The Use of a Bundle:
Promoting Spontaneous Progress in Labor Bundle
Option B
Efforts to Reduce Primary Cesarean Delivery

AIM BUNDLES

TOOLKITS

ARREST DISORDER TOOLS

Latent Labor Checklist Option A

Promoting Spontaneous Progress in Labor Option B
What is a Quality Improvement Bundle?

“A bundle is a structured way of improving the processes of care and patient outcomes: a small, straightforward set of evidence-based practices.”

— Institute for Healthcare Improvement
What is a Quality Improvement Bundle?

• All practices are “necessary” and, taken together, “sufficient” to expect improvement in patient outcomes.

• All practices are supported by high quality evidence.

• It is clear and straightforward to document when each practice is completed.

• All practices occur in a timeline that leads to being conducted in the same time frame.
# Patient Safety Bundles

## Maternal Safety Bundles

- Maternal Mental Health: Depression and Anxiety
- Maternal Venous Thromboembolism (+AIM)
- Obstetric Care for Women with Opioid Use Disorder (+AIM)
- Obstetric Hemorrhage (+AIM)
- Postpartum Care Basics for Maternal Safety: Transition From Maternity to Well-Woman Care (+AIM)
- Postpartum Care Basics for Maternal Safety: From Birth to the Comprehensive Postpartum Visit (+AIM)
- Prevention of Retained Vaginal Sponges After Birth
- Reduction of Peripartum Racial/Ethnic Disparities (+AIM)
- **Safe Reduction of Primary Cesarean Birth (+AIM)**
- Severe Hypertension in Pregnancy (+AIM)
- Support After a Severe Maternal Event (+AIM)

## Non-Obstetric Bundles

- Prevention of Surgical Site Infections After Gynecologic Surgery
Key Foundational Materials

New National Guidelines for Defining Labor Abnormalities and Management Options

Safe Reduction of Primary Cesarean Births: Supporting Intended Vaginal Births

REACHINESS
Every Patient, Provider and Facility
- Build a provider and maternity unit culture that values, promotes, and supports spontaneous onset and progress of labor and vaginal birth and understands the risks for current and future pregnancies of cesarean birth without medical indication.
- Optimize patient and family engagement in education, informed consent, and shared decision making about normal healthy labor and birth throughout the maternity care cycle.
- Adopt provider education and training techniques that develop knowledge and skills on approaches which maximize the likelihood of vaginal birth, including assessment of labor, methods to promote labor progress, labor support, pain management (both pharmacologic and non-pharmacologic), and shared decision making.

RECOGNITION AND PREVENTION
Every Patient
- Implement standardized admission criteria, triage management, education, and support for women presenting in spontaneous labor.
- Offer standardized techniques of pain management and comfort measures that promote labor progress and prevent dysfunctional labor.
- Use standardized methods in the assessment of the fetal heart rate status, including interpretation, documentation using NICHD terminology, and encourage methods that promote freedom of movement.
- Adopt protocols for timely identification of specific problems, such as herpes and breech presentation, for patients who can benefit from proactive intervention before labor to reduce the risk for cesarean birth.
“Build a provider and maternity unit culture that values, promotes, and supports spontaneous onset and normal progress of labor and vaginal birth.”
Comprehensive

- Triage, Admission Criteria
- Pain Management Options
- Fetal Assessment Options
- Protocols for Herpes, Breech

Safe Reduction of Primary Cesarean Births: Supporting Intended Vaginal Births

**READINESS**

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Fig. 3. Indications for primary cesarean delivery. (Data from Barber EL, Lundsberg LS, Belanger K, Pettke CM, Funai EF, Illuzzi JL. Indications contributing to the increasing cesarean delivery rate. Obstet Gynecol 2011;118:29–38.)
Bundles which drill down on specific drivers of Cesareans

- Promoting Progress in Labor
- Supporting Comfort and Coping in Labor
- Intermittent Auscultation
Each Bundle has 5 sections

• **Readiness**
  • *Every unit (e.g. training, equipment, policies)*

• **Risk and Appropriateness Assessment**
  • *Every patient (e.g. means of selecting women to receive the care bundle)*

