

# Assisting the Prevention of the Primary Cesarean Section

How Nurses Can “Cut” The  
Cesarean Section Rate



**EARLY MORNING**

**Ways Nursing Can Assist in  
Decreasing the Primary  
Cesarean Section**

Be  
Knowledgeable

#10



**Mary: "Kayla, Remember when we mixed our own Pitocin bags on the unit?"**

**Kayla: " Aww, NO!"**

**What Are  
You Doing??**



**Leave me  
Alone I am  
Mixing Up The  
Pitocin Elixir  
#\$%%#@!!\*\*\***

# National Initiative

The following organizations have advocated adoption of standard practices that reduce the cesarean delivery rate



Centers for Disease Control and Prevention  
CDC 24/7: Saving Lives, Protecting People™



# CMQCC's

## CMQCC Labor Dystocia Checklist (ACOG/SMFM Criteria)

### 1. Diagnosis of Dystocia/Arrest Disorder (all 3 should be present)

- Cervix 6 cm or greater
- Membranes ruptured, then
- No cervical change after at least 4 hours of adequate uterine activity (e.g. strong to palpation or MVUs > 200), or at least 6 hours of oxytocin administration with inadequate uterine activity

### 2. Diagnosis of Second Stage Arrest (only one needed)

#### No descent or rotation for:

- At least 4 hours of pushing in nulliparous woman with epidural
- At least 3 hours of pushing in nulliparous woman without epidural
- At least 3 hours of pushing in multiparous woman with epidural
- At least 2 hour of pushing in multiparous woman without epidural

### 3. Diagnosis of Failed Induction (both needed)

- Bishop score >6 for multiparous women and  $\geq 8$  for nulliparous women, before the start of induction (for non-medically indicated/elective induction of labor only)
- Oxytocin administered for at least 12-18 hours after membrane rupture, without achieving cervical change and regular contractions. \*Note: At least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit

# What might you do/suggest ?

- Primip, external monitor, membranes intact, has an epidural and was induced. She has been on pitocin for 10 hours at 12mu/min.
  - Her dilatation is 5cm/100% / -1
  - She has not changed her cervical status for 6 hours
- Are there any nursing interventions or interventions by the provider you would request?

# What might you do/suggest ?

- Primip, admitted in spontaneous labor and spontaneous rupture of membranes. Pitocin has not been started.
  - Contraction pattern
    - External monitor
    - Frequency – every 2 minutes
    - Duration – 60-90 seconds
    - Intensity – palpate moderate to strong
  - She has remained 7cm/90%/-1 for 5 hours
- What are your thoughts?????

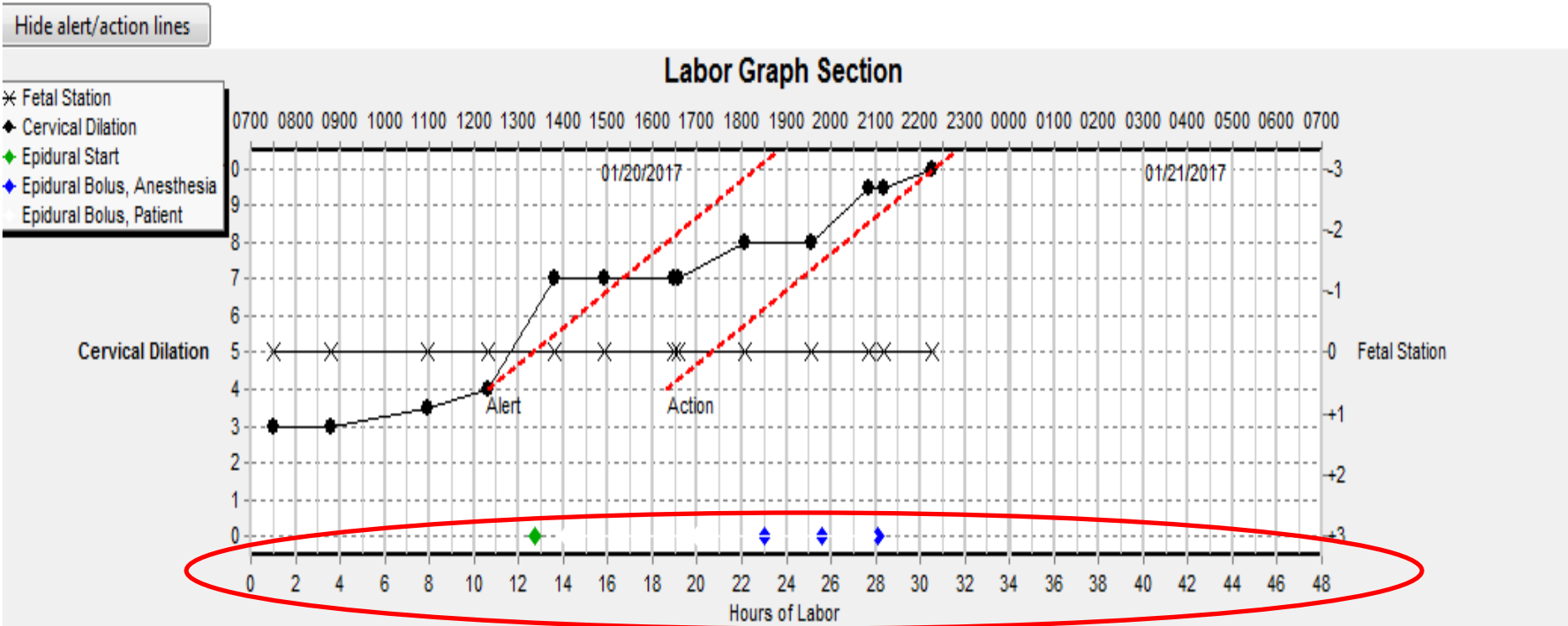
# Always consider the entire clinical picture!



