CMQCC
California Maternal
Quality Care Collaborative

Latent Labor Management

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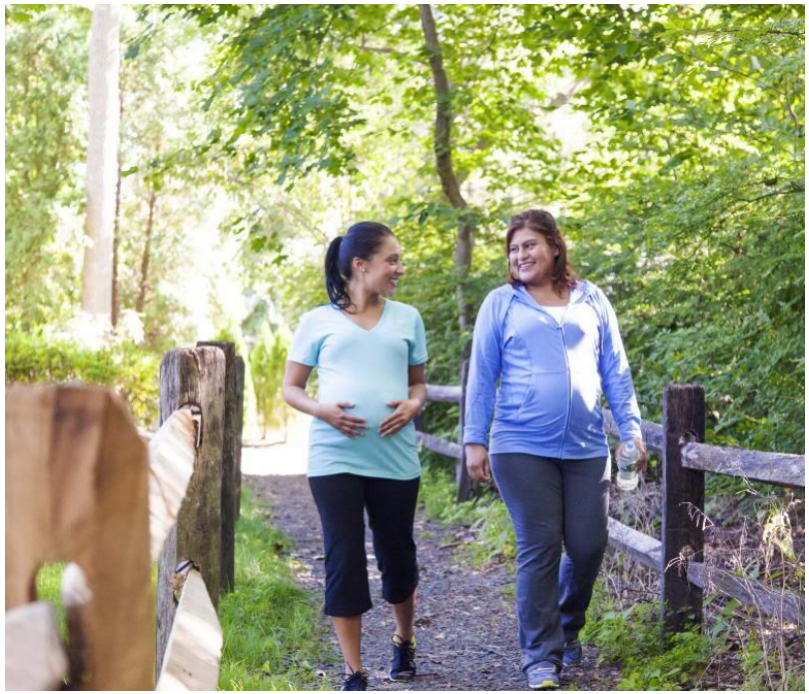
We start in latent labor

- We approach the issue of labor progress by identifying the start of labor.
- We need to use revised expectations for it's progress based on current evidence.
- No longer using Friedman's curve!



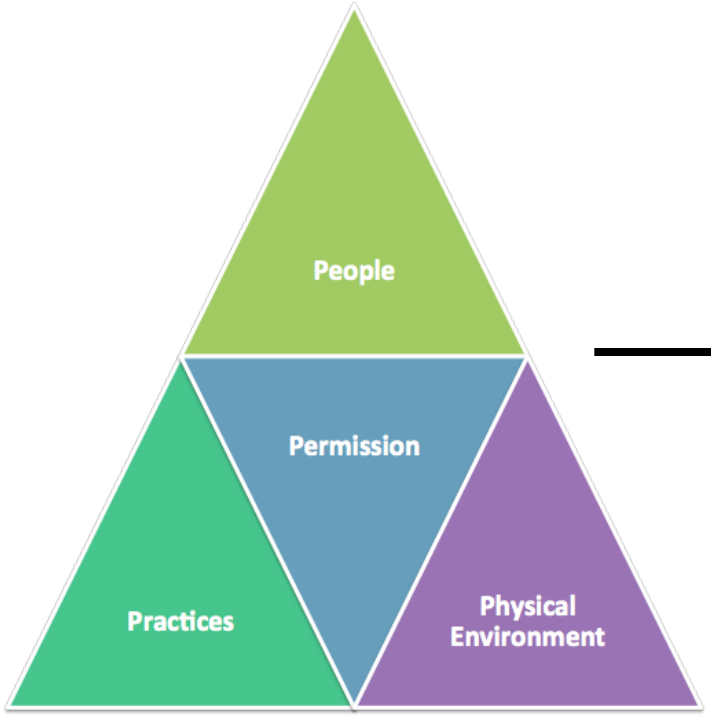
Evidence supporting this approach

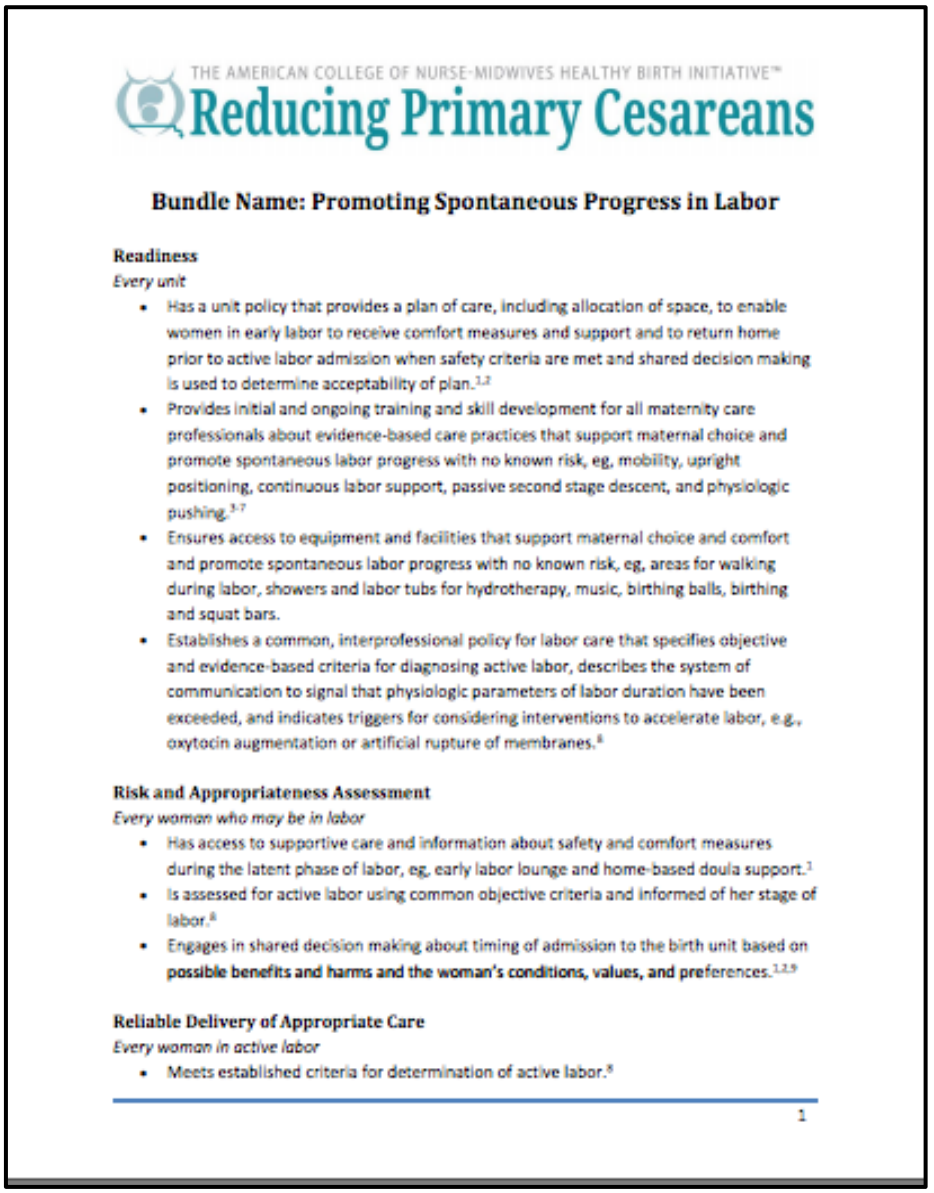
- New parameters for active labor
- Shared decision making
- Admission in active labor
- Continuous support
- Movement in labor
- Water immersion

