (Shorten, 2002).

Non-Supine Positions

- Like squatting and standing, the dimensions of the pelvis can be maximized by the hands-and-knees position that is often used to relieve the back pain that may occur when the infant remains in a persistent occiput posterior presentation (Stremler, 2005).
- Throughout the course of labor, including the second stage, women benefit from frequent position changes and ideally, should be free to select or reject them at will

Which type of pushing do you encourage your patients to do?

Open Glottis

Push when you feel the urge to bear down and don't hold your breath

Closed Glottis

Hold your breath and pushing for as long as it takes to count to 10

Non-Directed Pushing

- Research does not support the widespread practice of directed pushing, which has been shown to stress the maternal cardiovascular system, reduce circulating oxygen, and trigger changes in the fetal heart rate.
- Women who are encouraged to push in coordination with a self-perceived urge consistently limit efforts to short bursts of 5 to 7 seconds and often grunt, groan, or moan, releasing air through an open glottis. **This practice improves oxygenation through synchronized efforts of the uterus and respiratory systems** (Osborne, 2014).

Non-Directed Pushing

- **Directed, forceful pushing had the potential to increase pressure on the baby and the umbilical cord, and the tissues of the perineum, resulting in more tears and a weaker pelvic floor musculature which can result in urinary incontinence (Goer and Romano 2012)**
- One study (Bloom, 2006) showed that directed pushing shortened the second stage of labor by an average of 13 minutes, which is not considered a significant difference.
- Open-Glottis pushing results in better maternal-fetal circulation, less maternal fatigue, and less chance of bladder, pelvis floor, and perineal damage (CMQCC)



Disadvantages of Directed Pushing and Prolonged Breath-Holding/Valsalva

- **Decreased** cardiac output
- Increased incidence of FHR decelerations
- lower cord pH values¹⁵
- **Rapid and unnatural** distention of the vagina & pelvic musculature (pelvic floor trauma and incontinence¹⁶)
- Maternal **exhaustion**¹⁷



A Better Way to Push (Spontaneous, Open-Glottis Pushing)

- A more physiologic way to push (mimics natural pushing tendencies⁹)
- The RN supports the woman's spontaneous efforts and assesses effectiveness
- The woman bears down spontaneously, however feels right, when she feels the urge/rectal pressure
- Often results in 3-4 pushes of 6-8 seconds in length during each contraction
- The woman pushes while breathing out, groaning, moaning, or making other "deep noises" that help to direct her pushing efforts downward



Are there Reasons to Use Old-Fashioned Directed Pushing?

Yes!

- When open-glottis pushing is not effective after at least one hour¹⁹
- When pushing is continuously diffuse/uncoordinated for at least 30 minutes^{14,19}
- For women with an epidural, *after* laboring down, with minimal urge to push or no sensation¹⁴
- During operative vaginal delivery when maximal expulsive efforts are necessary

Explaining Benefits to Patients

Open Glottis

- Blood flow to your uterus and baby is not affected, so there is less chance that your baby will have heart rate changes.
- There is less chance that you will get so tired you can't push anymore.
- There is less chance that your bottom will tear when your baby comes out.

Closed Glottis

- This type of pushing might shorten the time it takes you to push your baby out.



Explaining Risks to Patients

Open Glottis

- The second stage of labor may be slightly longer

Closed Glottis

- The blood flow to your uterus and baby is lowered, which can raise the chance that your baby will have heart rate problems.
- There is a higher chance that you will feel so tired you can't push anymore.
- There is a higher chance that your bottom will tear when your baby comes out.
- There is a higher chance that you will have problems urinating after your baby is born.



How to do Open Glottis Pushing

- A health care provider and/or support person is there to encourage you to trust your body and support you as you push.
- You push when you feel the urge to bear down or when you feel like having a bowel movement.
- Most women take several breaths between pushes.
- You probably will push for about 5 seconds 3-5 times during each contraction.
- You may grunt or make a deep noise when you are pushing. This is a sign that you are pushing well.





THE 3 P'S OF LABOR

POWER

Uterine Contractions & Pushing

Do we have an impact on how functional the powers are?