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# Use of a Labor Graph Maybe Helpful

## Example of Labor Graph Within Cerner



# 9

## Communication and Teamwork



# Communication: The Words We Use

- “Failed induction”
- “Failure to progress”
- “Inadequate pelvis”
- Inadequate contractions
- Unfavorable cervix
- “You are “only” 3 cm”
- You are not making any change
- You aren’t doing anything
- Your body isn’t ready
- She has a birth plan; “Well that’s a C-Section waiting to happen!”



<http://www.netpicks.com/wp-content/uploads/2015/11/failure.jpg>

# What Education Do You Give Patient's who Are Discharged Home?

***No, it's probably not real labor***

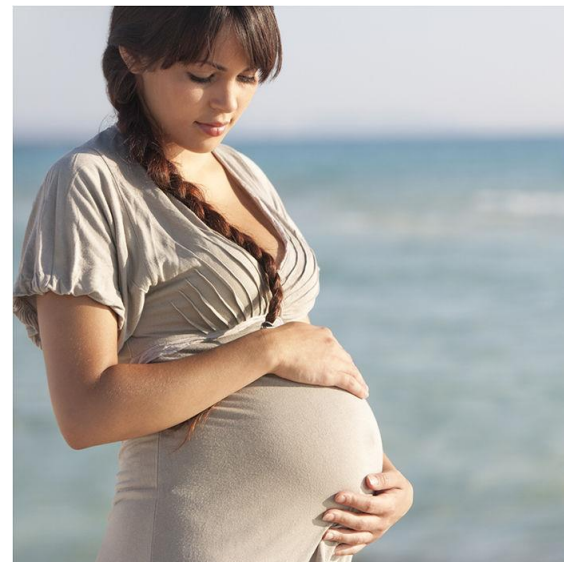
Signs of false labor include:

- Your contractions aren't regular or strong.
- You feel the contractions only in your lower uterus.
- Your contractions go away when you walk or change position.
- Your contractions go away after drinking fluids.

# What if we said.....

**Signs your body is preparing for the labor process but labor may not have begun:**

- Your contractions are irregular and do not feel strong.
- You feel the contractions only in the front part of your uterus/abdomen
- Your contractions go away or space apart in frequency or strength when you walk or change position
- Your contractions go away or space apart in frequency or strength when you drink water, juice or non-caffeine fluids.



# Birth Language

- The language birth attendants use reflects their attitudes and beliefs
- Language is powerful
- Words may reflect an unconscious need to be in control
  - Zeidenstein, 1998, p.75

**WORDS:** SO INNOCENT  
AND POWERLESS  
AS THEY ARE, AS STANDING IN  
A DICTIONARY, HOW POTENT  
FOR GOOD AND EVIL  
THEY BECOME IN THE HANDS OF  
ONE WHO KNOWS HOW TO  
COMBINE THEM. NATHANIEL  
HAWTHORNE

# Birth Language

- Who are the women who are
  - Delivered
  - Sectioned
  - Vacuumed
  - Suctioned



Best Upright Vacuums 2016



# Birth Language

- Truthful birth language
  - Puts the birthing person at the center
  - The birthing person “gives birth” ...they are not delivered..
- **It is the birthing person’s birth experience**
  - **Not ours....**



# Recommendations Regarding How To Communicate

- Start with good news first
- No exaggeration



# Example

- For a birthing person who is receiving cervical ripening instead of saying your cervix is still 1 to 2 cm, how about
  - Your cervix is ripening and thinning nicely...this is what is expected at this time
    - (as long as it is true that the cervix is effacing and softening)



[http://4f20lz3r4bii3yfqufzx0o17ou-wpengine.netdna-ssl.com/wp-content/uploads/2014/10/pregnant\\_birthing\\_person\\_belly\\_red\\_clock\\_birth\\_time.jpg](http://4f20lz3r4bii3yfqufzx0o17ou-wpengine.netdna-ssl.com/wp-content/uploads/2014/10/pregnant_birthing_person_belly_red_clock_birth_time.jpg)

# Recommendations Regarding How To Communicate

- Inform birthing person on the signs of progress as you identify them
  - Cervix moves from posterior to anterior position
  - Cervix ripens or softens
  - Cervix effaces
  - Cervix dilates
  - Fetal head rotates, flexes and molds
  - Fetus descends, rotates further, and is born
    - Simkin & Ancheta, 2017, p. 100

# What if we replaced the verbiage:

---

**“The patient REFUSES”**

With.....

*“The patient declines”*



# 8

## Respect the Birth Plan

You're a first-time  
mom with a  
detailed birth plan?  
Let me know how  
that works out  
for you.



someecards  
user card

<https://s-media-cache-ak0.pinimg.com/236x/de/5d/f1/de5df11b70f328e609a2a2765f83a971.jpg>



What if We  
Replaced the  
verbiage:  
“Birth Plan”  
with  
“Birth  
Preferences”

We're very excited to welcome our first child. We're committed to a natural, non-medicated labor and birth and in preparation have completed natural child birth class. However, we realize things don't always go as we might hope. We'll accept alternate interventions if medical staff, in conjunction with us, the parents, deem them to be medically necessary to preserve the safety of mother and/or baby. Our core goal is a healthy and happy mom and baby.