The "4 P's" of Labor Progress

- Permission
- Physical Environment
- People
- Practices

Slide courtesy of Amy Romano





THE AMERICAN COLLEGE OF NURSE-MIDWIVES HEALTHY BIRTH INITIATIVE™

Reducing Primary Cesareans

Bundle Name: 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, continuous labor support, passive second stage descent, and physiologic pushing.[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, e.g., 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]

Reliable Delivery of Appropriate Care

Every woman in active labor

- Meets established criteria for determination of active labor.[8]

1

Hospitals/obstetric units wishing to change the culture in all 4 of these areas can implement this Quality Improvement action bundle. The bundle and supporting tools can be found at **www.birthtools.com**

Slide courtesy of Amy Romano

Permission

Promoting autonomy and mobility

"Integrative power"

- Movement/position changes
- Eat and drink
- Control lighting and ambient sound
- Wear or shed clothing
- Informed consent and refusal

Slide courtesy of Amy Romano

Physical Environment

"Sanctum" vs. "Surveillance Room"

- Promotes privacy and sense of safety
- Options for comfort and mobility
- Supports partner / family involvement

Slide courtesy of Amy Romano

People

"Guardianship" vs. "Domination"

- Trust and connectedness
- Attending to woman
- Attending to environment
- Keeping a watchful eye

Slide courtesy of Amy Romano

Practices

"Physiologic care"

vs.

"Medical Management"

- Promote, protect, and support physiologic birth
- Minimize routine interference
- Standards for diagnosing active labor and admitting

Slide courtesy of Amy Romano

Definitions

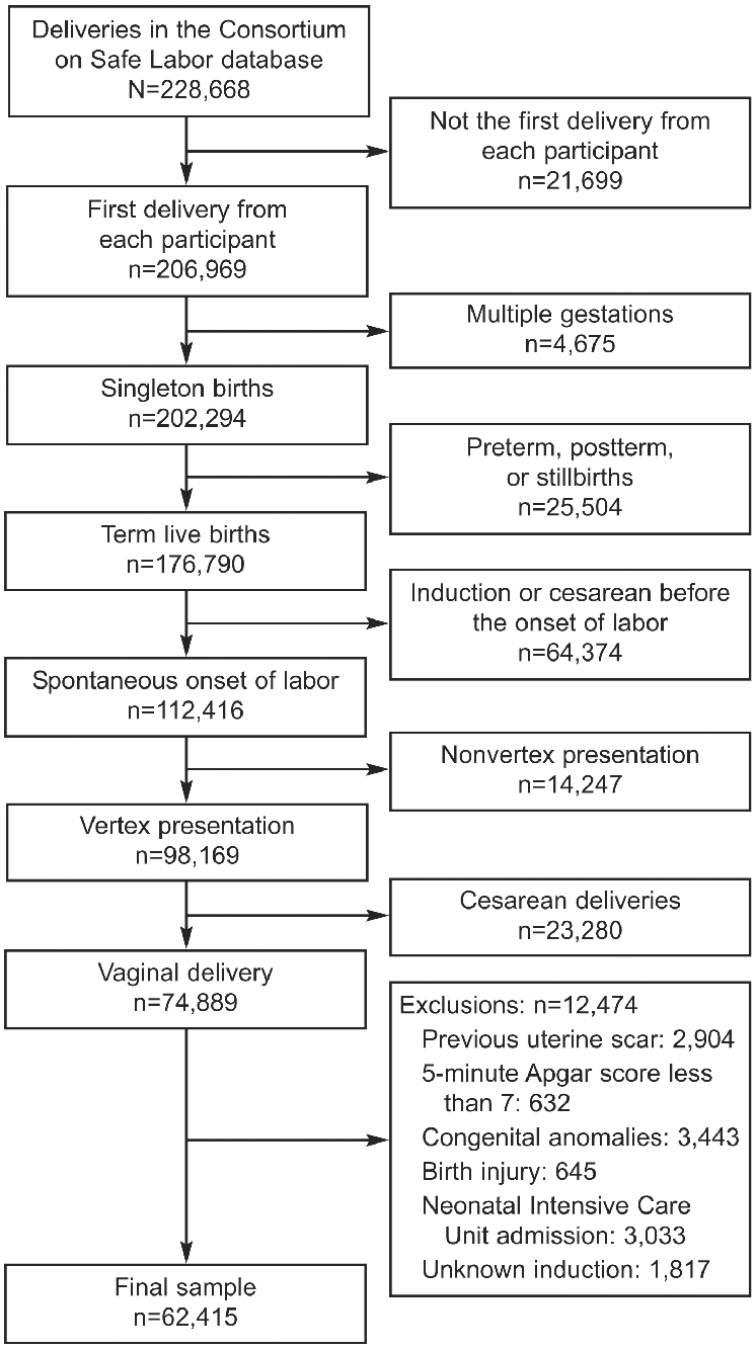
Labor: Uterine contractions resulting in cervical change (dilation and/or effacement)

Phases:

- **Latent phase** – from the onset of labor to the onset of the active phase
- **Active phase** – accelerated cervical dilation typically beginning at 6 cm

Evidence to support our activities

New parameters for active labor



Zhang- Low risk women meeting NTSV criteria

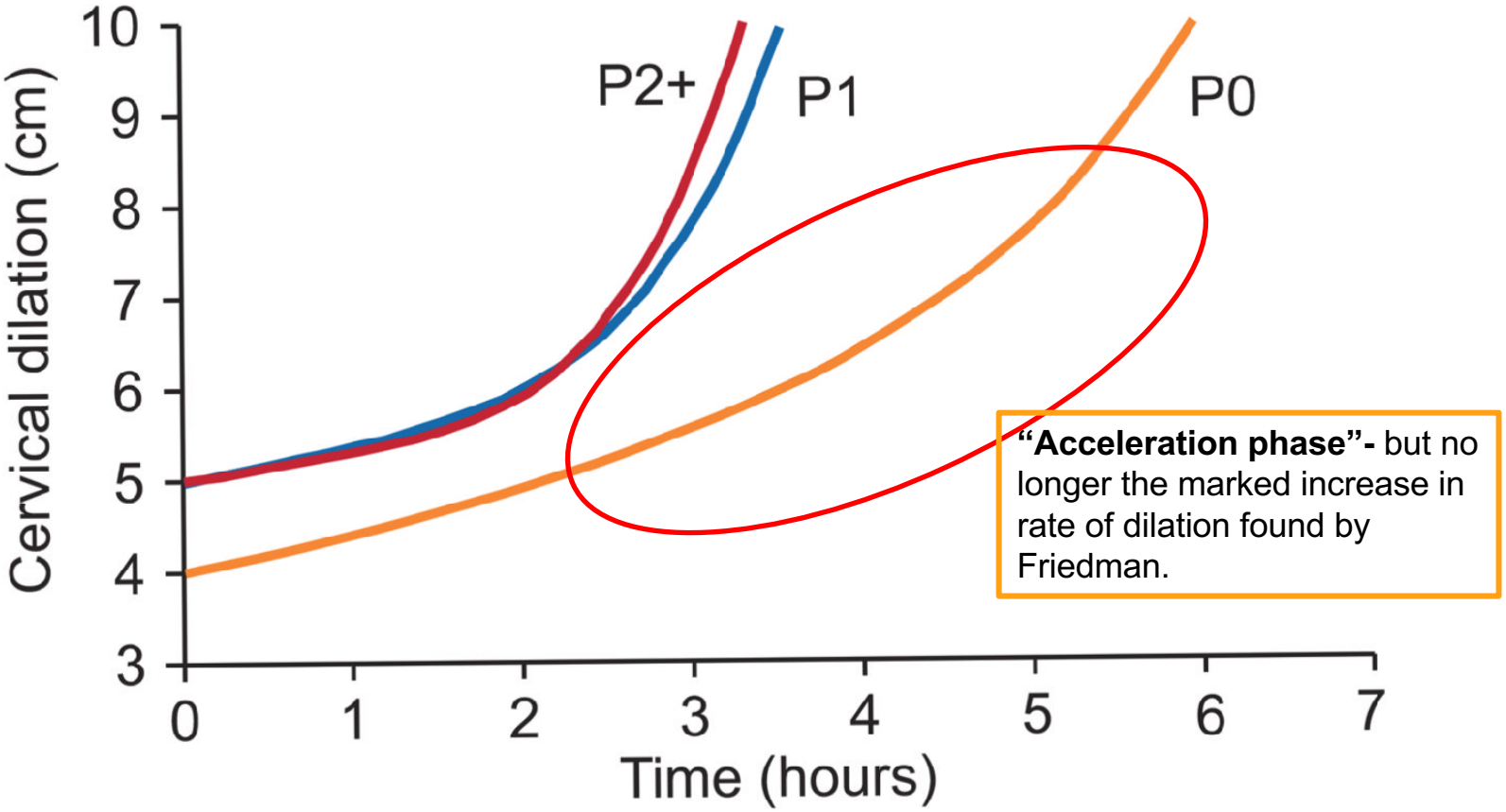
N= >62,000

Method: A repeated-measures analysis was used to construct average labor curves by parity.

Results: Labor may take over 6 hours to progress from 4 to 5 cm and Over 3 hours to progress from 5 to 6 cm of dilation.

