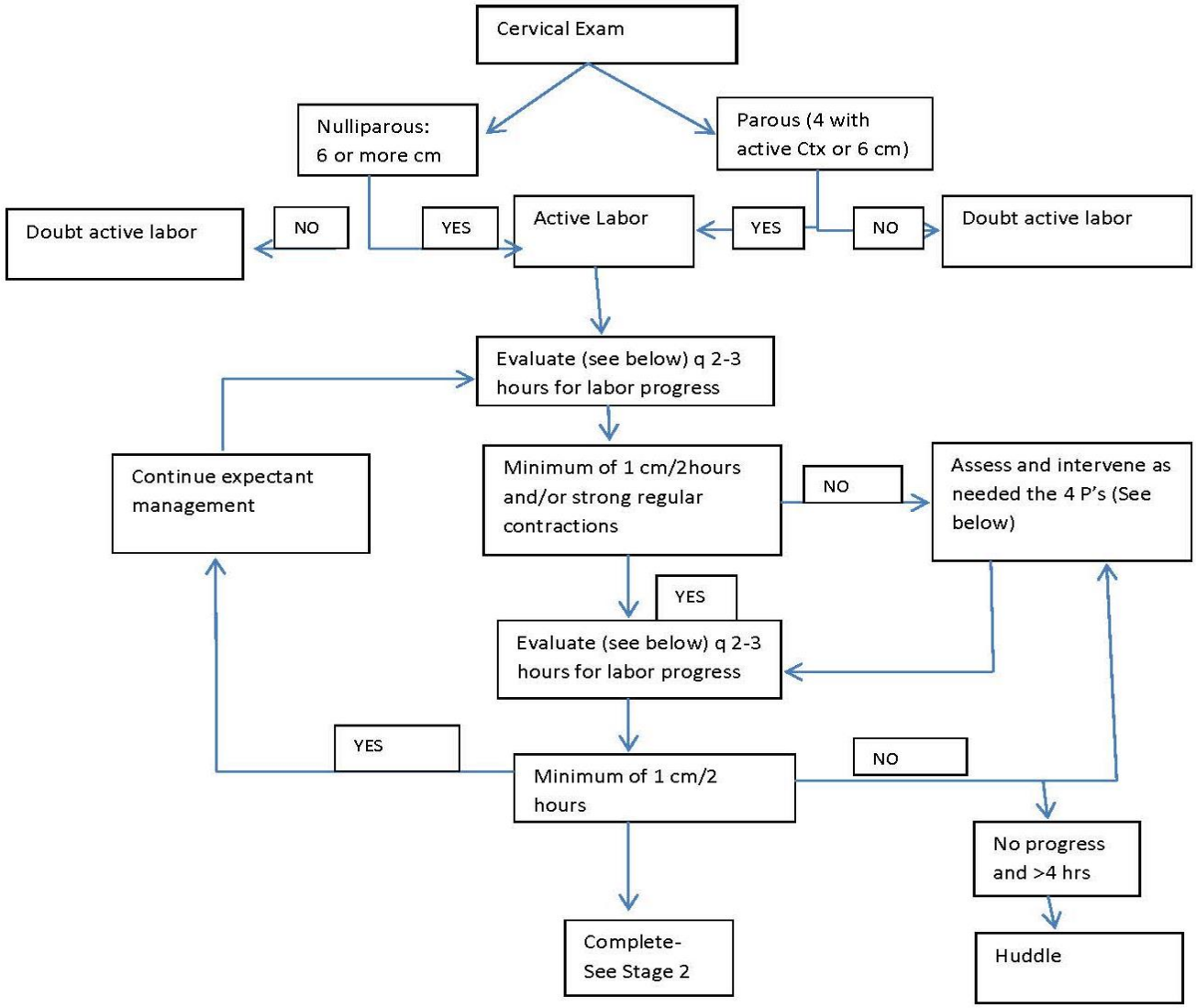
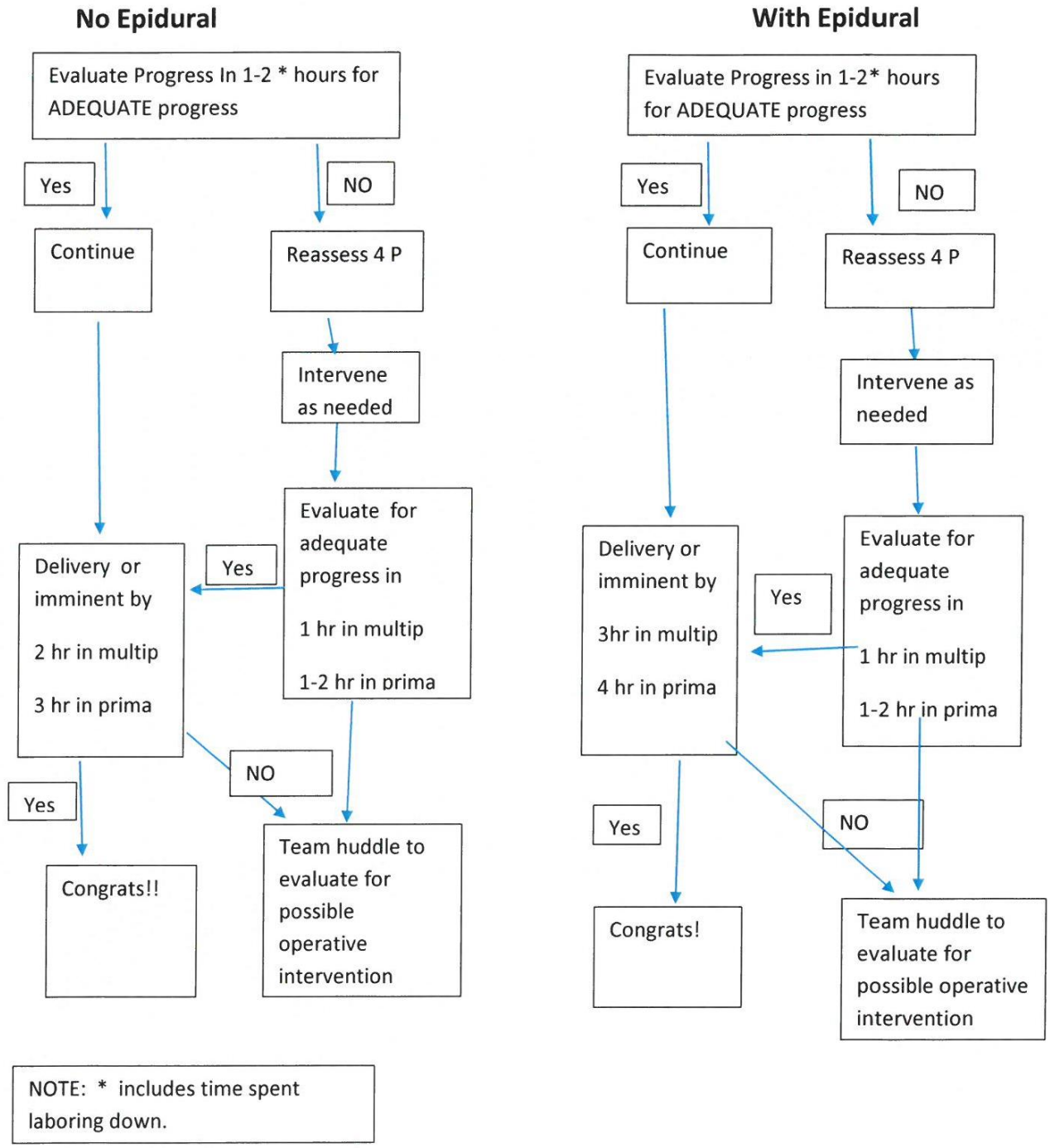
Title: **Management of Labor Progress**	**Policy**