**Preferences for Managing Pain:** We strongly prefer a natural, non-medicated birth. Please don't suggest pain medications. If I get discouraged, suggest other comfort measures and offer encouragement. If I really need pain medications, I will ask for them.

**Preferences for Normal Labor and Birth:**

*First Stage of Labor*

- Minimize vaginal exams with as few different care providers as possible (prefer female practitioners)
- Intermittent fetal monitoring
- Freedom to change positions, stand, walk around, and use a birth ball
- Want to drink clear fluids, juices, and eat popsicles and avoid use of an IV
- Plan to use movement, bath/shower, breathing and relaxation techniques (music, lights dimmed) as comfort measures

*Second Stage of Labor:*

- Use of gravity-enhancing positions/positions that are comfortable to me at the time
- Push instinctively, in response to my body's cues
- Avoid episiotomy

*Third Stage of Labor and first hours after Baby's Birth:*

- Baby immediately placed skin-to-skin on abdomen
- Delay clamping and cutting the cord until it's stopped pulsating. Joe would like to cut the cord.
- Delay baby's medical procedures (eye drops, etc.) for first few hours, until there's a chance to breastfeed
- Breastfeeding only, no supplements unless necessary

**Preferences for Unexpected Labor Events:**

*Prolonged Labor:*

- Open to rupture of membranes, if labor is not progressing
- Prefer to avoid Pitocin

*Cesarean Birth:*

- Prefer regional anesthesia
- Please explain everything during surgery
- Skin-to-skin contact with baby/baby immediately held by partner

# Respectful Maternity Care

FOR EDUCATIONAL PURPOSES



## Providing Respectful Maternity Nursing Care

Respectful Maternity Care (RMC) is an approach to care that emphasizes the fundamental rights of women, newborns, and families, promoting equitable access to evidence-based care while recognizing unique needs and preferences.<sup>1</sup>

### The Core Elements of Respectful Care Are:

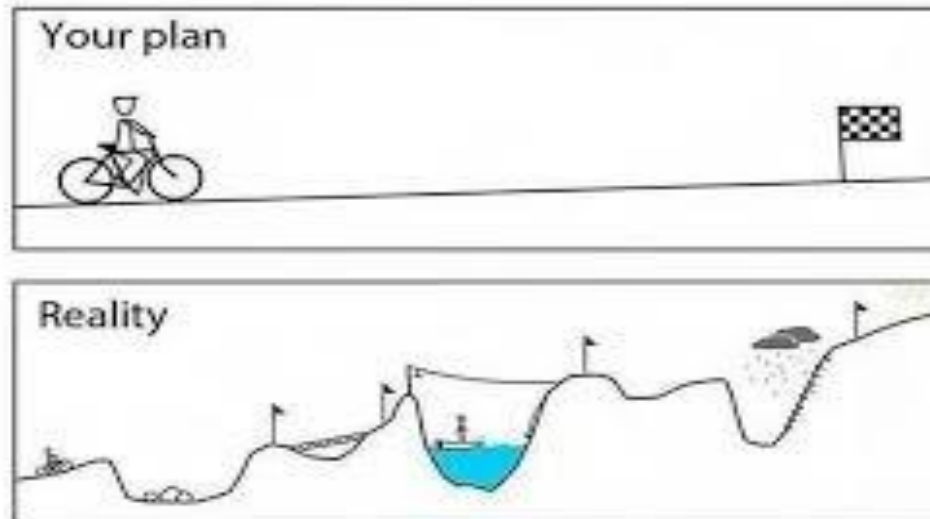
|  |  |
|--|--|
| <p><b>AWARENESS</b></p> <p>The state of being conscious of potential biases with the intent of using this consciousness as a platform to address these biases to optimize the patient-provider relationship and improve care.<sup>2</sup></p>  | <p><b>INFORMED CONSENT</b></p> <p>The voluntary decision of the patient regarding care or treatment, after having been given "adequate, accurate, and understandable information" concerning the treatment options and their important benefits and risks.<sup>3</sup></p> |
| <p><b>MUTUAL RESPECT</b></p> <p>The reciprocal process in which two or more individuals or groups honor the other by exhibiting care, concern, or consideration for the other's needs or feelings.<sup>12</sup></p>  | <p><b>AUTONOMY</b></p> <p>The core ethical principle in maternity care; it refers to the right and ability of individuals to make self-governed decisions about their health and health care.<sup>4</sup></p>  |
| <p><b>SHARED DECISION MAKING</b></p> <p>The communication process in which two or more individuals or groups work together to make optimal health care decisions that align with the goals or values of the patient, taking into consideration the best available evidence to support the decision.<sup>14</sup></p> | <p><b>DIGNITY</b></p> <p>The ethical assertion that each person has inherent worth and value as a human being; patients must be treated so that they are able to feel, think, and behave in relation to their own worth or value.<sup>4</sup></p>                          |
| <p><b>ACCOUNTABILITY</b></p> <p>The process of acknowledging and taking responsibility for one's actions, including when they are harmful to another.<sup>7</sup></p>  |  |

