A Nurse's Role on Educating About Laboring Down

Courtney David

Margaret H. Rollins School of Nursing

NUR 201: Nursing Care of Special Populations

Dr. D. Blankenship

November 4th, 2024

A Nurse's Role on Educating About Laboring Down

"We're fully dilated in room 2, it's time to start pushing". Ever walk onto the Labor and Delivery floor for the start of your shift and hear strenuous amounts of screaming and groaning from laboring mothers, and thinking to yourself how long has she been going through labor? Well, if the staff has her "bearing down" exactly when she was fully dilatated, then she could have been going at it for hours until the bundle of joy is ready to make their appearance into this world. Bearing down is defined as "the action of pushing exactly when fully dilated even without the natural urge to push" (Kleinmann, W, 2024). "Laboring down" however, is the process of not actively pushing during the second stage of labor when intense contractions begin (Cleveland Clinic, 2022). Of course, a laboring mother wants to see her baby as soon as possible, but the action of bearing down when dilatated to 10cm results in excessive fatigue, fetal hypoxia, maternal low blood pressure, and risk for trauma in the perineum area for the mother. As a nurse, it's important and potentially beneficial to educate your laboring mother about not bearing down if the fetus is still further up in the birthing canal, but rather wait to push to prevent potential complications for both mom and baby. This delay will allow for the fetus to naturally descend the birthing canal and thereby allow for a shorter, agonizing "pushing" phase for the mother.

Second Stage of Labor

The second stage of labor is defined as "the time between complete cervical dilation and the birth of the infant" (Kathryn Osborne). The second stage of labor also consists of two different phases, known as the Latent and Active phases.

The Latent phase is when the fetus descends passively through the birth canal and rotates to an anterior position. This is when the providers measure the station of the baby. Station is the

relationship of the presenting fetal part to an imaginary line drawn between the maternal ischial spines and is the measurement of degree of descent of the presenting part of the fetus through the birth canal. This is measured in centimeters above or below ischial spines. When you begin to have plus numbers, that indicates that the fetus is further down the birthing canal, and you are able, and sometimes encouraged, to begin pushing.

The active phase is the pushing and the descent of the fetus. "In addition, despite the long-held assumptions that feeling an urge to push marks the onset of the second stage, many women reach complete dilation and experience no urge to bear down" (Kathryn Osborne). With the relationship between the birthing canal and the ischial spines, you could have a fetus that is further up in the birthing canal, but the mom is fully dilated to 10cm with no urge to push. This is when it's important for the nurse to have open communication with the mother. As the nurse you should instruct your patient to alert you when they feel the natural urge to push. According to a recent study performed, "delayed pushing reduced the duration of pushing by about 19 minutes and slightly increased the number of women with a spontaneous vaginal birth" (Lemos, A, 2017).

To further elaborate on the act of pushing during the Active phase; normally when the cervix is completely dilated to ten centimeters "many women are instructed to assume a lithotomy position and bear down using Valsalva efforts against a closed glottis" (Kathryn Osborne). This method consists of taking a deep breathe at the beginning of each contraction and holding it while sustaining the bearing down efforts for a count of ten seconds. This is then repeated for the duration of each contraction until the baby is born.

Complications of Bearing Down

Bearing down comes with an array of complications that could occur for not only the mother, but for baby as well. Starting with the mother, some of the complications could be excessive fatigue, increased rate for Cesarean birth, increased blood pressure and perineum trauma, tearing, distention, and tissue damage (Table 1. Kathryn Osborne). Excessive fatigue comes from the additional pushing if baby is not positioned in the birthing canal at plus ischial spines. This would involve pushing for an extended amount of time to further move the baby in the birthing canal before the descent of the baby through the vagina could occur.

"Delaying maternal bearing-down efforts during second-stage labor until a woman feels an urge to push (laboring down) results in optimal use of maternal energy" (Osborne, K., & Hanson, L. 2014). "Spontaneous bearing down is associated with less fatigue and enhanced comfort as women respond to their own cues" (Lisa Hanson, 2009). This spontaneous bearing down is another form of laboring down, as it begins when the mother receives her own cues, or natural urge, to push during a contraction.

Increased Cesarean birth rates track along with excessive fatigue, especially if the mother can't get the baby out. Then, for the safety of both the mother and baby a C-section or Cesarean birth is necessary. Additionally, increased blood pressure would come from excessive bearing down during each contraction and holding the position for a full 10 seconds. Further, many bear down using a close glottis, this also would increase blood pressure from the straining and could cause increased intercranial pressure as well. "Valsalva pushing efforts sustained for longer than 5 to 6 seconds leads to alterations in maternal and fetal hemodynamic such as lowering maternal blood pressure and blood flow to the placenta" (Lisa Hanson, 2009). Lastly, the perineum trauma

"with spontaneous pushing, the perineum has gradual distension, and improved rates of intact tissue" (Table 1. Kathryn Osborne).

Aside from maternal complications we also have to think about the baby and complications that could arise from bearing down too early and too long. The fetus could potentially see complications such as significant decelerations and hypoxia. For example, "The fetus experiences a decrease in oxygens saturation with Valsalva bearing down that is not observed when the mother is supported to use spontaneous bearing down" (Lisa Hanson, 2009). This further corraborates the theroy that with the natural urge to push the baby is not under constant distress with the mother holding her breathe and decreasing the blood flow to the placenta.