Flow Chart for Stage One of Active Labor



Evaluation Includes:	Possible activities for the evaluate
Power	Ambulation, hydration, temperature, AROM, IUPC, pitocin
Passenger	Reassess EFW, fetal position, change maternal position
Passageway	Pelvimetry, assess bladder, soft tissue dystocia (fibroid?), Full rectum
Pain/Psyche	Pain management, decrease stressors in room, increase support

Management flow chart for second stage of labor



NOTE: * includes time spent laboring down.

POLICY STATEMENT:

Applies to all low-risk laboring women from 35 to 42 weeks gestational age with reassuring fetal monitoring.

PURPOSE:

National initiatives aim to decrease rates of primary and repeat cesarean delivery. A key facet of initiatives to decrease rates of c-sections is the standardization of criteria for the diagnosis of active labor and for intervention during spontaneous or induced labor. As we appropriately manage longer labors, we must take care to minimize complications of prolonged labor including chorioamnionitis, more complicated C-sections, and uterine atony – all of which may lead to postpartum hemorrhage or other maternal/fetal morbidities. This guideline is to facilitate the standardized active management of all stages of labor to balance the reduction of c-section rates while minimizing the complications of prolonged labors.

DEFINITIONS:

1. DEFINITION OF ACTIVE LABOR: The consistent dilation and/or descent of the infant in response to contractions. This phase of labor may be entered at 4-6 cm if the patient is actively contracting with resulting consistent cervical change. Once the cervix changes in response to contractions at a rate of $\geq$1 cm approximately every 2 hours, the woman is considered in active labor.