|   |  |  |
|---|--|--|
| <p><b>RESPECT</b></p> <p>Every Patient<br/>Every Interaction<br/>Every Time</p> | <p><b>How to integrate core elements of RMC in routine care practices:</b></p>   |  |
|   | <p>Reflect on past interactions that promote RMC. Were you faced with a situation that you used one or more of these elements of RMC? What would you charge about how you responded?</p>         | <p>Consider strategies to support shared decision making and informed consent. Which decision aids are available within your practice? Do you have procedures for documenting consent or refusal of consent?</p> |
|   | <p>Develop conscious awareness of your own biases. Take various implicit bias assessments. Reflect on how you honor patient's approaches that may be different than your own personal views.</p> | <p>Demonstrate personal and organizational accountability. Incorporate RMC strategies into communication and education. Does your organization collect data on RMC performance measures?</p>                     |

# What About When Things Don't Go As Planned?

- “found that birthing persons who had symptoms of PTSD were more likely than others to have been pressured to have an induction, epidural or planned cesarean birth.”

– Adams, Stark and Low (2016) pg.82



# What Can You Do As a Labor and Delivery Nurse?

- During handoff – report to oncoming shift patient's birth experience
  - Review documentation with patient present
  - Requesting post-partum staff ask the question in a non-judgmental format
    - Can you tell me about your birth experience?



# Respectful Maternity Care

- Includes respectfully communicating to the entire Obstetric Team



7

Encourage Labor  
Support



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# Encourage Childbirth Attendance

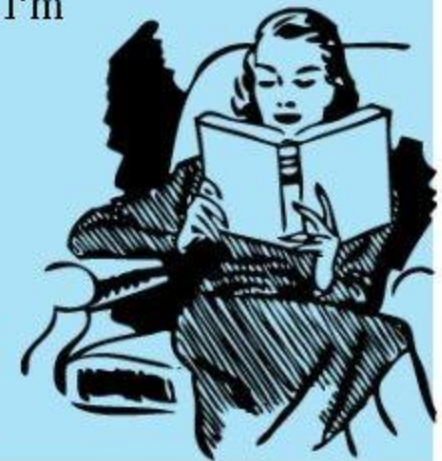


[http://www.newyorkfamily.com/wp-content/uploads/2014/02/PRIMARY-IMAGE\\_\\_\\_A-child-birth-education-class-at-Birth-Day-Presence-photo-by-Bellamy-Blue-1024x682.jpg](http://www.newyorkfamily.com/wp-content/uploads/2014/02/PRIMARY-IMAGE___A-child-birth-education-class-at-Birth-Day-Presence-photo-by-Bellamy-Blue-1024x682.jpg)

# Are You the Facilitator in the Patient's Labor?



As long as everything is exactly the way I want it, I'm totally flexible.



ROTTEN&CARDS USER CARD

# Establishing a Trusting Relationship

## Definition of TRUST

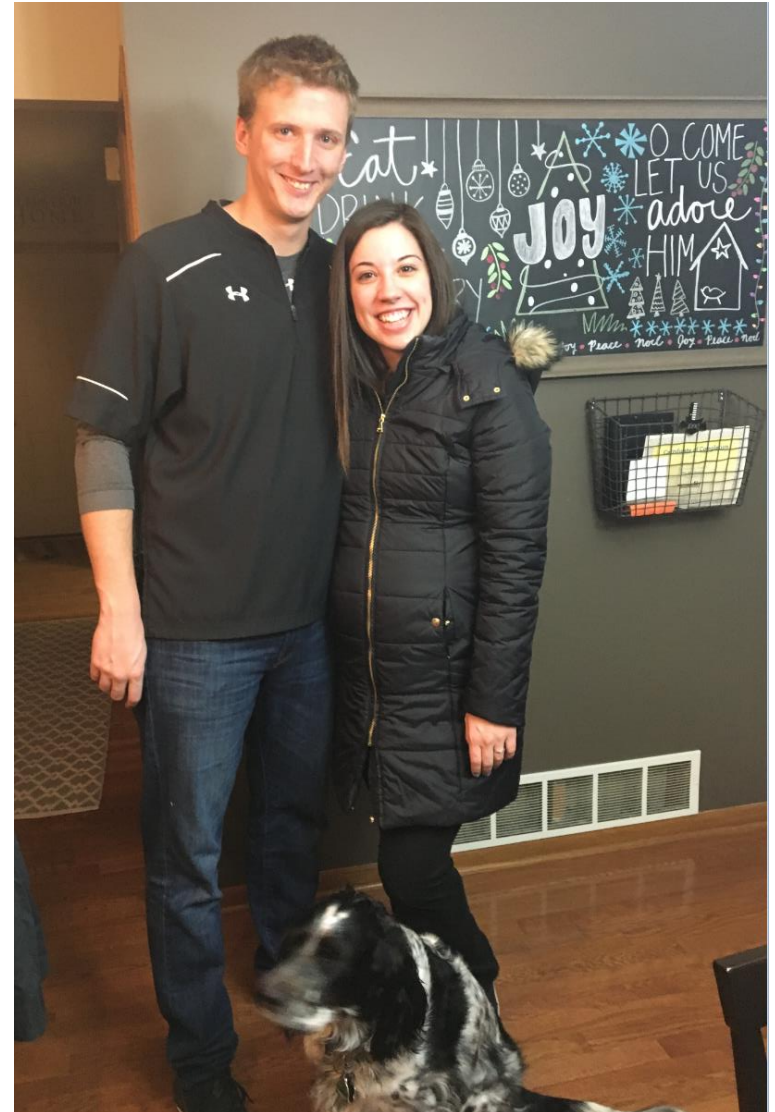
- a** : assured reliance on the character, ability, strength, or truth of someone or something  
**b** : one in which confidence is placed
- a** : dependence on something future or contingent : HOPE  
**b** : reliance on future payment for property (such as merchandise) delivered : CREDIT
  - bought furniture on *trust*
- a** : a property interest held by one person for the benefit of another  
**b** : a combination of firms or corporations formed by a legal agreement; *especially* : one that reduces or threatens to reduce competition
- archaic** : TRUSTWORTHINESS
- a** (1) : a charge or duty imposed in faith or confidence or as a condition of some relationship (2) : something committed or entrusted to one to be used or cared for in the interest of another  
**b** : responsible charge or office  
**c** : CARE, CUSTODY
  - the child committed to her *trust*

