CMQCC
California Maternal
Quality Care Collaborative

Appendix N

Algorithm for the Management of Second Stage of Labor

NO EPIDURAL

Cervix 10cm

Encourage the woman to listen to her body. Many women without an epidural still experience a period of physiologic rest before having an urge to push. Allow rest and hydration during this time. Encourage the woman to push for as long as seems natural with each contraction. Open glottis pushing is preferable to "purple pushing" or "counting to 10" while holding breath. If pushing seems ineffective, advise 3 to 4 pushing efforts of 6 to 8 seconds in length, per contraction. Provide continuous nursing presence when pushing.

NULLIP

1 HOUR Pushing

If slow or no progress, RN to notify provider and document appropriately.

Consider directed pushing and position changes (e.g. upright, forward leaning, squatting, hands and knees).

1.5 - 2 HOURS

If continued slow progress, RN to notify provider. Provider to bedside at 1.5 hours to evaluate progress and address cause.

If malposition is suspected, confirm by u/s. Consider manual rotation. Continue frequent position changes to encourage fetal rotation if necessary.

3 HOURS

Provider to bedside to evaluate progress

Consider continued pushing if FHR reassuring and approaching NSVD; consider operative vaginal delivery (OVD) if appropriate; CS if delivery remote or OVD not possible.

MULTIP

1 HOUR Pushing

If remote from delivery, RN to notify provider and document appropriately. Provider to bedside to evaluate progress and address cause.

If malposition is suspected, confirm by u/s. Consider manual rotation. Continue frequent position changes to encourage fetal rotation if necessary.

2 HOURS

Provider to bedside to evaluate progress

Consider continued pushing if FHR reassuring and approaching NSVD; consider operative vaginal delivery (OVD) if appropriate; CS if delivery remote or OVD not possible.

EPIDURAL

If no urge to push, consider 1 to 2 hours of passive descent. If not already done, consider use of peanut ball if available

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. If pushing seems ineffective, advise 3 to 4 pushing efforts of 6 to 8 seconds in length, per contraction. Provide continuous nursing presence when pushing.

NULLIP

1 HOUR Pushing

RN to notify provider of progress. Continue pushing.

Continue frequent position changes (e.g. modified squat with squat bar, sidelying with open pelvis) to promote fetal rotation and prevent malposition.

2 HOURS

If slow or no progress, RN to notify provider. Provider to bedside to evaluate progress and address cause.

If malposition is suspected, confirm by u/s and consider manual rotation, ideally by the 2 hour point. Continue frequent position changes to encourage fetal rotation if necessary. RN to communicate frequently with provider with status updates.

3 HOURS

If continued slow progress, RN to notify provider. Provider at bedside to evaluate progress since last exam.

4 HOURS

Provider to bedside to evaluate progress

Consider continued pushing if FHR reassuring and approaching NSVD; consider operative vaginal delivery (OVD) if appropriate; CS if delivery remote or OVD not possible.

MULTIP

1 HOUR Pushing

RN to notify provider of progress. Continue pushing.

Continue frequent position changes (e.g. modified squat with squat bar, sidelying with open pelvis) to promote fetal rotation and prevent malposition

1.5 - 2 HOURS

If remote from delivery, provider to bedside to evaluate progress and address cause.

If malposition is suspected, confirm by u/s and consider manual rotation, ideally by the 1.5 hour point. Continue frequent position changes to encourage fetal rotation if necessary. RN to communicate frequently with provider with status updates.

3 HOURS

Provider to bedside to evaluate progress

Consider continued pushing if FHR reassuring and approaching NSVD; consider operative vaginal delivery (OVD) if appropriate; CS if delivery remote or OVD not possible.