PROCEDURES:

STAGE 1 – Women in active labor:

- Evaluate every 2-3 hours at for progress.
    - Evaluation may include assessing contraction frequency and intensity (by palpation or IUPC), patient's discomfort, fetal tracing, and/or cervical exam
    - If progressing at approximately 1cm/1-2 hours, expectant management for anticipated vaginal delivery is appropriate
    - If progress is < 1 cm / 2hours consider a basic evaluation and appropriate interventions:
        - Power (adequate frequency and intensity of UCs),
        - Passageway (full bladder, soft tissue dystocia (morbid obesity, fibroid etc.),
        - Passenger (position, presentation, size)
        - Psycho-emotional components (ex. Pain, stressors)

      Document assessment and any intervention such as AROM, hydration, ambulation/position changes, improved pain management, chorioamnionitis diagnosis/treatment, and oxytocin augmentation. Reassess whether the patient is truly in active labor – e.g., admitted at 4 or 5 cm and has not progressed may represent that the woman is still in latent labor. Consider discharge home with shared decision-making if not in labor.
    - If labor progress is <1cm. following a 4 hour interval re-evaluate power, passenger and passageway. Notify attending/surgical consultant of potential arrest of labor or protracted labor to determine management plan that may involve continued labor, need for intervention or operative delivery. Document plan
- After 4 hours of adequate contractions (IUPC confirmed if possible) in the first stage of labor without adequate progress, a diagnosis of arrest of active labor can be made. Notify attending/consultant to determine and document plan.
- Huddle with maternity provider, nurse, and patient to discuss plan.
- If after 6 hours of Pitocin at maximal dose (36 mu or the maximum the fetus will tolerate) inadequate contraction pattern (by IUPC or clinically by strong regular contractions q 2-3 minutes) and inadequate

change, consider arrest of labor and notify attending/surgical consultant to determine and document plan.

- Huddle with maternity provider, nurse, and patient to discuss plan.
- If after 6 hours of Pitocin with inadequate contraction pattern (by IUPC) and inadequate change consider dysfunctional labor and notify attending/surgical consultant to determine and document plan.
- Rupture of membranes is indicated if technically possible prior to proceeding to cesarean for failure to progress in first stage of labor.
- If patient remains with anterior lip for >1 hour –consider malpresentation (especially OP) and consider positon changes, assess bladder and potential u/s to evaluate. At >2 hours of persistent anterior lip u/s to evaluate for malposition

STAGE 2 – Complete dilatation of the cervix.

- Delivery is usually achieved or should be imminent after a second stage of : (note the % is the women who have <u>not</u> delivered by this point – Laughon)
    - 2 hours in multiparous woman without an epidural (2%)
    - 3 hours in multiparous woman with an epidural (1.2%)
    - 3 hours in primiparous woman without an epidural (6%)
    - 4 hours in a primiparous woman with an epidural (4.1%)
- "Laboring down" may be considered if:
    - Patient is having adequate contractions of at least moderate (by palpation or IUPC) intensity every 2-3 minutes. Consider Pitocin augmentation if contractions inadequate
    - If station is above +2 and there is no spontaneous urge to push
    - That the time spent in laboring down be included in the times outline above
    - Laboring down for up to two hours prior to pushing is appropriate *if there is continued descent of the head* and the maternal and fetal status is stable
- After one hour of second stage in a parous woman and 2 hours in a primiparous woman an evaluation of progress and need for possible intervention should be considered. If adequate progress (head visible, urge to push, station is +2 or below and OA, ROA or LOA) continue with second stage including consideration of initiating active pushing if not already pushing.
- If inadequate progress re-assess the Power (contractions frequent enough, good maternal effort, etc.), passageway (full bladder, contracture ring, cervical stenosis, vaginal pathology, etc) and passenger (presentation, position, size, caput). Address any modifiable issues including changing maternal positions, more active coaching, manual rotation if occiput posterior etc.
- If delivery not imminent within time frames noted above involve the attending/consultant in further plans for labor management since significant maternal complication such as postpartum hemorrhage, third/fourth degree lacerations, chorioamnionitis, and a complicated emergent c/s are increased. Huddle involving maternity provider, nursing and patient is encouraged. A progress note should document the plan.

STAGE 3 (Delivery of Placenta)

- With delivery of anterior shoulder/infant start bolus of 6 units of Pitocin IV followed by continuous infusion of 3 units/hr (or 10-20 mg IM dose if patient has no IVs)
- Encourage skin to skin with delayed cord clamping if mother and infant are stable.

- Perform active management of third stage with traction on cord until delivery.
- If placenta not delivered within 30 minutes notify senior resident and/or attending to determine if manual removal or D&C is indicated.

Team approach to labor dystocia management and consultation: Long labors and inductions are often stressful for the patient, her family and maternity care providers including obstetric provider (MD, DO, CNM) and labor and delivery nurses. When these situations arise a maternity care team (including provider and nursing) huddle to discuss labor management is encouraged and may address issues such as oxytocin management, family dynamics, or consideration of OP position.

Risk factors for dysfunctional labor that may indicate need to consider modification of the expected progression noted above due to association with dysfunctional labor progression.

- Overdistended uterus (twins, poly, macrosomia)
- Prolonged labor induction/augmentation
- Chorioamionitis
- Maternal obesity
- Pre-eclampsia
- IUFD
- Abruption
- Advanced maternal age

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APPROVAL

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SOP # / Version #	Effective Date	Supersedes	Review Date	Summary of Change(s)