<https://www.merriam-webster.com/dictionary/trust>



[http://images.wookmark.com/102789\\_wallpaper-460322.jpg](http://images.wookmark.com/102789_wallpaper-460322.jpg)

# Is the Patient's Partner Supportive?



# Doula



# 6

## Resources

***SPINNING BABIES  
WORKSHOPS  
2026:  
October 20<sup>th</sup>  
MWH***



# MWH

## Labor Support

### April 1<sup>st</sup> and September 3<sup>rd</sup>

No April Fools!



# Requesting Assistance From Provider



# 5

## Addressing the Patient's Pain

# How Do You Address The Patient's Pain???



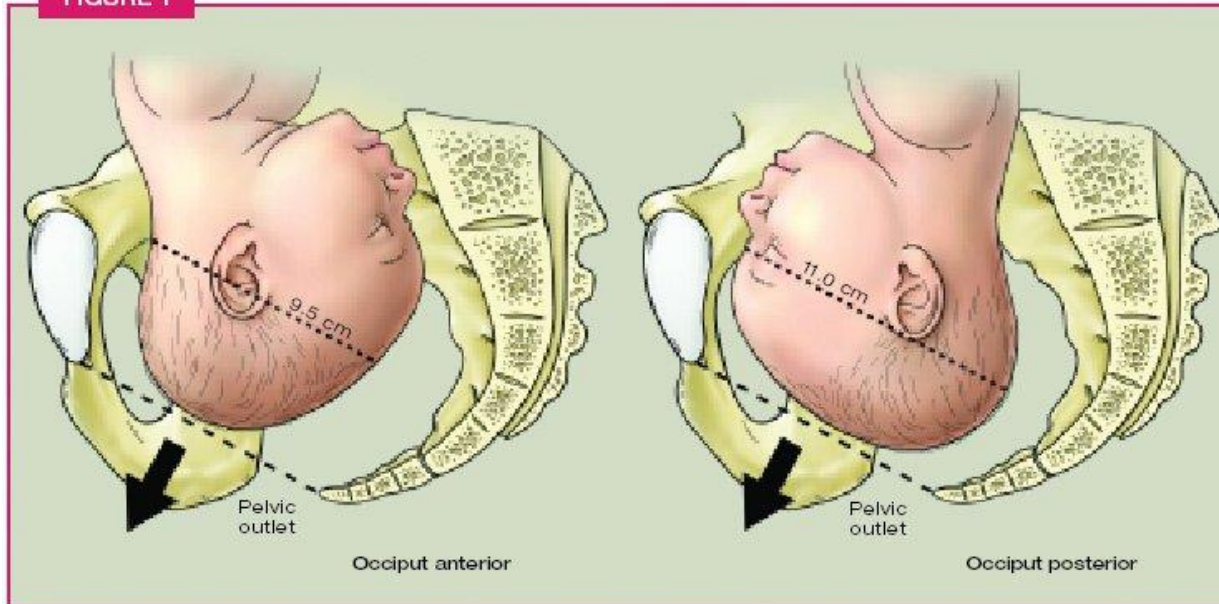
[https://childdevelopmentinfo.com/wp-content/uploads/2011/09/child-developmentpreparing\\_for\\_birtheasing\\_labor\\_pain-3.jpg](https://childdevelopmentinfo.com/wp-content/uploads/2011/09/child-developmentpreparing_for_birtheasing_labor_pain-3.jpg)