PASSENGER

Position, Attitude, Size

Can we change how the passenger travels?

PASSAGE

Pelvic Dimensions and Shape

Is there a way to make the passage larger?



The Power

- Does mom feel urge to push or contractions?
- Epidural: Does she feel pressure? Can she benefit from passive descent?
- No epidural: Can you focus her attention to maximize her power to push?

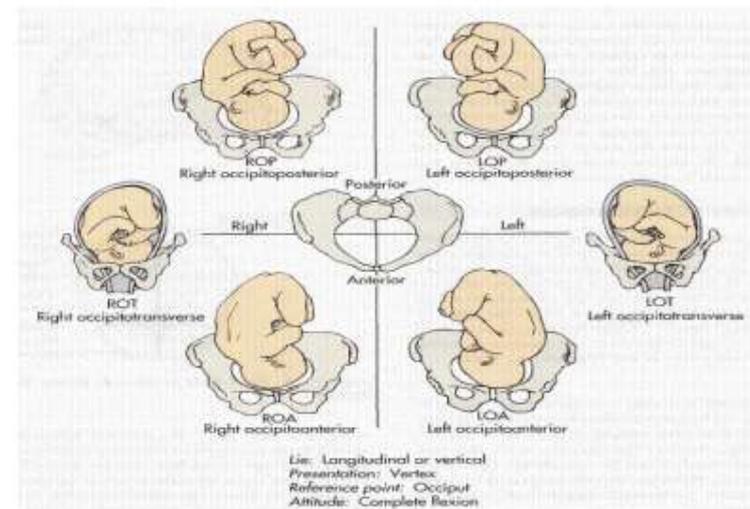


Passenger

- Evaluate the presenting vertex – OA, OP, OT, Asynclitic
- Can you facilitate maternal positions that best facilitate decent?

– Examples:

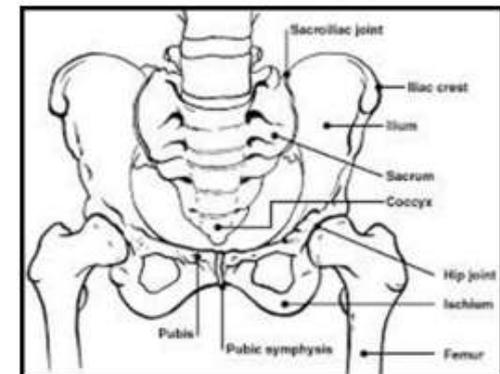
- Left lateral
- Right Lateral
- Hands & Knees
- Squatting with birthing bar





The Passage

- **What station is the presenting part?**
 - Consider passive descent if station is not optimal for pushing (laboring down)
- **Evaluate presenting vertex – OA, OP, OT**
 - Consider position changes to help with descent
- **Interventions to assist passage**
 - Empty bladder
 - Position changes **every 30 mins**





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SUPPORTING THE PATIENT IN 2ND STAGE

Change Positions

- Changing pushing positions at least every 15-20 minutes allows for optimal fetal descent into the pelvis.
- Position changes during pushing are essential if the patient is pushing but not making progress.



- Lithotomy and semi--reclined positions with legs pulled back may decrease comfort/coping in the 2nd stage, may prevent fetal descent, and denies the benefit of gravity.
- Use upright, forward-leaning, and/or squatting positions as much as possible (based on what feels comfortable to woman at that time)