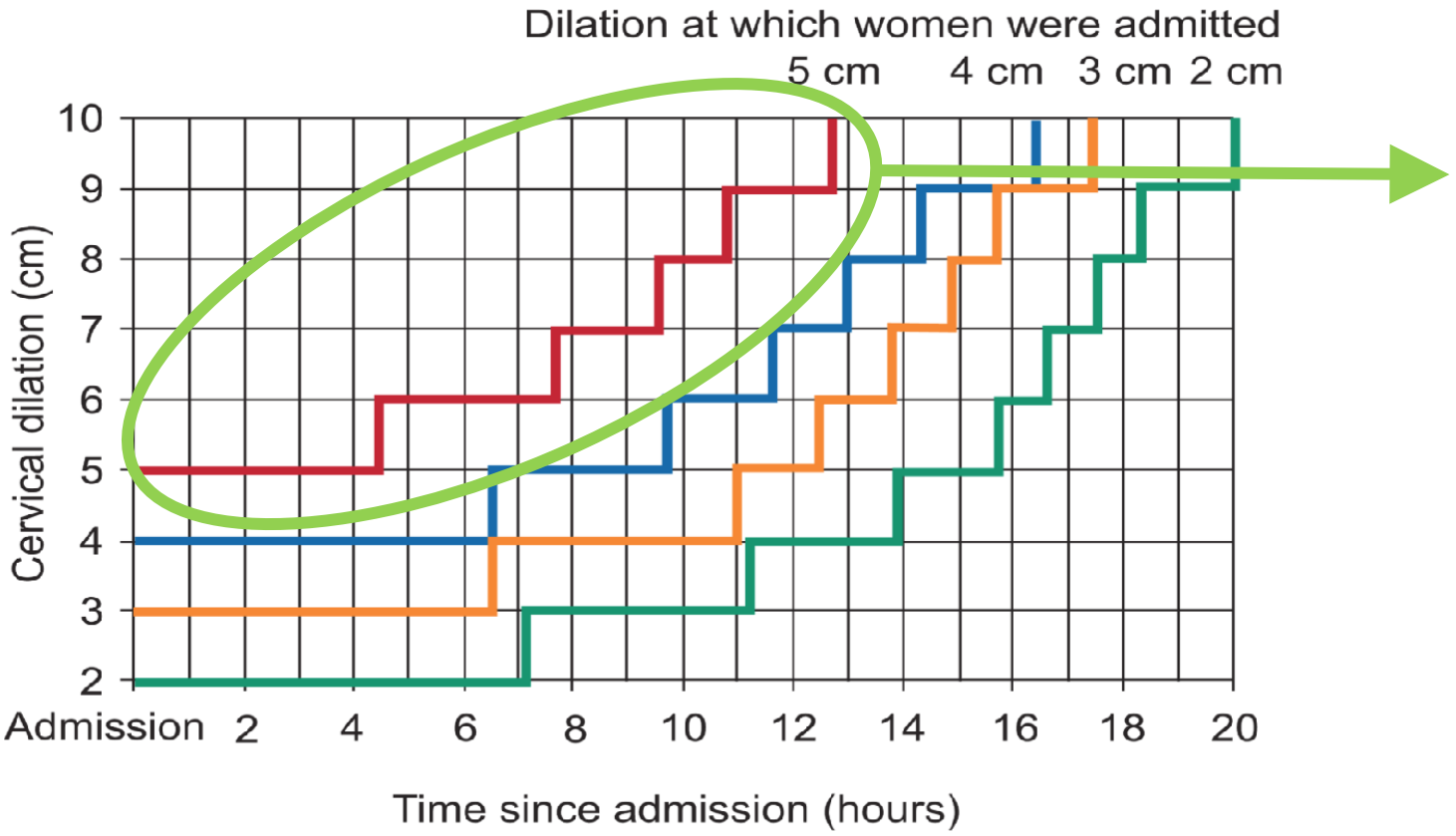
Nulliparas and multiparas appeared to progress at a similar pace before 6 cm. However, after 6 cm labor accelerated much faster in multiparas than in nulliparas.

Zhang, J. et al. (2010) Contemporary Patterns of Spontaneous Labor with Normal Neonatal Outcomes. Obstetrics and Gynecology, Vol. 116, no. 6. p 1281-1287

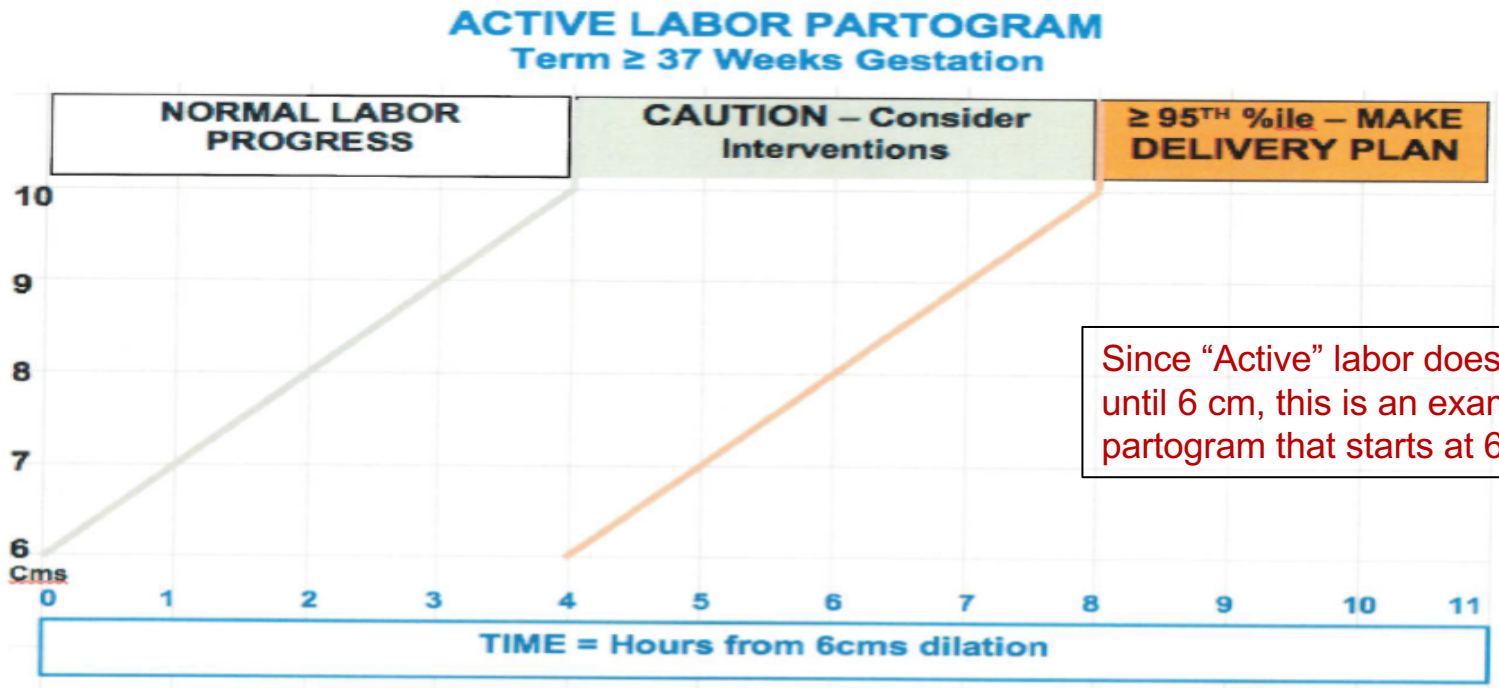


Zhang, 2010: **Figure 2.** Average labor curves by parity in singleton, term pregnancies with spontaneous onset of
labor, vaginal delivery and normal neonatal outcomes. P0: nulliparas; P1: women of parity 1; P2+: women of parity 2 or higher.

Zhang 201 Figure 3. The 95th percentiles of cumulative duration of labor from admission among singleton, term nulliparas with spontaneous onset of labor, vaginal delivery, and normal neonatal outcomes.