• **Reliable Delivery of Appropriate Care**
  • *Every eligible patient (e.g. the care bundle)*

• **Recognition and Response**
  • *Every patient for whom risk/appropriateness changes (e.g. when and how to intervene, including how to preserve normalcy as safely possible)*

• **Reporting/Systems Learning**
  • *Every unit (e.g. monitoring compliance, effectiveness, and safety)*
Promoting Spontaneous Progress in Labor

Adapted from the American College of Nurse-Midwives Healthy Birth Initiatives...Promoting Spontaneous Progress in Labor*

Readiness

Every unit

- Has a unit policy that provides a plan of care, including allocation of space, to enable women in early labor to receive comfort measures and support and to return home prior to active labor admission when safety criteria are met and shared decision making is used to determine acceptability of plan.\(^1,2\)
- Provides initial and ongoing training and skill development for all maternity care professionals about evidence-based care practices that support maternal choice and promote spontaneous labor progress with no known risk, eg, mobility, upright positioning in first and second stage, spontaneous pushing, and continuous labor support.\(^3-7\)
- Ensures access to equipment and facilities that support maternal choice and comfort and promote spontaneous labor progress with no known risk, eg, areas for walking during labor, showers and labor tubs for hydrotherapy, music, birthing balls, birthing and squat bars.
- Establishes a common, interprofessional policy for labor care that specifies objective and evidence-based criteria for diagnosing active labor, describes the system of communication to signal that physiologic parameters of labor duration have been exceeded, and indicates triggers for considering interventions to accelerate labor, eg, oxytocin augmentation or artificial rupture of membranes.\(^8\)

Risk and Appropriateness Assessment

Every woman who may be in labor

- Has access to supportive care and information about safety and comfort measures during the latent phase of labor, eg, early labor lounge and home-based doula support.\(^1\)
- Is assessed for active labor using common objective criteria and informed of her stage of labor.\(^8\)
- Engages in shared decision making about timing of admission to the birth unit based on possible benefits and harms and the woman’s conditions, values, and preferences.\(^1,2,9\)
Progress in Labor

- **Readiness**: labor policies, tools
- **Risk assessment**: dx of active labor, admission timing
- **Reliable delivery**: only necessary interventions
- **Recognition/response**: dx of abnormal labor
- **Evaluation**: outcomes, peer review of C/S
Readiness

Every unit

- Has a unit policy that provides a plan of care, including allocation in early labor to receive comfort measures and support and to discharge labor admission when safety criteria are met and shared decisions determine acceptability of plan.¹,²
- Provides initial and ongoing training and skill development for professionals about evidence-based care practices that support spontaneous labor progress with no known risk, e.g., mobility, use of second stage, spontaneous pushing, and continuous labor support
- Ensures access to equipment and facilities that support maternal comfort measures that promote spontaneous labor progress, such as showers and labor tubs for hydrotherapy
- Establishes a common, interprofessional policy for diagnosing active labor, evidence-based criteria for diagnosing active labor, and criteria to signal that physiologic parameters of labor duration have reached the point of triggers for considering interventions to accelerate labor, e.g., on-demand artificial rupture of membranes.³

- Unit Policy and Plan of Care for Early Labor (including space)
- Training About Evidence-Based Care to Support Labor Progress (mobility, upright positioning, spontaneous pushing, labor support)
- Comfort Measures
- Interprofessional policy for diagnosing active labor, parameters for labor progress, triggers for interventions to accelerate labor
Risk and Appropriateness Assessment

Every woman who may be in labor

- Has access to supportive care and information about latent phase of labor, e.g., early labor lounge.
- Is assessed for active labor using labor.
- Engages in shared decision making about timing of admission, possible benefits and harms and the woman’s conditions.