Positions with or without an Epidural

- Side-lying
- Hands-and-knees



Pushing with or without an Epidural

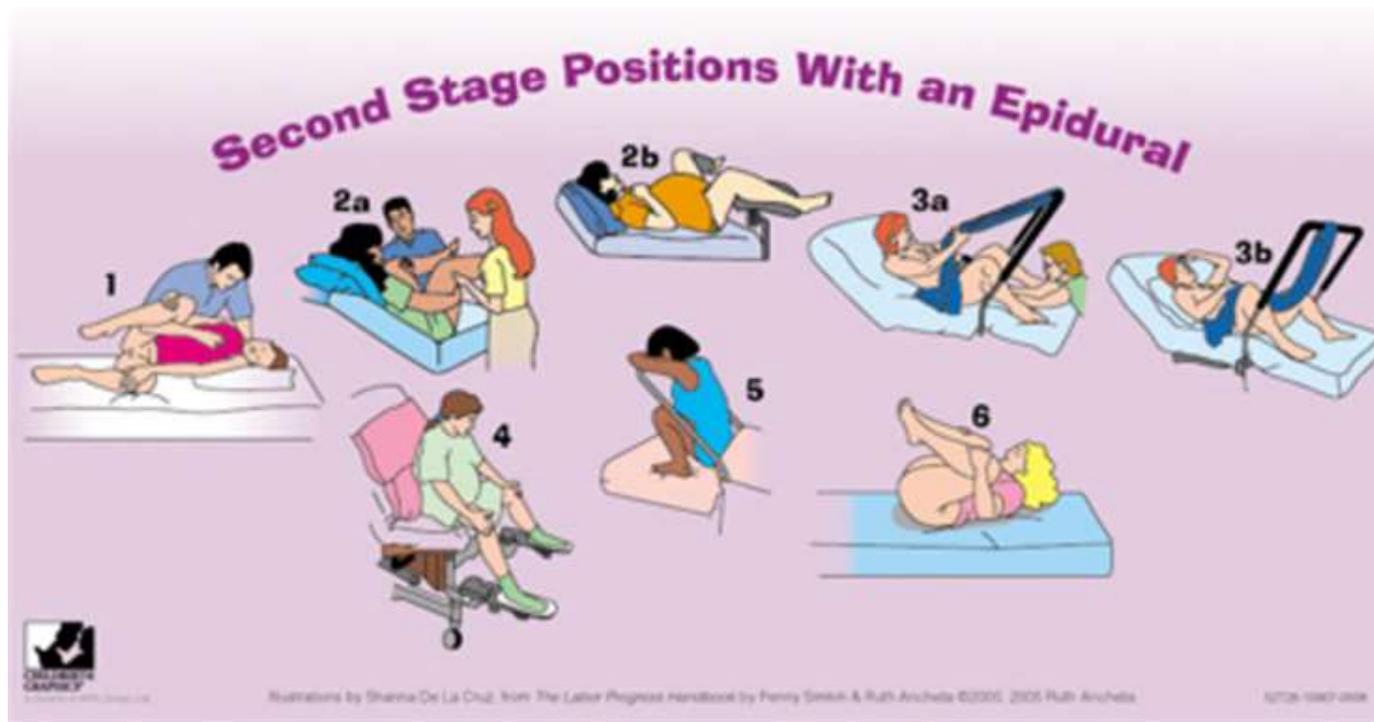
Sitting or Semi-seated
(with or without tug-o-war)

Squatting (with or
without the bar)



Pushing with an Epidural

Side-lying, supine, semi-sitting, supported squat, tug-o-war, full lithotomy



Walcher's Technique

- 👶 Can be use during the late first stage or second stage when the baby remains high.
- 👶 May open the inlet up to 1cm.
- 👶 Usually effective within 3 contractions.



- 👶 The laboring woman's legs hang off the bed into the air. The legs are NOT supported. The weight of the hanging legs pulls the pelvis open more at the inlet. The edge of the bed is at the lower border of the buttocks.
- 👶 Keep close eye contact with her face and speak soothingly to her through the approximately 15 minutes that it takes for 3 contractions to come and go.
- 👶 The mother lays back like that, almost a backbend, through three contractions. She remains there in between the contractions, too.



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ROTATING A BABY IN SECOND STAGE

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

CMQCC 2nd Stage Management of Malposition

- Assess fetal lie/position/presentation with--
 - Leopold's
 - visual examination,
 - auscultation of fetal heart



Rotation of ROP to OA

**Mother is supine &
Baby is ROP**



**Position changed to right
sidelying for 30 mins**





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.