Admission at or after 5 cm: Lower chance of routine interventions or non-evidence based interventions



Since "Active" labor does not start until 6 cm, this is an example of a partogram that starts at 6cm

CAUTION ZONE: Consider AROM, Augmentation if not already done and no contraindication

At 6cms or more, 4 hours without cervical change is ≥ 95%ile. Successful vaginal delivery is less likely and maternal & neonatal complications increase.

Refs: Zhang J, et al. Obstet Gynecol.2010;116(6):1281-87 & Neal JL and Lowe NK. Med Hypotheses.2012;78(2):319-26

SWEDISH

Active Labor Dx

3 or more painful ctx in 10 min

AND

More than 75% effacement

AND

4-5 cm immediately preceded by more than 1 cm cervical change in less than 2 hours

OR

6 or more cm dilation

Neal JL, Lowe NK, Schorn MN, et al. Labor dystocia: A common approach to diagnosis. *J Midwifery Womens Health*. 2015;60(5):499-509. doi: 10.1111/jmwh.12360 [doi].

Evidence to support our activities

Shared decision making

Definition

Shared decision making (SDM) has been defined as a process in which decisions are shared by patients and health care providers, informed by the best evidence available and weighted according to the specific characteristics and values of the patient.

Kaimal, Anjali J. et al. Decision Making for Primary Cesarean Delivery: The Role of Patient and Provider Preferences. Seminars in Perinatology , Volume 36 , Issue 5 , 384 – 389. A review of the literature on patient and provider preferences and obstetrical decision making in the context of primary cesarean delivery, and offer recommendations for future research directions, including potential interventions that may impact the patient and provider factors affecting the primary cesarean rate.

Why use shared decision making?

"SDM recognizes the **need to support autonomy** by building good relationships, respecting both individual competence and interdependence on others[1].

"SDM is supported by evidence from 86 randomized trials showing knowledge gain by patients, more confidence in decisions, more active patient involvement, and, in many situations, informed patients elect for more conservative treatment options.[2]"

It is an active process that results in decisions where both providers and patients are confident about the decision made.

[1]Elwyn G, Frosch D, Thomson R, et al. Shared Decision Making: A Model for Clinical Practice. *Journal of General Internal Medicine*. 2012;27(10):1361-1367. doi:10.1007/s11606-012-2077-6.

Stacey D, Bennett C, Barry M, Col N, Eden K, Holmes-Rovner, M

[2]Llewellyn-Thomas, H Lyddiatt A, et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database of System- atic Reviews. 2011;as well as(10):CD001431.

SDM addresses components of 2 of the "4 P's"

People and Permission

People

"Guardianship" vs. "Domination"

Permission

Promoting autonomy and mobility

"Integrative power"

- Trust and connectedness
- Attending to woman

- Informed consent and refusal

Slide courtesy of Amy Romano

How do we facilitate this process of decision making?

3 step process

1. **Choice talk**

Step back
Offer choice
Justify choice - preferences matter
Check reaction
Defer closure

2. **Option talk**

Check knowledge
List options
Describe options – explore preferences harms and benefits
Provide patient decision support
Summarize

3. **Decision talk**

Focus on preferences
Elicit preferences
Move to a decision
Offer review

Elwyn, et al 2012

Choice talk is a *planning* step

Components of the choice talk include:

- **Step back.** Summarize and say: "Now that we have identified your concerns, it's time to think what to do next"
- **Offer choice.** "There is good information about how these treatments differ that I'd like to discuss with you."
- **Justify choice**. Emphasize:
  1) the importance of respecting individual preferences
  2) the role of uncertainty
- **Check reaction**. Choice of options may be disconcerting: some patients may express concern about going home. Suggested phrase: "Shall I tell you about the options?"
- **Defer closure**. Some patients react by asking clinicians to "tell me what to do …" We suggest that *deferring closure* if this occurs, reassuring that you are willing to support the process. Say: "I'm happy to share my views and help you get to a good decision. But before I do so, may I describe the options in more detail so that you understand what is at stake?"

Elwyn, et al 2012

Options talk

- Components of the options talk include:

- **Check knowledge.** "What do you know about early vs active labor?"
- **List options.** Home with support, medication before going home, walking and returning
- **Describe options.** Point out differences between options
- **Harm and benefits.**
- **Provide patient decision support.** May need more than one encounter
- **Summarize.** Teach back

Elwyn, et al 2012

Decision Talk

- Components of the decision talk include:

- **Focus on preferences.** Guide the patient to form preferences. Suggested phrases: "What, from your point of view, matters most to you?"
- **Elicit a preference.** Be ready with a back-up plan by offering more time or being willing to guide the patient, if they indicate that this is their wish.
- **Moving to a decision.** Try checking for the need to either *defer* a decision or *make* a decision. Suggested phrases: "Are you ready to decide?" or "Do you want more time? Do you have more questions?" "Are there more things we should discuss?"
- **Offer review**. Reviewing decisions is a good way to arrive at closure.

Elwyn, et al 2012

Evidence to support our activities

Admission in active labor

Practices

"Physiologic care"

AND/OR

"Medical Management"

- Promote, protect, and support physiologic birth
- Minimize routine interference
- Standards for diagnosing active labor and admitting

Slide courtesy of Amy Romano

Admission Before Active Labor

- Is associated with increased cesarean
- Creates potential for over-diagnosis and over-treatment
- Impacts all 4 Preventive P's
- Costs more
- May improve patient satisfaction?

Tilden EL, Lee VR, Allen AJ, Griffin EE, Caughey AB. Cost-effectiveness analysis of latent versus active labor hospital admission for medically low-risk, term women. *Birth*. 2015;42(3):219-226. doi: 10.1111/birt.12179 [doi].