- Supportive Care including potential Doula Care
- Assessed for Active Labor and Informed of Status
- Shared Decision-Making about timing of Admission
Every woman in active labor

- Meets established criteria for determination of active labor
- Receives care that promotes spontaneous labor progress, e.g., mobility, upright positioning, continuous labor support
- Is assessed for progress in active labor using a graphic and contemporary physiologic parameters and/or health outcomes
- Progresses spontaneously without intervention (e.g., rupture of membranes, or cesarean delivery) until evidence-based parameters are exceeded and shared decision making undertaken.
- Receives support to push spontaneously in the position of labor, minimizing or avoiding intervention
Committee on Obstetric Practice

The American College of Nurse–Midwives and the Association of Women’s Health, Obstetric and Neonatal Nurses endorse this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists’ Committee on Obstetric Practice, in collaboration with American College of Nurse–Midwives’ liaison member Tekoa L. King, CNM, MPH, and College committee members Kurt R. Wharton, MD, Jeffrey L. Ecker, MD, and Joseph R. Wax, MD.

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Approaches to Limit Intervention During Labor and Birth

**ABSTRACT:** Obstetrician–gynecologists, in collaboration with midwives, nurses, patients, and those who support them in labor, can help women meet their goals for labor and birth by using techniques that are associated with minimal interventions and high rates of patient satisfaction. Many common obstetric practices are of limited or uncertain benefit for low-risk women in spontaneous labor. For women who are in latent labor and are not
Traditional Friedman curve

![Graph showing cervical dilatation over time with phases labeled: Latent phase, Active phase, Phase of maximum slope, Deceleration phase, and Second stage. The graph plots cervical dilatation (cm) against time (h).]
Nulliparous Labor Curves from Dilatations often associated with Active Labor Onset

- 7.3 hrs (median)
- 13.7 hrs (90th %)
- 16.4 hrs (95th %)

Dilatations commonly associated with active labor onset

(Friedman, 1955, 1971, 1978)  (Zhang, Troendle et al, 2002)  (n = 1162)
(Zhang, Landy et al, 2010)  (n = 27,170)
Contemporary Labor Progress Guidelines

- Slow but progressive labor in the 1st stage should not be indication for c/s
- Cervical dilation of 6cm is threshold for active labor and standards of active labor progress should not be applied before then

Summary of Evidence Supporting New Definitions of Labor Progress
Spong et al 2012 NICHD

BOX 29-4 Definition of Prolonged Second-Stage Labor

No progress in descent or rotation for:

- 4 hours or more in nulliparous women with an epidural
- 3 hours or more in nulliparous women without an epidural
- 3 hours or more in multiparous women with an epidural
- 2 hours or more in multiparous women without an epidural

Second Stage Labor

- At least 2 hours for multiparous women
- At least 3 hours for nulliparous women
- Longer durations may be appropriate on an individualized basis...e.g. epidural, fetal malposition

Recognition and Response

• When Labor Exceeds Evidence-Based Parameters, Shared Decision Making Should Occur to Plan for Necessary Interventions

Every woman whose labor progress exceeds evidenced by
• Is informed about the status of her
• Engages in shared decision making about use of a pain
  speeding labor and its potential harms and benefits.
Decisions for Cesarean Delivery for Lack of Labor Progress

C/S for active phase arrest in 1st stage should be reserved for women

- beyond 6cm with ROM who FTP despite 4 hours of adequate ctx
- or 6 hours of oxytocin administration.
Reporting/Systems Learning

Every unit
- Documents maternity care professional practices that promote the prevention of complications related to labor and birth.
- Reports rates of interventions.
- Establishes a policy for routine, interdisciplinary review of indications of disorders related to labor progress.\textsuperscript{12}

- Documents Training
- Reports on Rates of Spontaneous Labor and Birth
- Establishes Policy for Interdisciplinary Review of CS related to labor disorders
Maternity Care TEAM: Roles in Promoting Physiologic Birth

TEAM: Common Goal, Collective Approach, Experience working with each other

Adding TEAM members:
1. Doula
2. Training of family members as an alternative
3. Providing hands-on labor support training for L&D nurses
4. “Dial-a-Doula”

Committee Opinion

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Committee on Obstetric Practice

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Nothing is Simple
Our team is here for you!

KEEP CALM AND BIRTH ON
References for Promoting Spontaneous Progress in Labor Bundle