Natural Ways to Descend the Birthing Canal

To prevent complications and fear from the mother related to bearing down, when the baby is not further along in the birthing canal, a nurse can educate on natural ways to induce baby to advance the birthing canal without bearing down for an extended amount of time. Nurses should educate their patients that "standing, kneeling and squatting takes advantage of gravity to help the baby move down into the pelvis" (DiFranco, J. T., & Curl, M. 2014). Squatting also increases the size of the pelvis, providing more room for the baby to maneuver and begin to descend. Changing position every fifteen to thirty minutes will also promote descent and fetal head rotation (American College of Obstetricians and Gynecologists 2024). "The standing position removes pressure on the sacrum and therefore can increase the pelvic diameters" (Lisa Hanson, 2009). When it comes to birth, each birthing mother will be different. First the nurse will determine where the baby is sitting within the birthing canal, to help determine ways to naturally descend. If the baby is at the top of the pelvis, the nurse will

educate the patient to “jiggle, engage the posterior pelvic tilt, and abdominal lift and tuck” (Brookings 2022). If the baby is at the bottom of the pelvis, these movements focus on opening the pelvic outlet both front to back and side to side. The nurse will educate on performing the “anterior pelvic tilts, internal femur rotation, doing a kneeling lunge or laying on your side” (Brookings, 2022) to open the lower pelvis so that the baby can come out. Each movement mentioned above will encourage the baby to move down the birthing canal naturally without having to bear down for an extended amount of time and most importantly they can happen with the mother’s comfort and ques.

Nursing Resources During Labor

As this paper has demonstrated, the effort and demand of the birthing mother is tremendous. The one aspect not mentioned yet is the demand on the nursing staff during an active labor.

While the mother is in stage two active phase of labor, there is a nurse assigned to the mother and one assigned to the fetus/newborn. As some mothers can attest, the active phase of their labor went on for many hours. During this time, both nurses are exclusively assigned to that one room, while other patients are absorbed by other nurses. If the practice of laboring down or spontaneous bearing down is more readily utilized it could potentially alleviate the need for the second nurse for several hours.

With many hospitals experiencing extreme staffing shortages, having that one nurse available for a few extra hours, while the mother to be waits for the natural urge or cue to push, could provide critically needed relief for the nursing staff as a whole.

Conclusion

In summary, bearing down comes with a longitude of contradictions during labor. Laboring mothers should not be bearing down if they do not feel the natural urge to push. This natural urge will begin once the baby is positioned along the back side of the pelvis which will result in that feeling to push. As a nurse it's important to educate your laboring mother about not bearing down if the fetus is still further up in the birthing canal, during the second stage of labor. Rather they should wait to push to prevent potential complications for both the mother and baby and allow for fetus to naturally descend the birthing canal. Nurses should educate on natural ways of bringing the fetus further down the birthing canal and to alert when the urge to push is present. Nurses should be the patient's advocate in a unpredictable but joyful moment, and reassure them that it is okay to wait to push, especially if the mother and baby are safe. Assure them there is not urgent need to push just because she is fully dilated, as long as they are both still safe an not distressed. As a nurse, we must remember to encourage open mouth glottis when spontaneously laboring down to allow for more comfortable pushing (Barasinski, C 2020).

Thinking back to the start of this reading, when you began your shift on the labor and delivery floor, what would you do if you heard "We're fully dilated in room 2, it's time to start pushing". Would you wonder if the fetus has fully descended the birthing canal? Would you be a voice for your patient, who is scared and vulnerable, and ask them the simple question of - are *you* ready and do *you* feel the urge to begin pushing?

References

American College of Obstetricians and Gynecologists. (2024). Clinical Practice Guideline No. 8. First and second stage labor management. *Obstetrics & Gynecology*, *143*(1), 144–162. https://doi.org/10.1097/AOG.0000000000005447

Barasinski, C., Debost-Legrand, A., & Vendittelli, F. (2020). Is directed open-glottis pushing more effective than directed closed-glottis pushing during the second stage of labor? A pragmatic randomized trial—the EOLE study. *Midwifery*, 91. https://doi.org/10.1016/j.midw.2020.102843

DiFranco, J. T., & Curl, M. (2014). Healthy Birth Practice #5: Avoid Giving Birth on Your Back and Follow Your Body's Urge to Push. *The Journal of perinatal education*, *23*(4), 207–210. https://doi.org/10.1891/1058-1243.23.4.207

Kleinmann, W., Zofkie, A., McIntire, D., & Adhikari, E. H. (2024). A Prospective Study of Lactate Levels in Uncomplicated Spontaneous and Induced Labor. American Journal of Perinatology, 41(13), 1743–1747. https://doi.org/10.1055/a-2302-8828

Lemos, A., Amorim, M. M., Dornelas de Andrade, A., de Souza, A. I., Cabral Filho, J. E., & Correia, J.B. (2017). Pushing/bearing down methods for the second stage of labor. *The Cochrane database of systematic reviews*, *3*(3), Article, CD009124.https://doi.org/10.1002/14651858.CD009124.pub3

Osborne, K., & Hanson, L. (2014). Labor down or bear down: a strategy to translate second-stage labor evidence to perinatal practice. *The Journal of perinatal & neonatal nursing*, *28*(2), 117–126. https://doi.org/10.1097/JPN.0000000000000023

Roberts, J. M., González, C. B. P., & Sampselle, C. (2007). Why do supportive birth attendants become directive of maternal bearing-down efforts in second-stage labor? *Journal of*

midwifery & women's health, *52*(2), 134–141.https://doi.org/10.1016/j.jmwh.2006.11.005