| **GUIDELINES FOR CARE AND MANAGEMENT IN THE SECOND STAGE OF LABOR** | |
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| **PURPOSE** | To achieve the goal of safe care for mothers and infants during birth. To minimize the normal physiologic stress to the fetus in the second stage by shortening the active pushing phase. |
| **SUPPORTIVE DATA** | The active phase of second-stage labor is the period of maximum stress for the fetus. High reliability units minimize that stress by shortening the active pushing phase and using appropriate pushing techniques. (AJOG, 2010).  Coached pushing starting when the mother is complete does not result in a clinically significant decrease in the length of the second stage. Passive fetal descent until the urge to push results in about the same length of second stage of labor for women with epidurals as does coached pushing immediately upon complete dilation without the urge to push. (Gauthier, 2010).  A standardized second-stage labor protocol based on current evidence and recommendations from ACOG and AWHONN includes the following: (TJC, 2009)   1. Shortening the active pushing phase by delaying pushing for patients with epidural anesthesia who do not feel the urge to push when they are completely dilated (up to 2 hours for nulliparous patient and up to 1 hour for multiparous patients). 2. Using an upright or semi-fowler’s position for pushing and avoiding forcing the patient’s legs against her abdomen. 3. Discouraging prolonged breath-holding (instead, instructing the patient to bear down and allow her to choose whether or not to hold her breath while pushing). 4. Discouraging more than three to four pushing efforts with each contraction and more than six to eight seconds of each pushing effort. 5. Taking steps to maintain a normal FHR pattern while pushing. 6. Pushing with every other or every third contraction or discontinuing pushing temporarily if necessary to avoid recurrent FHR decelerations. 7. Repositioning as necessary for FHR decelerations. 8. Avoiding uterine tachysystole.   **BENEFITS:**  FETAL  Fewer decelerations  Increased cerebral oxygen  Increased blood volume  MOTHER  Decreased active pushing time  Increased efficiency  Decreased fatigue  Increased contractility  Decreased perineal tearing  Decreased operative delivery  **POTENTIAL RISKS:**  FETAL  Prolonged second stage  Shoulder dystocia  MOTHER  Obstructed labor  Increased PPH |
| **PROCEDURE** | 1. When the patient is found to be completely dilated, the best approach based on current evidence is to encourage the patient to do whatever comes naturally. If the patient wishes to begin pushing immediately she may do so. 2. Pushing is delayed until urge to push with the following (per ACOG):  * Nulliparous – 3 hours with epidural or 2 hours without epidural * Multiparous - 2 hours with epidural or 1 hour without epidural  1. Maintain a sufficiently interpretable FHR and UC tracing while pushing. Place FSE judiciously. 2. Reposition patient every 30 minutes to help facilitate descent and rotation of head. Use assessment of fetal position for effective and optimal position changes. Positions such as upright, lateral, hands and knees, side to side, kneeling, squatting, hanging onto birthing bar are recommended. 3. Instruct the patient to push for 6-8 seconds, slight exhale and repeat for 3-4 pushes per contraction. RN will offer coaching/advice on pushing technique. 4. Do not force the patient’s legs against her abdomen as she pushes. This causes perineal stretching; increases risk of laceration and may cause lumbo-sacral spine and lower extremity nerve injury. (AWHONN). 5. Consider having the patient push with every other or every third contraction if fetus is having recurrent variable or late decelerations or a Category II FHR. Stop pushing temporarily and let fetus recover to improve fetal oxygenation. The FHR should be used as an indicator of how well the fetus is tolerating the second stage and thus guide care and interventions. 6. Ensure at least 60 seconds of uterine resting time between contractions or tachysystole does not occur. 7. If pushing not effective, encourage the patient to consider passive descent for 30-60 minutes. 8. If patient not actively and effectively pushing after one hour of laboring down, notify MD or CNM. Consider notifying anesthesia if epidural rate needs to be decrease. 9. Maintain an empty bladder to facilitate descent and avoid bladder trauma. 10. Focus on how long she has been pushing, not how long has she been complete. 11. Evaluate effectiveness of pushing; provide feedback and encouragement regarding her progress. |
| **DOCUMENTATION** | 1. Document FHR every 5 minute intervals for one minute until delivery of the baby (per protocol). 2. Document station and fetal position at the onset of second stage and assess at least once every hour to show that progress is happening. 3. Document strength and frequency of contractions every 15 minutes (per protocol). 4. Document patient’s preference and wishes for pushing, if any, during active second stage. 5. Document notification to provider about progress. 6. Document the patient’s emotional and psychological needs. 7. Document other situation as appropriate. |
| **REFERENCES** | 1. Second Stage Labor: Assessing and Preserving Fetal Reserve; D. Gauthier, Cottage Health System,2010 2. Perinatal High Reliability, October,2010, American Journal of Obstetrics and Gynecology, Knox and Simpson 3. A Comprehensive Perinatal Patient Safety Program to Reduce Preventable Adverse Outcomes and Costs of Liability Claims; November, 2009, Joint Commission on Accreditation of Healthcare Organization, Volume 35, Number 11 4. Nursing care and Management of the Second Stage of Labor; 2nd Edition, Evidence-based Clinical Practice Guideline, AWHONN,2008 5. Evidence-based Labor and Delivery Management (Editor’s Choice) ; Berghella, Baxter and Chauhan, American Journal of Obstetrics and Gynecology, November, 2008 |
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