Rotation of ROP to OA

Baby turns to ROT



**Position changed to Hands
& Knees for final rotation to
OA**



CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

Identification, Prevention, and Treatment of the Malpositioned Fetus

What	How
Early identification	Manually, or by ultrasound (gold standard) if manual appraisal is uncertain
Prevention	Avoid early amniotomy
	For women with epidural, assist in changing position every 5-6 contractions, or about every 20 minutes
Promote rotation	Maternal position changes every 5-6 contractions or about every 20 minutes
	Consider the most effective pushing positions, such as various squatting positions and forward-leaning positions while sitting (e.g. on the toilet), while squatting with squat bar, or while standing. In lithotomy position, the woman's head should remain flat on the bed with buttocks slightly lifted (opposite of the "curl around the baby" approach)
Support maternal psyche and body	Family and professional support and encouragement is critical at this time
	Offer sips of carbohydrate liquid or light carbohydrate snack
Attempt to rotate the baby	Early to mid-second stage of labor; manually or by instrument if indicated
Tincture of time	Be patient! In instances of malposition, longer pushing durations for the healthy fetus are often necessary

Education Resources for Nurses

- Labor Progress Handbook (Penny Simkin)
- SpinningBabies.com
- FPQC.org → Current Projects → PROVIDE
→ Tool Box Resources



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PATIENT AND FAMILY EDUCATION

5. Avoid Giving Birth on Your Back, and Follow Your Body's Urges to Push

Watching women give birth on TV and in the movies, it is easy to think that there is only one way to push during birth—with the woman on her back with her legs propped up, holding her breath and pushing while others count to 10 and coach her to push harder. In fact, this is how most women in the United States push. But research tells us that this type of pushing is harder on mothers and babies than a more supportive approach.



Upright pushing positions use gravity to your advantage.

Use Upright Pushing Positions

Pushing while lying on your back is literally like pushing uphill. But if you stay off your back in the second stage of labor and use more helpful positions like standing, kneeling, squatting, or lying on your side, you use gravity to your advantage and allow your pelvic bones to stay loose and open to help the baby come down. This makes the entire pushing phase of labor shorter and easier—for you and your baby.

Most pregnant women have heard the advice that they should never lie on their backs late in pregnancy because the weight of the growing belly can reduce blood flow to the baby. This same advice holds true in labor! Babies are more likely to show signs of distress when women are flat on their backs while pushing.

Most labor rooms have adjustable beds that support a variety of upright pushing positions. Try adjusting the bed to experiment with different positions, such as squatting or kneeling and leaning toward the head of the bed. You might also want to have a squatting bar or birth stool available.

Spontaneous Pushing

When a woman follows her own body during the pushing stage of labor, she is likely to push when she feels a strong urge to do so, and she will hold her breath for only short periods of time, if at all. This is called “spontaneous pushing.”

Pushing when and how your body tells you to means you are pushing just the way you need to give birth to your baby. Pushing any harder, longer, or more often than you need to can be exhausting, and it puts more forceful pressure on the baby and the muscles and tissues of your pelvic floor. Not surprisingly, this increased pressure may cause stress for the baby and damage the pelvic floor. In addition, holding your breath while pushing may decrease your baby's oxygen supply.

PARTNER tip

Supporting Without Coaching

While coaching a woman how and when to push is rarely necessary and can even cause problems, most women do appreciate feedback when they are pushing.

Rather than give instructions, let your partner know she's doing a great job, and remind her that she knows just how to birth her baby. When you start seeing the baby's head, tell her! You can even show her the baby's head in a mirror or encourage her to touch the head as it begins to emerge. This can help her sense which type of pushing is most effective.

MothersAdvocate.org

LAMAZE HEALTHY BIRTH PRACTICE FIVE: AVOID GIVING BIRTH ON YOUR BACK, AND FOLLOW YOUR BODY'S URGES TO PUSH



Hospital beds can be adjusted to support a variety of pushing positions.

Pushing With an Epidural

An epidural will likely decrease and delay your ability to feel and respond to the urge to push and makes it harder to assume some upright positions. However, research finds that there are ways to increase the likelihood of your giving birth vaginally when an epidural is used:

- Wait for the urge to push before beginning to bear down. This may take an hour or longer. During this time, the force of your contractions alone will help bring the baby down and rotate her head into the best position.
- Ask for help getting into a side-lying or an upright position—such as sitting or squatting, using a support bar. Most women with epidurals can use these positions with a little assistance.