Ballilt et al., 2005
Outcomes of Women Presenting in Active Versus Latent Phase of Spontaneous Labor

- 6,121 women in latent phase labor
- More latent phase women were nulliparous
- Latent phase women had more active phase arrest

Neal et al., 2012
Outcomes of Nulliparous Women With Spontaneous Labor Onset Admitted to Hospitals in Preactive vs Active Labor

- Prospective study, 216 women
- Nulliparous, absence of major complications, 37–42 weeks gestation
- Singleton, cephalic presentation
- Dilated at least 1–5 cm, intact or SROM for less than 6 hours
- Cervical exam on admission and 4 hours later

Neal et al., 2012

- Results:
  - Preactive – Didn't progress more than 0.5 cm in 4 hours
  - Active – Progressed more than 0.5 cm in 4 hours

Neal et al., 2012

Preactive Group:

- Less effaced and had higher BMIs
  - Risk of increase for cesarean birth 5% for each unit increase in BMI (e.g., 1 kg/m2)
- Had higher temperatures after amniotomy
- More likely to be augmented with oxytocin
- Average 4 hours longer labor
- More likely to give birth by cesarean
  - Same indications for cesarean

Clinical Implications: Assessment

Women admitted <4 cm dilatation are approximately twice as likely to have their labors augmented with oxytocin (high alert drug), more interventions

- Holmes P, The relationship between cervical dilatation at initial presentation in labour and subsequent intervention BJOG 2001; 108(11):1120-1124
- Mikolajczyk R. Zhang, J Early versus late admission to labor/delivery labor progress and risk of cesarean section in nulliparous women Am J Obstet 2008: 1996 (6suppl A):S49
- McNiven PS, Williams JI. An early labor assessment program: A randomized, controlled trial. Birth 1998:25 (1):5-10

Bishop Score

Score	0	1	2
Cervical dilatation (cm)	<1	1-2	3-4
Length of cervix (cm)	>2	1-2	<1
Station of presenting part (cm)	Spines -3	Spines -2	Spines -1
Consistency	Firm	Medium	Soft
Position	Posterior	Central	Anterior

Appendix M

Spontaneous Labor Algorithm

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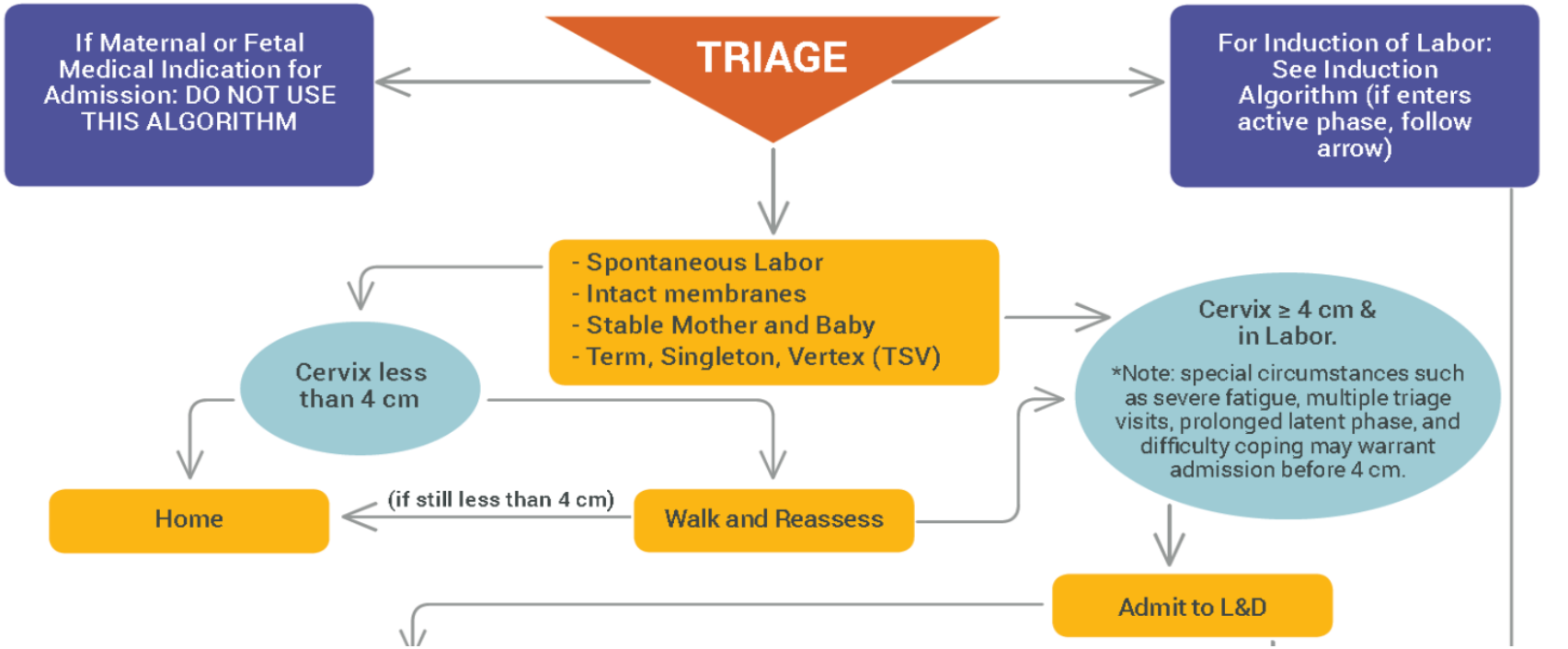


Therapeutic Rest

- Include therapeutic rest in latent labor policies
  - Administration of medication is a safe alternative to admission *(CMQCC Supporting Vaginal Birth and Reduce Primary Cesareans)*

Role of the Nurse in the OB Evaluation Unit

- The nursing interaction in the OB evaluation unit is a critical component of a woman's ability to successfully manage latent labor in the home setting
- Fear and anxiety will be reduced only if the woman feels supported and cared for
- Evaluate staffing and productivity

Other possibilities

Creating space and permission for activity BEFORE ADMISSION :

- Create a walking map with of the hospital, hospital grounds or unit with “resting stations” and activity stations
- Create a labor lounge
- Create a latent labor policy/guideline

South Shore Hospital
Julie Paul, CNM
University of Minnesota Medical Center
Carrie Neerland, MS, APRN, CNM and Becky Gams, MS, APRN, CNP

Permission

Promoting autonomy and mobility

"Integrative power"

- Movement/position changes
- Eat and drink
- Control lighting and ambient sound
- Wear or shed clothing
- Informed consent and refusal

Slide courtesy of Amy Romano

At home strategies

Slide courtesy of Amy Romano

- Assess home environment
- Movement
- Continuous support
  - Partner support,
  - Doula support
- Interventions to help women stay positive and conserve energy
  - Breathing and relaxation
  - Touch techniques and massage
  - Positions to promote comfort
  - Heat and cold therapy
  - Hydrotherapy
  - Eating and Drinking

Example of a patient teaching tool to use during shared decision making

Keep Calm and Labor On!

