ARROWHEAD REGIONAL MEDICAL CENTER
DEPARTMENT OF NURSING POLICY
LABOR AND DELIVERY

SECTION: **PATIENT CARE**

SUBJECT: **SECOND STAGE OF LABOR, NURSING CARE AND MANAGEMENT OF**

APPROVED BY: ____________________________________

Nurse Manager

POLICY

Provide clinical practice guidelines for the management of the second stage of labor in order to optimize perinatal outcomes.

PROCEDURE

I. Nursing Assessment
  A. Upon admission discuss/determine pain management options
  B. Determine the presence of support persons
  C. Assess patient and support person's knowledge of the labor process
  D. Provide instruction and information as needed
  E. Incorporate non-pharmacological interventions and/or labor support behaviors

II. Physical comfort
  A. Encourage ambulation
  B. Facilitate position changes
  C. Apply cool compresses
  D. Change linens, under pads, and gowns as needed
  E. Offer fluids, as ordered
  F. Provided massage and touch
  G. Explain the need for vaginal exams
    1.Perform vaginal exams only as needed
    2. Explain anticipated sensations
    3. Acknowledge the patients discomfort during the exam
    4. Share findings with patient and support person(s)

III. Emotional support
  A. Provide reassurance and encouragement
  B. Encourage patient to express fears and concerns
  C. Acknowledge the stress and work of labor

D. Assist and encourage support person(s)

IV. Instructional support
   A. Explain anticipated events, procedures, and findings
   B. Encourage patient and support person(s) to ask questions and seek clarification
   C. Establish the need for education to facilitate pushing

V. Advocacy
   A. Collaborate with Practitioners to support the patients care decision and preferences
   B. Limit the number of people at delivery to those requested or as clinically necessary
   C. Evaluate effectiveness of supportive care

VI. Maternal assessment
   A. Assess the patient’s knowledge of positioning
   B. Assess physical disabilities that can affect positioning
   C. Assess fetal presentations, position, station, and descent
   D. Assess comfort level to ensure adequate pain relief
      1. Continue epidural infusion if in place
   E. Assess for bladder distention
      1. Provide bed pan
      2. If unable to void, obtain Practitioner order for intermittent catheterization
      3. If foley catheter is in place, maintain placement until actively pushing then remove

VIII. Positioning
   A. Avoid the supine position
   B. Encourage repositioning every 30 minutes
   C. Incorporate the use of positioning aides
      1. Squat bar
      2. Peanut ball
      3. Towel pull
   D. Offer choices of pushing positions
      1. Side lying
      2. Squatting
      3. Sitting on the side of the bed
      4. 30-degree semi-fowler position
         a. Increases pelvic diameter
         b. Facilitates fetal oxygenation
         c. Promotes fetal descent
         d. Decreases duration of the second stage
         e. Decrease perineal trauma
   E. Methods to enhance fetal rotation from occiput posterior to occiput anterior
      1. Hands-and-knees position for at least 30 minutes
      2. Sim’s position (have patient lay on the same side as the fetal spine)

IX. Passive fetal descent
   A. When the patient begins the second stage of labor (10 cm. dilated), assess the following to determine the patient’s readiness to begin pushing
      1. Assess woman’s urge to push or feelings of perineal pressure
      2. Provide options to patient for immediate or delayed pushing
         a. Discuss advantages of delayed pushing

(i) Fewer lacerations
(ii) Fewer episiotomies
(iii) Fewer operative vaginal deliveries
(iv) Fewer fetal heart rate decelerations
(v) Decrease maternal fatigue
(vi) Decrease time spent bearing down

b. Discuss disadvantages of delayed pushing
(i) Increased risk of postpartum hemorrhage
(ii) Chorioamnionitis

c. Delayed pushing for nulliparas women up to two (2) hours with an epidural
d. Delayed pushing for multipara's women up to one (1) hour with an epidural

B. Assess and document the fetal heart rate and contraction pattern every 30 minutes

X. Active pushing

A. Primary nurse remains at the bedside
B. Encourage women to bear down and "do whatever comes naturally"
C. Assist with open-glottis pushing for 6-8 seconds for 3-4 pushes with each contraction
   1. Avoid counting to 10 to sustain prolonged breath holding
   2. Assess effectiveness and progress of pushing efforts
D. Allow for pushing if appropriate for fetal and maternal conditions
   1. Two (2) hours for multiparas
   2. Three (3) hours for nulliparas
   3. Longer durations may be appropriate for women with epidural analgesia or with fetal malposition, if progress is documented
E. Continuously assess fetal heart rate and contraction pattern and document every 30 minutes
F. Modify maternal pushing efforts based on fetal status
   1. Push with every other or every third contraction to avoid recurrent fetal heart rate decelerations
   2. In some instances it may be necessary to stop pushing efforts in order to allow the fetus to recover
G. Assess uterine activity
   1. Avoid uterine Tachysystole
   2. Notify Practitioner and obtain orders for abnormal uterine activity
H. Notify Practitioner for fetal scalp electrode placement for difficulty maintaining continuous fetal heart rate tracing, if not contraindicated

XI. Document assessments and interventions in the electronic medical record

REFERENCES:

American College of Obstetricians and Gynecologist. (2014). Safe prevention of the primary cesarean delivery. Committee consensus. Vol. 123, No. 3

Association of Women's Health, Obstetric, and Neonatal Nurses. (2019). Nursing care and the management of the second stage of labor. 3rd ed.

California Maternal Quality Care Collaborative. (2017). Toolkit to support vaginal birth and reduce primary cesareans.

Healthcare Accrediting Body

DEFINITIONS: **First stage of labor**- Onset of contractions to complete dilation

- **Latent phase**- from the onset of labor to the onset of the active phase
- **Arrest of labor in the first stage/Active phase arrest**- more than or equal to 6 cm. dilation with ruptured membranes and one of the following:
  - 4 hours or more of adequate contractions (e.g., more than 200 montevideo units)
  - 6 hours or more of inadequate contractions and no cervical change
- **Active labor**- accelerated cervical dilation typically beginning at 6 cm.

Failed induction of labor- oxytocin administered for 12-18 hours after rupture of membranes

Second stage of labor- begins when the cervix is fully dilated and ends with the delivery of the neonate

Second stage arrest without epidural

- 3 hours of pushing in nulliparous women
- 2 hours of pushing in multiparous women

Second stage arrest with epidural

- 4 hours of pushing in nulliparous women
- 3 hours of pushing in multiparous women

ATTACHMENTS: N/A

APPROVAL DATE:

Date	Committee
09/16/2019	**Nursing Standards Committee**
08/28/2019	**Women's Health Division** Applicable Administrator, Hospital or Medical Committee
11/07/2019	**Quality Management Committee (QMC)** Applicable Administrator, Hospital or Medical Committee
11/21/2019	**Medical Executive Committee (MEC)** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES:

EFFECTIVE: **RIVISED:**