



The Oregon Perinatal Collaborative (OPC), a group of perinatal health care leaders in Oregon, commits to safely reduce the rate of Cesarean Sections (C-Section) births, particularly for women who haven't delivered in this manner before. In order to safely reduce first-time C-Sections, the OPC leaders are implementing strategies for a successful birth in labor and delivery departments throughout Oregon. The OPC recommends all Oregon Providers delivering babies review and adopt these best practices strategies that will support safe deliveries in all labor units. The OPC will continue to monitor and revise these strategies for best practice on a regular basis. The OPC endorsed strategies and references for successful birth can be found at:

<http://www.oahhs.org/quality/quality-resources>.

<i>Aspect of Care</i>	Decision Point	Practices/Indications
<i>Prenatal:</i>	Assessment of Gestational Age	<ul style="list-style-type: none"> ✓ Provide documentation on how and when gestational age determined (most recent ACOG criteria or 8% rule) – note: 1st trimester ultrasound dating is most accurate.
<i>Labor induction:</i>	Pre-procedure	<ul style="list-style-type: none"> ✓ Consent form discussed with patient and signed for any induction; medical and non-medical (ACOG induction consent or equivalent).
	Non-medically indicated	<ul style="list-style-type: none"> ✓ Not done prior to 39 0/7 weeks gestation. ✓ Between 39 0/7 – 40 6/7 weeks gestation must have Bishop Score of 8 or greater for nulliparas or 6 or more for multiparas (no cervical ripening).



	<p>Medically indicated</p>	<ul style="list-style-type: none"> ✓ Done for accepted medical indications within evidence-based or National Association guidelines (ACOG, SMFM, etc.) for definition and most appropriate gestational age for delivery. For indications not on above lists, consultation or advice is recommended. ✓ Cervical ripening if needed for unfavourable cervix.
	<p>Failed induction (assuming stable mother and fetus) – parameters to use when not entering active labor (≥ 6 cms):</p> <p>If failed induction, discuss options regarding further management: consider risks, benefits, and alternatives of all options (i.e.: discharge home with plan to return versus Cesarean Section, depending on clinical situation)</p>	<p>Failure to achieve uterine contractions every 3 minutes with cervical change after 24 hrs of oxytocin and with AROM (if no contraindications), OR uterine contractions every 3 min x 24 hrs without entering active phase if initial Bishop score was less than 6-8 or if cervical ripening was used.</p> <ul style="list-style-type: none"> ✓ Inadequate response to a needed, clinically appropriate, second cervical ripening agent defined as membranes have been ruptured with inadequate progress (assuming feasible and no contraindications to AROM) and oxytocin has been given per hospital protocol if inadequate frequency and/or intensity of contractions occurring after cervical ripening alone. ✓ If ROM, oxytocin given x 12 hrs without regular contractions resulting in cervical change.



<i>Labor - first stage:</i>	Consider delay in admission to labor unit (all conditions to be met for discharge)	<ul style="list-style-type: none"> ✓ Cervix 0-3 cm. ✓ Membranes intact. ✓ Reactive NST/ FHR category 1 (Confirmed by 2 practitioners - RN, MD, DO, CNM) ✓ Pain control adequate with appropriate outpatient interventions as needed.
	May consider discharge home or further observation (All criteria must be met)	<ul style="list-style-type: none"> ✓ Cervix 4-5 cm without change x 2 - 4 hours. ✓ <80% effacement. ✓ Membranes intact. ✓ Reactive NST/FHR category 1 • Contractions less than 4/10 minutes. • (Assuming < 41 weeks GA; nulliparous; if multiparous, either this plan or simply AROM if medically acceptable).
	Consider AROM and/or Oxytocin administration	<ul style="list-style-type: none"> ✓ Cervix 4-5 cm without change x 2- 4 hours. ✓ 90 - 100% effacement.



		<ul style="list-style-type: none"> ✓ Membranes intact. ✓ Reactive NST/FHR category I (if uterine contractions present). ✓ Contractions less than 5/10 minutes.
	Consider Cesarean delivery (all three present)	<ul style="list-style-type: none"> ✓ Cervix 6 cm or greater. ✓ Membranes ruptured (if feasible). ✓ Uterine activity: <ul style="list-style-type: none"> >200 Montivideo units x 4 hours, or every 3 minute palpably strong contractions x 4 hours when not feasible to rupture membranes <li style="text-align: center;">OR <200 Montivideo units or < 3/10 minute contractions x 6 hours despite Oxytocin administration per protocol.
<i>Labor – second stage:</i>	Assessment of descent (and position) of presenting part	<ul style="list-style-type: none"> ✓ Ideally every 1 hour.