Some care providers suggest letting the epidural wear off before pushing. Unfortunately, research suggests that this practice does not decrease the likelihood of a forceps- or vacuum-assisted birth.

RESEARCH insights

Researchers who looked at the entire body of research on position in the pushing stage found that women who gave birth using upright positions had a shorter pushing time and less severe pain than women who gave birth while lying on their backs.

Benefits of Upright Pushing

- A shorter second stage of labor
- A possible reduction in vacuum- or forceps-assisted birth
- Less severe pain
- Fewer abnormal fetal heart-rate patterns
- Fewer episiotomies
- Less damage to the vagina and perineum

Research also suggests that spontaneous pushing is more beneficial than coached pushing.

Benefits of Spontaneous Pushing

- Less damage to the perineum
- Stronger pelvic floor muscles several months after birth (this may reduce incontinence)
- Fewer abnormal fetal heart-rate changes

TALK it over

Speaking Up for Good Care During Pushing

The pushing stage of labor tends to be the part of labor that is most managed by care providers, who often have a certain way they prefer to care for women while they push. Discuss this with them well before labor, and share your desires to use upright positions and spontaneous, non-directed pushing.

When it comes time to push, get into whatever position feels best, and remind your care provider and support people that you want to follow your own urges and will ask for direction if you need it.

Positions for Labor (continued)

Helpful Positions for Every Stage of Labor

Positions for the second stage of labor (pushing and birth)

PUSHING POSITIONS: There are several beneficial positions for the second stage of labor. Consider trying these positions instead of lying flat on your back, which doesn't offer any gravity advantage and may not give your baby enough room to move.



Sitting

- These positions offer gravity advantage and a little more room for your baby to rotate
- Semi-sitting or sitting upright may not always give babies enough room to move, so consider pushing in a variety of ways



Hands & Knees

- This position uses gravity to help your baby rotate
- Modify the hands-and-knees position during the second stage by leaning on the back of the bed, a squatting bar, or over a birth ball



Squatting

- Squatting has a significant gravity advantage and opens your pelvis to assist the baby's rotation
- Keep your feet flat on the floor or a sturdy lowered section of the bed, and lower yourself into a squatting position with the help of a partner (you can also use a squatting bar, which attaches to the hospital bed)



Side-Lying

- During pushing and birth, your legs will need to be far enough apart that the baby can come out
- Your upper leg will be supported by a support person or by a leg rest that's attached to the hospital bed

take NOTE

- Practice all of these positions at home with a support person (becoming familiar with them now will make it easier to use them during labor and childbirth)
- Don't attempt actual pushing before your labor begins
- It's helpful to change positions every 30 minutes, switching from being restful to being active
- If you find that a certain position or movement feels better than others, and your labor continues to progress, you may stay in that position for as long as you like
- Don't use any position that doesn't feel right or if the baby's heart rate decreases as you're using it
- Movement can be applied to most of these positions, so experiment until you find movements that feel soothing and natural

Second Stage of Labor: Pushing Your Baby Out



What is the second stage of labor?

The second stage of labor starts after your cervix has dilated (opened) to 10 centimeters (about 4 inches), and it continues until your baby finishes moving through your vagina and is born. During this time, you will push or bear down (like you do when you have a bowel movement) to help your baby come out. The second stage of labor can last from a few minutes to a few hours. It may last longer if this is your first baby and/or if you have an epidural.

How do I know when it is time to push?

Women's bodies are smart and know how to give birth. If you do not have an epidural, you will feel a very strong urge to push down as if you are having a bowel movement. If you have an epidural and cannot feel your lower body as well, your body will give you clues that it is time to push. You may feel pressure or pain in your vagina or rectum (bottom), or you may feel as if you need to have a bowel movement.

When should I start pushing?

Some women start to feel like pushing or bearing down before the cervix is dilated to 10 centimeters. Others feel like pushing right after the cervix is completely dilated. For other women, after the cervix has dilated to 10 centimeters, it takes time for the baby to move down into the vagina, then they feel like pushing. Until recently, women have been asked to start pushing as soon as the cervix has dilated to 10 centimeters, but as long as you do not have a fever and your baby's heart rate is normal, there are many benefits to waiting to push until you feel the need to push. Waiting until this feeling occurs is sometimes called "laboring down" or "rest and descend." If you wait until you have the feeling that you want to push or bear down:

- you are more likely to push for less time,
- you are less likely to need help with a vacuum tool or forceps to get your baby out,
- you are less likely to get so tired you can't push anymore, and
- your baby is less likely to have heart rate problems while you are pushing.

