A Clinical Practice Guideline in Women During Second-Stage Labor: Quality Improvement

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Introduction

Nursing interventions during second-stage labor vary widely due to the lack of updated research evidence. The lack of research evidence has led to a disparity in birthing outcomes. Studies have shown that cesarean, spontaneous vaginal births and vacuum-assisted births are all associated with maternal morbidity. Along with physical demands on the birthing woman's body in the second stage of labor, there are increased risks of inadvertent injury to the neonate or mother, increased risk for hemorrhage, and even maternal death. This study aims to set standard guidelines in nursing interventions for better birth outcomes. Quality Improvement uses knowledge to "describe approaches for changing processes of care" (QSEN Institute, 2020, Table 4). Clinical practice guidelines (CPG), Levine's conservation model, and the advancing research and clinical practice through close collaboration (ARCC) model guide the nursing interventions for women during second-stage labor.

Article Summary

The intervention includes implementing the clinical practice guideline (CPG), Levine's conservation model, and the advancing research and clinical practice through close collaboration (ARCC) model to create a nursing intervention guideline for women in the second stage of labor. These models offer different approaches to creating evidence-based steps to improve outcomes and using knowledge for quality improvement, as described by QSEN. Using researched data,

CPGs bundle physiologic birth principles such as passive descent and rotation of the fetus through the pelvis and allow longer periods for second-stage labor, up to 4 hours (Waller-Wise et at., 2020). Levine's conservation model implemented delaying active pushing to conserve energy and push more effectively at the appropriate time. Levine's conservation of structural integrity also prevents perineal trauma. Lastly, the ARCC model uses five steps to guide nursing intervention for women during second-stage labor. The first step assesses the organizational willingness to translate evidence into practice (Waller-Wise et at., 2020), then the organization is assessed for its strengths and weaknesses to change. Third, mentors are found within the clinical agency to aid in mentoring the clinic staff. The fourth step applies the use of the evidence-based practice. Lastly, in the fifth step, the outcomes of evidence in practice are evaluated. The three models use different approaches in order to improve overall birth outcomes.

Garpiel (2018) looked at differences between pre-intervention data for two months and post-intervention data for four months and found there were benefits to using standardized, evidence-based nursing interventions during second-stage labor. The study showed that birth experience satisfaction rose from the 69th percentile to the 81st percentile (Garpiel, 2008).

References

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