

# Key Strategies for Supporting Intended Vaginal Birth

## 1 Implement Institutional Policies that Uphold Best Practices in Obstetrics, Safely Reduce Routine Interventions in Low-Risk Women, and Consistently Support Vaginal Birth

- Perform a comprehensive review of existing unit policies and edit such policies to provide a consistent focus on supporting vaginal birth

## 2 Implement Early Labor Supportive Care Policies and Establish Criteria for Active Labor Admission

- Implement policies that support the physiologic onset of active labor, reduce stress and anxiety for the woman and family, and improve coping and pain management
- Implement written policies that establish criteria for active labor admission, versus continued observation of labor status and/or discharge home
- Give adequate anticipatory guidance during the prenatal period about early labor expectations and the safety of completing early labor at home
- Educate women and families on supportive care practices and comfort measures to facilitate completion of early labor at home

## 3 Improve the Support Infrastructure and Supportive Care during Labor

- Improve nursing knowledge and skill in supportive care techniques that promote comfort and coping
- Improve unit infrastructure and availability of support tools
- Improve assessment of pain and coping
- Remove staffing and documentation barriers to supportive bedside care
- Educate and empower spouses, partners, and families to provide supportive care

## 4 Encourage the Use of Doulas and Work Collaboratively to Provide Labor Support

- Integrate doulas into the birth care team
- Improve teamwork, communication, and collegial rapport between nurses and doulas in order to promote safe, patient-centered care and continuous labor support
- Develop unit guidelines to foster the delineation of roles and expectations

## 5 Utilize Best Practice Recommendations for Laboring Women with Regional Anesthesia (Epidural, Spinal, and Combined Spinal Epidural)

- Do not avoid or delay placement of epidural anesthesia as a method of reducing risk for cesarean delivery
- There is no arbitrary cervical dilation that must be met in order to administer epidural anesthesia
- The woman should be assisted in changing position at least every 20 minutes to assist necessary fetal rotation
- Allow for longer durations of the second stage of labor for women with regional anesthesia (e.g. 4 hours in nulliparous women, 3 hours in multiparous women), as long as maternal and fetal statuses remain reassuring
- Allow for passive descent when there is no urge to push (delayed pushing until there is a stronger urge to push, generally 1-2 hours after complete dilation)
- Preserve as much motor function as possible by administering the lowest concentration of epidural local anesthetic necessary to provide adequate maternal pain relief
- Turning an epidural off during the second stage of labor likely has minimal beneficial effect on the length of the second stage
- Utilize patient-controlled epidural anesthesia (PCEA) with background maintenance infusion that is intermittent or continuous (for laboring women, this is superior to PCEA alone and continuous infusion epidural)

## 6 Implement Intermittent Monitoring Policies for Low-Risk Women

- Implement policies that include a risk assessment tool, or checklist with exclusion criteria, to assist in identifying patients for which intermittent auscultation or intermittent EFM is appropriate
- Modify standing admission orders to reflect the use of intermittent auscultation or EFM as the default mode of monitoring for women who do not meet exclusion criteria
- Implement initial and ongoing training and education of all nurses and providers on intermittent auscultation and/or intermittent EFM procedures
- Provide patient education for the use of intermittent methods of monitoring and engage in shared decision making in order to determine the most appropriate method for each patient
- Ensure appropriate nurse staffing to accommodate intermittent monitoring

## 7 Implement Current Treatment and Prevention Guidelines for Potentially Modifiable Conditions

- Assess fetal presentation by 36 weeks gestation and offer external cephalic version (ECV) to patients with a singleton breech fetus
- Ensure initial training and ongoing physician competency in ECV
- Offer oral suppressive therapy at 36 weeks gestation, or within 3-4 weeks of anticipated delivery, to all women with a history of genital herpes, including those without active lesions during the current pregnancy
- A cesarean delivery need not be performed on women with a history of genital herpes but no active genital lesions at the time of labor