Know what to expect in early labor

Oh baby! You just had your first contraction.
Is this it? Should you grab your birthing bag and head out?

You may be in early labor — the phase that comes before active labor.

WHAT HAPPENS IN EARLY LABOR?[1]

- Hormonal changes continue to prepare mom and baby for birth and breastfeeding
- Pre-labor (irregular on and off contractions that occur during the last weeks of pregnancy) gradually gives way to early labor
- Contractions may start and stop several times before developing a rhythm
- Contractions generally start off mild, may last 30-45 seconds and occur every 20 minutes or so apart, then become longer, stronger and closer together
- Cervix dilates to 6 cm to prepare for childbirth as the baby moves down into your pelvis[2]
- Early labor is most often the longest phase, more than half of the total labor time

DID YOU KNOW?

The average length of early labor is 6-12 hours for first-time moms (early labor is usually shorter for experienced moms).[7]

It may even last 24 hours or more, which can be perfectly normal.

THERE ARE BENEFITS TO STAYING HOME DURING LABOR AS LONG AS POSSIBLE:

Gives you more flexibility to move freely—which can reduce the risk of medical interventions[3]

Helps increase the labor hormone, oxytocin—which allows the cervix to thin and open[4]

HOW CAN YOUR PARTNER OR DOULA SUPPORT YOU?

- Offering comfort, physical care and reassurance
- Helping time contractions – Lamaze's *Pregnancy to Parenting* app has a contraction counter
- Keeping your mind off labor with simple activities, like playing games

STAY COMFORTABLE BY[5]:

- Resting and relaxing
- Drinking plenty of fluids and eating what appeals to you
- Going for a short walk
- Moving around or changing positions
- Focusing on slow, deep breathing
- Using a warm pad or ice pack on your lower back
- Reading a good book or watching TV
- Asking your doula or partner for a gentle massage

HOW DO I KNOW WHEN TO GO?

Active labor begins when contractions are roughly 3-5 minutes apart, last 1 minute and have been that way for 1-2 hours.[6]

However, listen to your body. If you feel it's time to go to your birthing facility, follow that instinct and/or call your care provider first-especially if your water breaks.

Learn more about early labor in a Lamaze class, in-person or online, so you can be prepared!

PUSH FOR THE SAFEST, HEALTHIEST BIRTH POSSIBLE. VISIT WWW.LAMAZE.ORG/PUSHFORYOURBABY TO LEARN MORE. Lamaze International Push for your baby

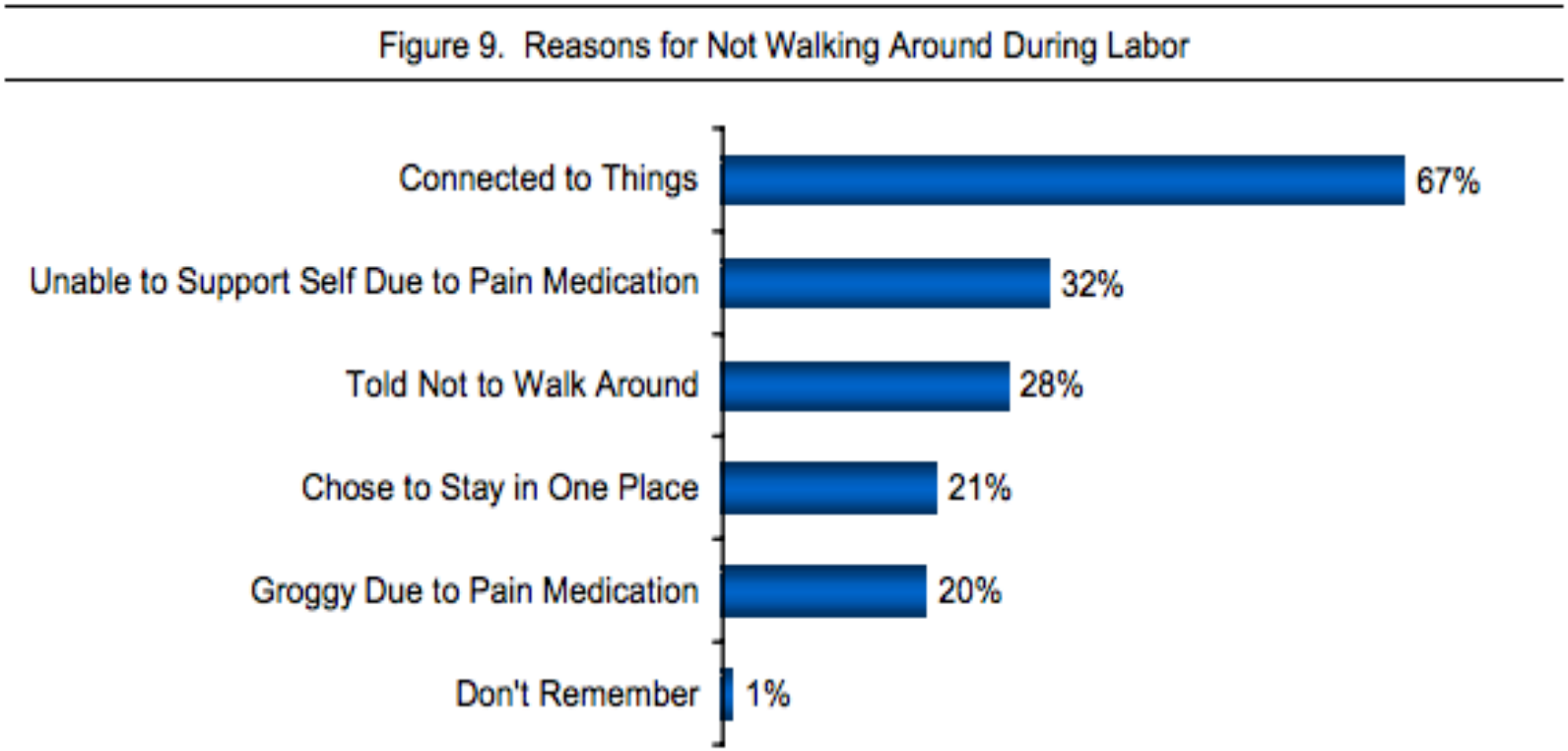
1,6 Lothian, J.A., McGrath, K. (2012., April 24). Your step-by-step guide to giving birth. [Web log post]. Retrieved from http://www.lamaze.org/StagesOfLabor
2 American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine. Safe prevention of the primary cesarean delivery. Obstetric Care Consensus No. 1. American College of Obstetricians and Gynecologists. American Journal of Obstetrics and Gynecology (2014); 123:693–711. doi: 10.1097/01.AOG.0000444441.04111.1d
3 Regan, M., McElroy, K., Iobst, S., and Lothian, J. (2015). Optimizing childbirth outcomes through adoption of healthy birth practices.