	<p>Consider Operative Vaginal Delivery or Cesarean delivery (if presenting part not on perineal floor: +2 or lower)</p>	<p>Pushing time from complete dilation*:</p> <ul style="list-style-type: none"> ✓ Nulliparous with epidural anesthesia – 4 hours. ✓ Nulliparous without epidural anesthesia – 3 hours. ✓ Multiparous with epidural – 3 hours. ✓ Multiparous without epidural – 2 hours. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> ✓ Total time from complete dilation 5 hours or greater. <p>* Each may need an additional hour if occiput posterior position and rotation of greater than 45 degrees toward anterior has been previously achieved.</p>
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REFERENCES

Assessment of Gestational age

Provide documentation on how and when gestational age determined (most recent ACOG criteria or 8% rule) – note: 1st trimester dating is most accurate.

References

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Pre-Procedure

Consent form discussed with patient and signed for any induction; medical and non-medical (ACOG induction consent or equivalent).

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Non-Medically Indicated

Not done prior to 39 weeks gestation.

Between 39 – 40 6/7 weeks gestation must have Bishop score of 9 or greater in nulliparous women and 6 or greater in multiparous women (no cervical ripening).

References

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Medically Indicated

Done for reasons that are medically indicated and not included in the non-medically indicated guideline (Appendix A).

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Failed Induction (stable mother and fetus) – check all that apply: If failed induction, discuss options regarding further management (i.e. discharge home with plan to return versus Cesarean section)

No cervical change after 24 hours of Oxytocin and membranes have been artificially ruptured (if feasible and no contraindications).

Failure to enter active phase (6 cms) despite uterine contractions every 3 mins x 24 hours with ruptured membranes.

Inadequate response to 2nd cervical ripening agent and failure to respond to Oxytocin per hospital protocol.

In the setting of ruptured membranes, no cervical change after 12 hours of Oxytocin.

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Delay Admission to Labor Unit (all conditions to be met for discharge)

Membranes intact.

Cervix is less than 4cm.

Reactive NST/ FHR category I (if uterine contractions present). Confirmed by 2 practitioners (RN, MD, DO, CNM).

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Adapted from WSHA's Labor Management Bundle @ <http://www.wsha.org/0513.cfm>

Pain control adequate with appropriate outpatient interventions as needed.

References

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Consider Discharge Home or Further Observation if:

Cervix 4-5 cm without change x 2 - 4 hours.

< 80% effacement.

Membranes intact.

Reactive NST/FHR category I (if uterine contractions present).

Contractions less than 3/10 minutes.

References

Spong, C. Y., Berghella, V., Wenstrom, K. D., Mercer, B. M., & Saade, G. R. (2012). Preventing the first cesarean delivery: Summary of a joint Eunice Kennedy Shriver National Child Health and Human Development, Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists workshop. *Obstetrics and Gynecology*, 120(5), 1181-1193. doi: <http://10.1097/AOG.0b013e3182704880>

Consider AROM and/or Oxytocin Administration if:

Cervix 4-5 cm without change x 2- 4 hours.

80 - 100% effacement.

Membranes intact.

Reactive NST/FHR category I (if uterine contractions present).

Contractions less than 3/10 minutes.



References

Rouse, D. J., Owen, J., Savage, K. G., & Hauth, J. C. (2001). Active phase labor arrest: Revisiting the 2-hour minimum. *Obstetrics and Gynecology*, 98(4), 550–554.

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Consider Cesarean Birth (All 3 Present)

Cervix 6 cm or greater.

Membranes ruptured (if feasible).

Uterine activity:

> 200 Montivideo units x 4 hours, or Q 3 minute palpably strong contractions when not feasible to ROM.

OR

< 200 Montivideo units x 6 hours with Oxytocin administration.

References

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Assessment of Descent and Position of Presenting Part

At least every 2 hours.

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Adapted from WSHA's Labor Management Bundle @ <http://www.wsha.org/0513.cfm>



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Consider Cesarean Birth (if presenting part not on perineal floor; +4 or lower)

Time from complete dilatation:

Nulliparous woman with epidural anesthesia: 4 hours

Nulliparous woman without epidural anesthesia: 3 hours

Multiparous woman with epidural anesthesia: 3 hours

Multiparous woman with epidural anesthesia: 2 hours

OR

Total time from complete dilatation 5 hours or greater.

References

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