What are the best positions for pushing?

The most common position for pushing and giving birth is lying on your back, but this position raises the chance your baby will have heart rate problems before birth. It also raises the chance that the tissue at the opening of your vagina will tear when your baby comes out. Several other positions are better for pushing. Changing positions frequently while you are pushing may be the best of all.

Side lying. Lying on your side helps you rest between contractions when you are pushing. This position can also lower your pain levels, lower your need for pain medication, and lower the chance that your bottom will tear when your baby comes out. Lying on your side can also help your baby's head turn to a position that is better for birth.

Sitting or squatting. Upright positions like sitting or squatting can reduce the time it takes to push your baby out by making the contractions stronger and by making the space between your pelvic bones a little bit bigger. Upright positions can also lower your pain levels, lower your need for pain medication, and lower the chance that your bottom will tear when your baby comes out.

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Journal of Midwifery & Women's Health

can College of Nurse-Midwives

What is the best way to push?

You may be told to push by holding your breath and pushing for as long as it takes to count to 10. This method is called "closed glottis pushing" and has been the way women have been told to push for many years. Today, we know that the best and safest way to push your baby out is by pushing when you feel the urge to bear down or have a bowel movement and by not holding your breath. This method is called "open glottis pushing." When you push this way, your work will add to the work of the contraction. The table describes the 2 ways to push and lists the pros and cons of each:

	Open Glottis Pushing	Closed Glottis Pushing
How to do it	<ul style="list-style-type: none"> • A health care provider and/or support person is there to encourage you to trust your body and support you as you push. • You push when you feel the urge to bear down or when you feel like having a bowel movement. • Most women take several breaths between pushes. • You probably will push for about 5 seconds 3-5 times during each contraction. • You may grunt or make a deep noise when you are pushing. This is a sign that you are pushing well. 	<ul style="list-style-type: none"> • A health care provider and/or support person tells you how and when to push. • You take a big breath and hold it before you start pushing, then you bear down as if you are having a bowel movement. • You push for a count of 10, starting at the beginning of a contraction, then take a breath and push again. • You push about 3 times with each contraction. • You may be asked not to make any noise when you push.
Benefits	<ul style="list-style-type: none"> • Blood flow to your uterus and baby is not affected, so there is less chance that your baby will have heart rate changes. • There is less chance that you will get so tired you can't push anymore. • There is less chance that your bottom will tear when your baby comes out. 	<ul style="list-style-type: none"> • This type of pushing might shorten the time it takes you to push your baby out.
Risks	<ul style="list-style-type: none"> • The second stage of labor may be slightly longer. 	<ul style="list-style-type: none"> • The blood flow to your uterus and baby is lowered, which can raise the chance that your baby will have heart rate problems. • There is a higher chance that you will feel so tired you can't push anymore. • There is a higher chance that your bottom will tear when your baby comes out. • There is a higher chance that you will have problems urinating after your baby is born.

For More Information

Lamaze

Describes the 3 different stages of labor, what to expect, and what may help you cope
<http://magazine.lamaze.org/Birth/LaborDay/tabid/71/Default.aspx>

Giving Birth Naturally

Discusses the most effective way to push, good positions for pushing, and what to expect and do while you are pushing
<http://www.givingbirthnaturally.com/pushing-stage.html>

Videos

Second Stage Positions Video on YouTube

- [Positions for Pushing, Natural](https://youtu.be/r2aI2WtHJ_0) - https://youtu.be/r2aI2WtHJ_0
- [Positions for Pushing, Epidural](https://youtu.be/tn8H5JV3lec) - <https://youtu.be/tn8H5JV3lec>

Lamaze: Get Upright and Follow your Body's Urges to Push

<http://mothersadvocate.org/videos.pushing.html>

Take Home Points

- 👶 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



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Q & A

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