# 4

## Know the Position of the Fetus

# Find Your Landmarks

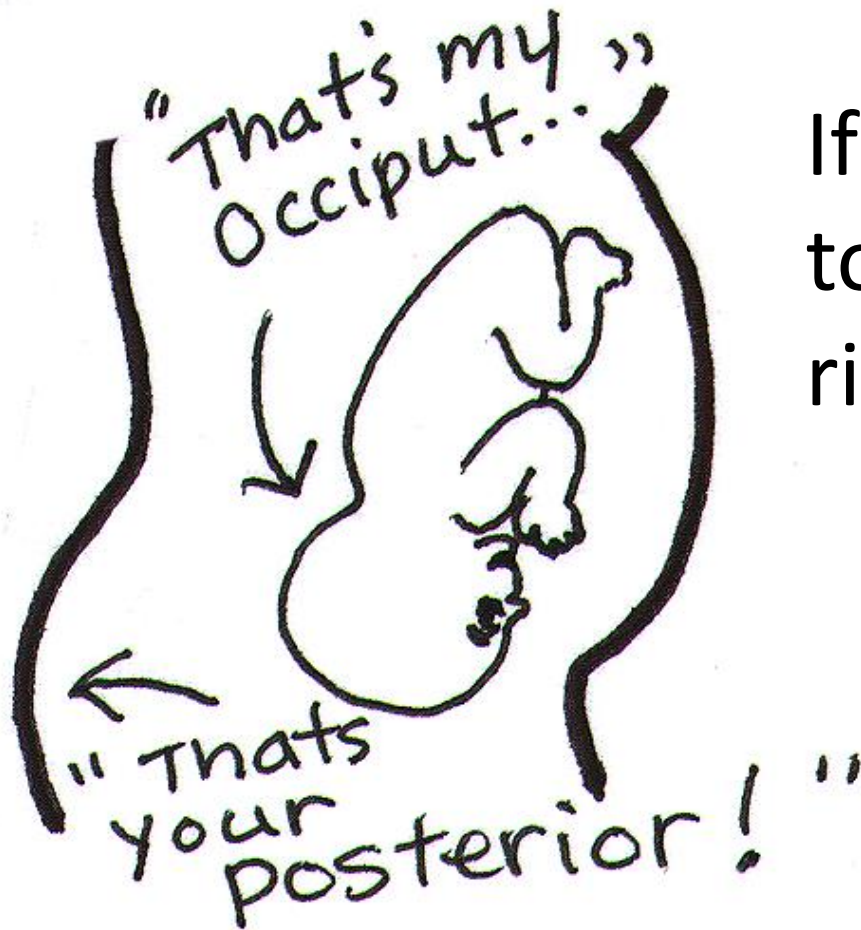
FIGURE 1



For vertex presentations the fetal occiput is the reference

[http://images.alfresco.advanstar.com/alfresco\\_images/HealthCare/2012/10/30/7719b301-9e59-4c5e-87b9-856736ec4b2f/i4.jpg](http://images.alfresco.advanstar.com/alfresco_images/HealthCare/2012/10/30/7719b301-9e59-4c5e-87b9-856736ec4b2f/i4.jpg)

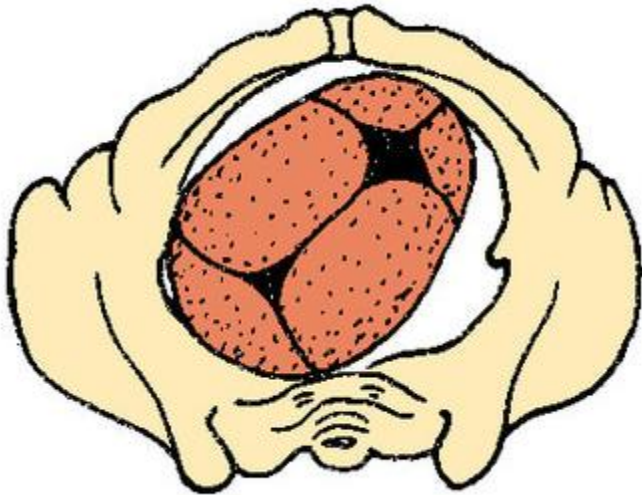
# Find Your Landmarks



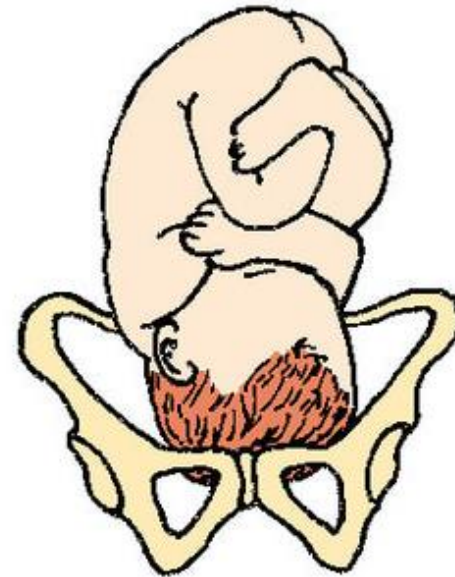
If the occiput is turned toward the mother's right-side it is ROA

What Position is the Fetus IN?????

