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
   - Provide 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, 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