Driver 3: Labor Management

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SAFE REDUCTION OF PRIMARY CESAREAN BIRTH

FLORIDA PERINATAL QUALITY COLLABORATIVE

FPQC

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Global Aim: Support hospitals and care teams in implementing evidence-based, patient-centered labor and birth practices that promote vaginal birth and safely reduce unindicated cesarean births.

Primary Key Driver

Standardize protocols for identification and response to labor challenges

Secondary Drivers

- Implement standards and checklists for prevention, diagnosis, and management of failed induction, arrest of labor, and malposition
- Implement standardized assessment and response to indeterminate and abnormal fetal heart rate patterns
- Implement a workflow process for shared decision-making during labor

Respectful care is a universal component of every driver and activity

3a. Implement standards and checklists for prevention, diagnosis, and management of failed induction, arrest of labor, and malposition

Potentially Better Practices:

1. Establish evidence-based unit criteria for failed induction and arrest of labor
2. Use a pre-cesarean (Pro SVD) checklist completed by physicians/CNMs and nurses in real time to ensure criteria are met in all cases

CMQCC
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Quality Care Collaborative

Pre-cesarean Checklist for Labor Dystocia or Failed Induction

Patient Name:_____ MR#: _____

Gestational Age: _____ Date of C-section: _____;

Time: _____

Obstetrician: _____ ; Initial:_____

Bedside Nurse: _____ ; Initial:_____

Indication for Primary Cesarean Delivery:

___ Failed Induction (must have both criteria if cervix unfavorable, Bishop Score < 8 for nullips and <6 for multips)

___ Cervical Ripening used (when starting with unfavorable Bishop scores as noted above). Ripening agent used: _____Reason ripening not used if cervix unfavorable: _____

AND

___ Unable to generate regular contractions (every 3 minutes) and cervical change after oxytocin administered for at least 12-18 hours after membrane rupture.* *Note: at least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit

___ Latent Phase Arrest <6 cm dilation (must fulfill one of the two criteria)

___ Moderate or strong contractions palpated for > 12 hours without cervical change

OR

___ IUPC > 200 MVU for > 12 hours without cervical change

*As long as cervical progress is being made, a slow but progressive latent phase e.g. greater than 20 hours in nulliparous women and greater than 14 hours in multiparous women is not an indication for cesarean delivery as long as fetal and maternal statuses remain reassuring. Please exercise caution when diagnosing latent phase arrest and allow for sufficient time to enter the active phase.

___ Active Phase Arrest ≥ 6 cm Dilation (must fulfill one of the two criteria)

Membranes ruptured (if possible), then:

___ Adequate uterine contractions (e.g. moderate or strong to palpation, or ≥ 200 MVU, for ≥ 4 hours) without improvement in dilation, effacement, station or position

OR

___ Inadequate uterine contractions (e.g. < 200 MVU) for ≥ 6 hours of oxytocin administration without improvement in dilation, effacement, station or position

___ Second Stage Arrest (must fulfill any one of four criteria)

___ Nullipara with epidural pushing for at least 4 hours

OR

___ Nullipara without epidural pushing for at least 3 hours

OR

___ Multipara with epidural pushing for at least 3 hours

OR

___ Multipara without epidural pushing for at least 2 hours

___ Although not fulfilling contemporary criteria for labor dystocia as described above, my clinical judgment deems this cesarean delivery indicated

___ Failed Induction: Duration in hours: _____
Latent-Phase Arrest: Duration in hours: _____
Active-Phase Arrest: Duration in hours:_____
Second-Stage Arrest: Duration in hours: _____

Comments:

