Second Stage Labor Care
Kathleen Rice Simpson, PhD, RN, FAAN

Are you still coaching women to push at complete cervical dilation when they don’t yet feel the urge to push? Do you continue during nonreassuring fetal heart rate (FHR) patterns? If so, it’s time to change your practice. Adverse outcomes related to care during the second stage of labor are a significant source of successful obstetric litigation. Nurses are in an ideal position to promote safe second stage care because they are continuously at the bedside, assisting women during pushing efforts and monitoring maternal-fetal status. The quality of second stage nursing care is an important determinant of birth outcomes.

The second stage is physiologically stressful for the fetus. One way to minimize this stress is to shorten the pushing time (Roberts, 2002). When caring for women with epidural anesthesia, wait until they feel the urge to push before encouraging their pushing efforts. Contrary to widely held beliefs, coached pushing starting at complete cervical dilation does not result in a clinically significant decrease in the length of the second stage (Mayberry et al., 2000). Passive fetal descent until the urge to push will result in about the same length of the second stage for women with epidural anesthesia, as does coached positioning immediately at complete dilation without the urge to push.

Second stage labor care often includes continued coached pushing despite nonreassuring FHR patterns. This practice can lead to iatrogenic fetal stress, as evidenced by recurrent variable decelerations, loss of baseline, minimal or absent variability, tachycardia, and bradycardia. According to a common myth, despite the nonreassuring FHR pattern, it is better to “get the baby out” rather than allow the mother to rest and the fetus to recover. Many care providers fail to realize that their aggressive coaching techniques are the cause of these nonreassuring FHR patterns. Some nurses and physicians expect FHR decelerations during the second stage and thus consider them to be a benign pattern. Although most fetuses tolerate decelerations during pushing, some fetuses enter the second stage with less physiologic reserve than others.

It is critical to recognize nonreassuring FHR patterns during the second stage of labor and intervene appropriately. If the fetus is not responding well to pushing efforts, the best approach is to stop pushing temporarily and let the fetus recover. Avoid sustained, coached, closed-glottis pushing (i.e., “take a deep breath and hold it for 10 seconds, four times with each contraction”). If the fetus continues to respond poorly and there is a compelling reason to continue pushing, try pushing with alternate contractions. It may be necessary for the woman to limit pushing to every other or every third contraction to maintain a reassuring FHR pattern. A baseline FHR should be able to be identified between contractions. Repetitive variable decelerations during the second stage are associated with respiratory acidosis at birth. Some fetuses develop metabolic acidosis if this type of pattern continues over a long period. These babies are difficult to resuscitate and may not transition well to extrauterine life. The FHR pattern must be used as an indicator for how well the fetus is responding to second stage labor, and thus to guide care and interventions during that time.

The FHR pattern must be used as an indicator for how well the fetus is responding to second stage labor.

References

Kathleen Rice Simpson is a Perinatal Clinical Nurse Specialist at St. John’s Mercy Medical Center, St. Louis, MO, and an Editorial Board Member of MCN. Dr. Simpson can be reached via e-mail at KRosimpson@prodigy.net.

Safe Care During the Second Stage of Labor

• Review the literature about the best approaches to second-stage pushing to avoid adverse fetal effects. Follow-up with changes in practice to promote safe care.
• For women with epidural anesthesia who do not feel the urge to push when they are completely dilated, delay pushing until the urge to push is felt (up to 2 hours for nulliparous women and up to 1 hour for multiparous women).
• Discourage prolonged breathing holding. Instead, instruct the woman to bear down and allow her to choose whether or not to hold her breath while pushing.
• Discourage more than three pushing efforts with each contraction and more than 6 to 8 seconds of each pushing effort.
• Take steps to maintain a reassuring FHR pattern while pushing. Push with every other or every third contraction if necessary to avoid repetitive FHR decelerations. Reposition as necessary for FHR decelerations.
• Avoid uterine hyperstimulation during the second stage of labor. Titrate oxytocin to the maternal-fetal response.
• A copy of the AWHONN Second Stage Management Monograph (Mayberry et al., 2000) should be available on the unit and should be used to guide clinical practice during the second stage of labor.