## Right Occiput Posterior



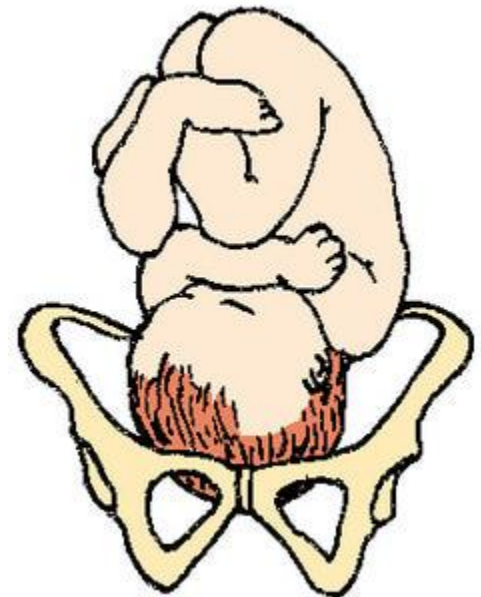
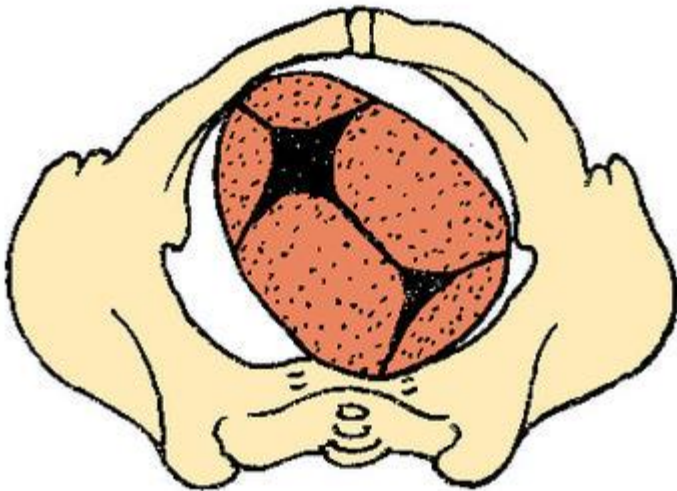
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- Fetal back is on maternal right side
- Mother feels fetal kicks on left side and fetal feet, legs and arms are felt are palpated on the maternal left side
- Murray & Huelsmann ( 2009) pg159

# What Position is the Fetus IN?????

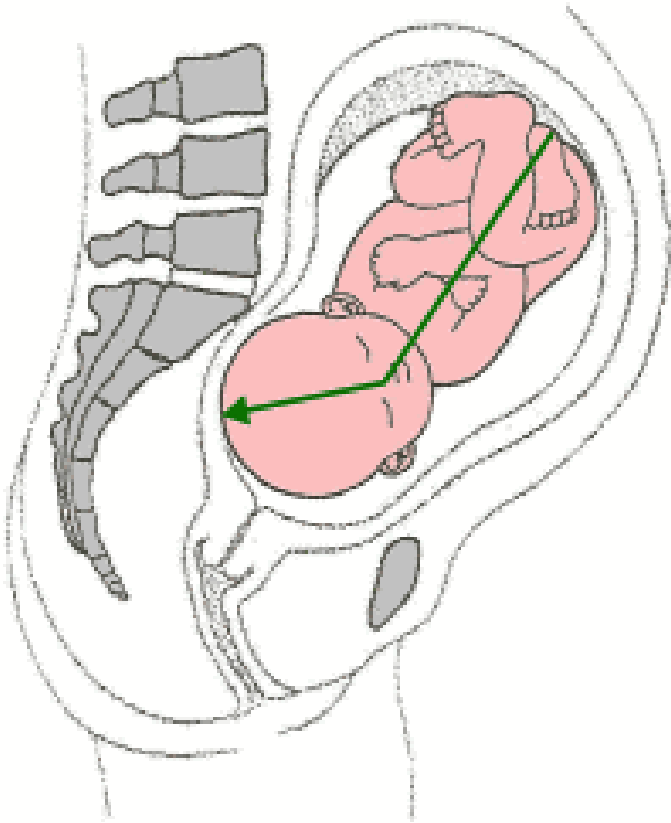
## Left Occipital Posterior



<https://s-media-cache-ak0.pinimg.com/originals/00/30/b7/0030b7b502c495af5360bf99bf687898.jpg>

- Fetal back is on maternal left side
- Mother feels fetal kicks on right side and fetal feet, legs and arms are felt are palpated on the maternal right side
  - Murray & Huelsmann ( 2009) pg159

# Asynclitism



<http://spinningbabies.com/wp-content/uploads/2015/02/Asynclitism-OA-3-225x300.png>

Occurs when the sagittal suture is not directly central relative to the maternal pelvis .

# Fetal Malposition and Epidurals

*“Fetal position changes are common during labor, with the final fetal position established close to delivery. Our demonstration of a strong association of epidural with fetal occiput posterior position at delivery represents a mechanism that may contribute to the lower rate of spontaneous vaginal delivery consistently observed with epidural.”*

• Lieberman, E. et.al (2005) pg. 974

Does the epidural slow labor progress?

- May slow labor progress, influence the rate of fetal malposition at delivery with a decrease in spontaneous vaginal deliveries and subsequent increase in instrumental deliveries

» Simkin & Ancheta (2011) pg. 149

# Use of the Ultrasound

- To Confirm Fetal Position

## Intrapartum Sonography and Persistent Occiput Posterior Position: A Study of 408 Deliveries

*MIKAEL GARDBERG, MD, PhD, EERO LAAKKONEN, MSc, AND  
MARI SÄLEVAARA, MD*

*Conclusion:* In most cases, persistent occiput posterior position develops through a malrotation and only in a little more than one-third of cases through absence of rotation from an initially occipitoposterior position. Higher maternal BMI correlates with higher fetal weight, increased operative deliveries, lower Apgar scores at 1 minute, and posterior placental locations. Intrapartum sonography proved to be useful in investigating the development of the persistent occipitoposterior position. (Obstet Gynecol 1998;91:746–9. © 1998 by The American College of Obstetricians and Gynecologists.)