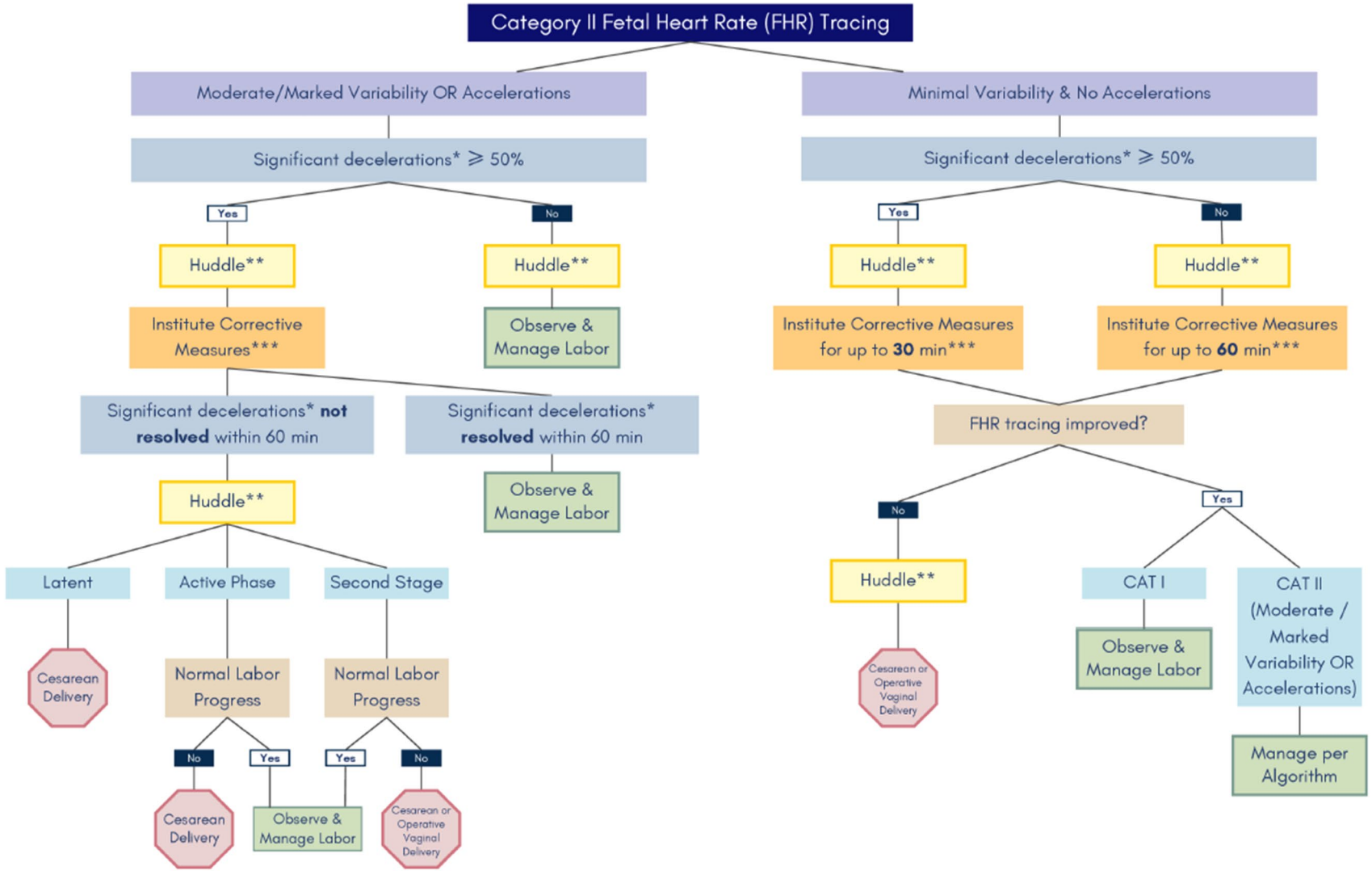
Adapted with permission from Miller Children's and Women's Hospital.

3b. Implement standardized assessment and response to indeterminate and abnormal fetal heart rate patterns

Potentially Better Practices

1. Standardize evidence-based unit guidelines for identification and management of abnormal fetal heart rate patterns
2. Conduct periodic interdisciplinary reviews of fetal heart rate strips to allow nurses and providers to practice communication and decision-making in these situations

Category II Fetal Heart Rate Tracing Management Algorithm



Category II Fetal Heart Rate Tracing Management requires ongoing patient support and education.

Adapted from Clark et.al. AJOG. 2013. doi: 10.1016/j.ajog.2013.04.030. Given the wide variation of FHR tracings in Category II, this algorithm is not meant to represent assessment and management of all potential FHR tracings, but provide an action template for common clinical situations.

OBSTETRICS INITIATIVE

3c. Implement a workflow process for shared decision-making during labor

Potentially Better Practices:

1. Implement multiple decision huddles about labor progress with provider, nurse, patient, and support persons

Questions?

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