# 3

Encourage  
Movement and  
Turn Your Patient

# CMQCC

- Recommends maternal position change with an epidural every 20 minutes



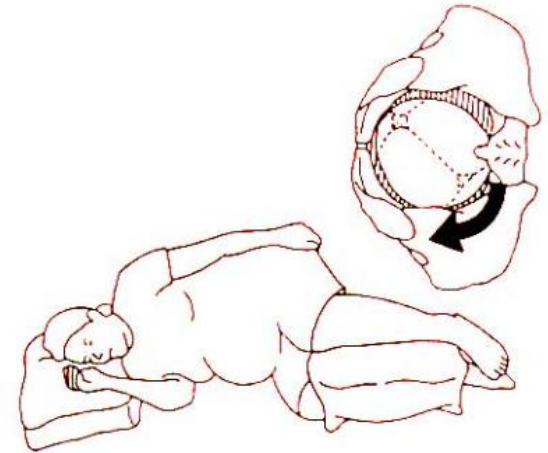
# CMQCC Recommendations

- Allow for passive descent when there is no urge to push.
- Delay pushing until there is a stronger urge to push
  - Generally, one to two hours after complete dilation
    - If maternal and fetal conditions allow



# Positions to Use for the Laboring Patient Who Has an Epidural – 1<sup>st</sup> Stage

- Semi sitting and Side lying
  - When would you use it?
    - When the patient is progressing too fast
  - Why it slows down labor?
    - Negates the gravity component
    - Increases oxygen to the fetus
  - When not to use it?
    - Pure side lying position should be used on the same side of the fetus's posterior position
    - Example - ROP – patient should be placed in right side lying position
      - Fetal back should be toward the bed
        - » Gravity pulls the fetus to the OT position
        - » Then position her (if able) to kneel and lean forward to facilitate rotation from OT to OA



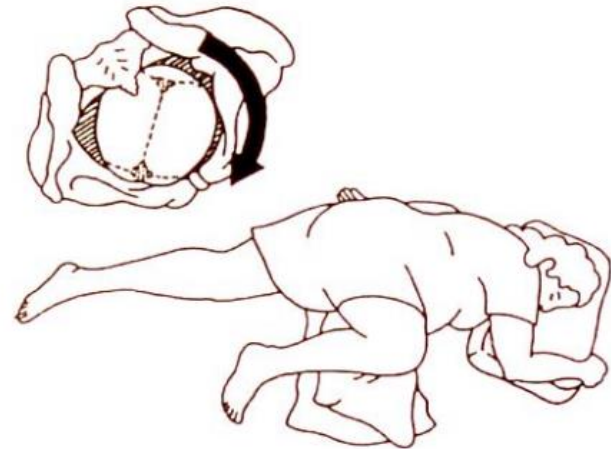
file:///C:/Users/msegerb/Downloads/Supporting\_the\_birthing\_person\_Epidural\_Complete3-06.pdf



© Healthwise, Incorporated

# Semi Prone or Exaggerated Sim's Position

- When to use it
  - When dilatation has slowed
  - Suspected fetal malposition
    - If the birthing person is in the exaggerated Sim's position she should be placed on the side opposite of the fetal malposition
    - Example – fetus is LOP – place birthing person on her right side
      - Fetal back is toward the ceiling and gravity pulls the fetal back and OP to OT position
- Use of the peanut ball



file:///C:/Users/msegerb/Downloads/Supporting\_the\_birthing\_person\_Epidural\_Complete3-06.pdf



# Upright Position

- When would you use this position?
  - This position would take advantage of gravity to apply pressure of the presenting part to the cervix which may ↑ labor progress
- When would you not use this position
  - Known or suspected OP
  - Fetal heart rate does not tolerate
  - Hypertensive
  - Patient refuses



<https://s-media-cache-ak0.pinimg.com/originals/98/bd/80/98bd80cfae40949a837365af413ee1a5.jpg>

# Leaning Forward

- When would you use this position?
  - To enhance rotation or to maintain OA position
- How does this work?
  - Aligns fetus with the pelvis
  - Enlarges the pelvic inlet compared to supine position



[http://www.bestdoulas.com/images/350\\_2a.jpg](http://www.bestdoulas.com/images/350_2a.jpg)



5. Sitting, leaning  
on tray table

# Positions to Use for the Laboring Patient Who Has an Epidural – 2<sup>nd</sup> Stage

- Sheet Pulling
  - Use the squatting bar versus having the support person/staff hold the end of the sheet/towel
  - What this position does?
    - Aids in pushing more effectively especially with the use of an epidural
  - When not to use this position
    - When supine hypotension is present
    - With non-reassuring fetal heart tones

# Not This!!!



Gustave Witkowski, Pioneer Birth Scene, 1877

[http://4.bp.blogspot.com/-4bWituWO748/VJdUmxJNC9I/AAAAAAAAACNw/otz5eNiWw\\_w/s1600/PioneerBirthScene.jpg](http://4.bp.blogspot.com/-4bWituWO748/VJdUmxJNC9I/AAAAAAAAACNw/otz5eNiWw_w/s1600/PioneerBirthScene.jpg)

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# But This



<https://s-media-cache-ak0.pinimg.com/736x/df/d1/07/dfd10744700084d448962d83fe1e5713.jpg>

# Don't Forget

## The importance of keeping the bladder empty



2

Look at the entire  
clinical picture

# Every Patient and Every Birthing Experience is Individual

Look at the Entire Clinical Picture!



1

Celebrate Your  
Victories and Share  
Your Stories

CONGRATULATIONS  
TO THE  
WOMEN'S HOCKEY TEAM



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