Lamaze.org/pushforyourbaby

Evidence to support our activities

Movement in labor

Why don't more women move in labor?



Declercq ER, Sakala C, Corry MP, Applebaum A, Risher P. Listening to mothers: Report of the first national U.S. survey of women's childbearing experiences. . 2002.

Benefits of Movement in Labor

"There is clear and important evidence that walking and upright positions in the first stage of labor:

- reduces the duration of labor
- the risk of caesarean birth
- the need for epidural
- does not seem to be associated with increased intervention or negative effects on mothers' and babies' well being."

Lawrence A, Lewis L, Hofmeyr GJ, Styles C. Maternal positions and mobility during first stage labour. Cochrane Database of Systematic Reviews 2013, Issue 10. Art. No.: CD003934. DOI: 10.1002/14651858.CD003934.pub4.

What we know about movement in labor

- Women who are **free to move** in labor will move
- Women who are **encouraged** to move will move even more
- Most women don't move as much **once they are admitted to the hospital**

Evidence to support our activities

Continuous support

Definition

- The term "continuous labor support" refers to non-medical care of the laboring woman throughout labor and birth by a trained person.
- Supportive care during labor may involve physical support, emotional support, comfort measures, information and advocacy.

*Caring activities should focus on support and comfort measures to assist a woman to cope with labor, e.g., freedom of movement, hydrotherapy, nutrition and hydration in labor, and use of non-pharmacologic pain management techniques.

Continuous labor support

↑ spontaneous vaginal birth

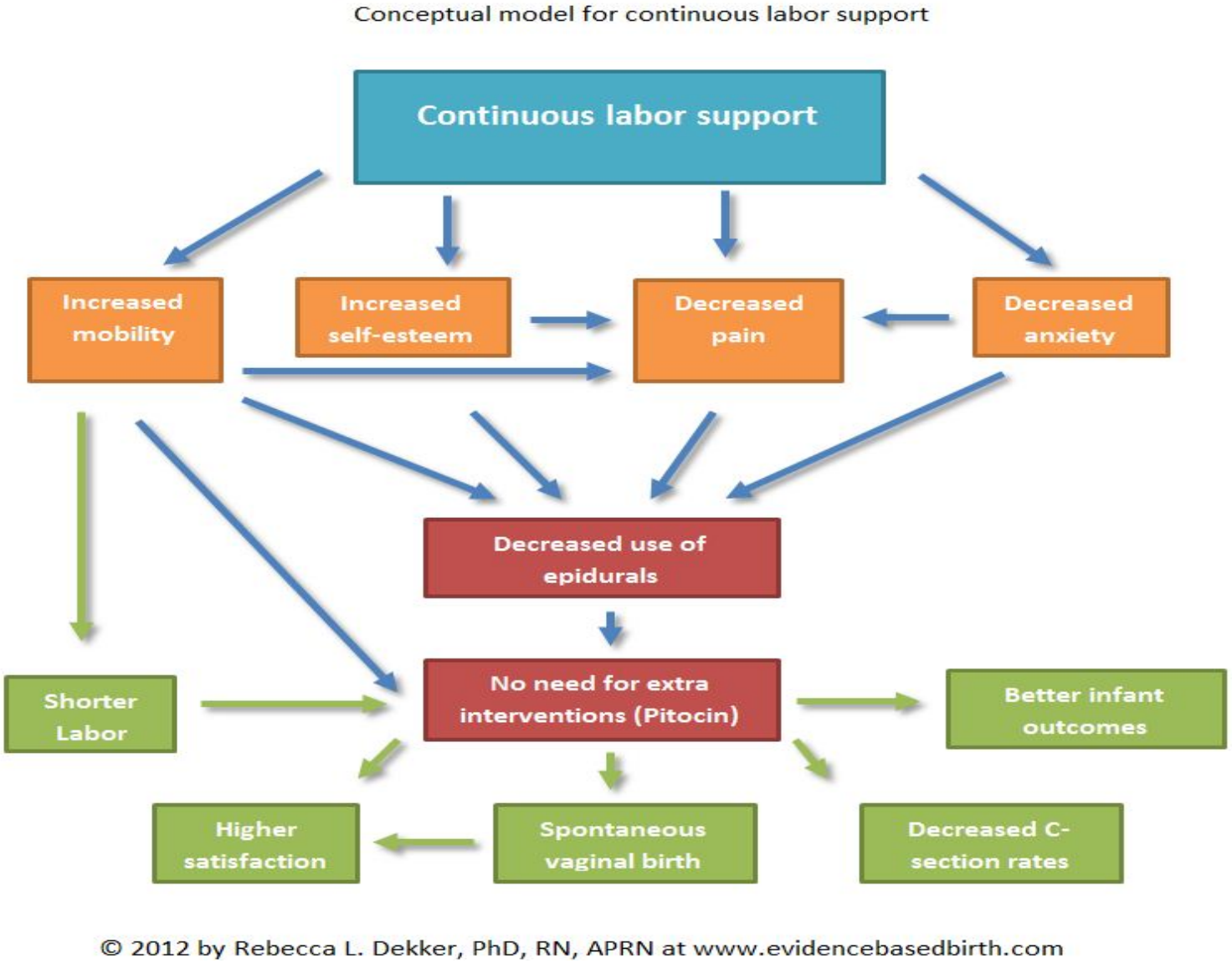
↓ length of labor

↓ intrapartum analgesia

↓ dissatisfaction

↓ low 5-minute Apgar

Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. *Cochrane Database Syst Rev*. 2013;7:CD003766. doi: 10.1002/14651858.CD003766.pub5 [doi].



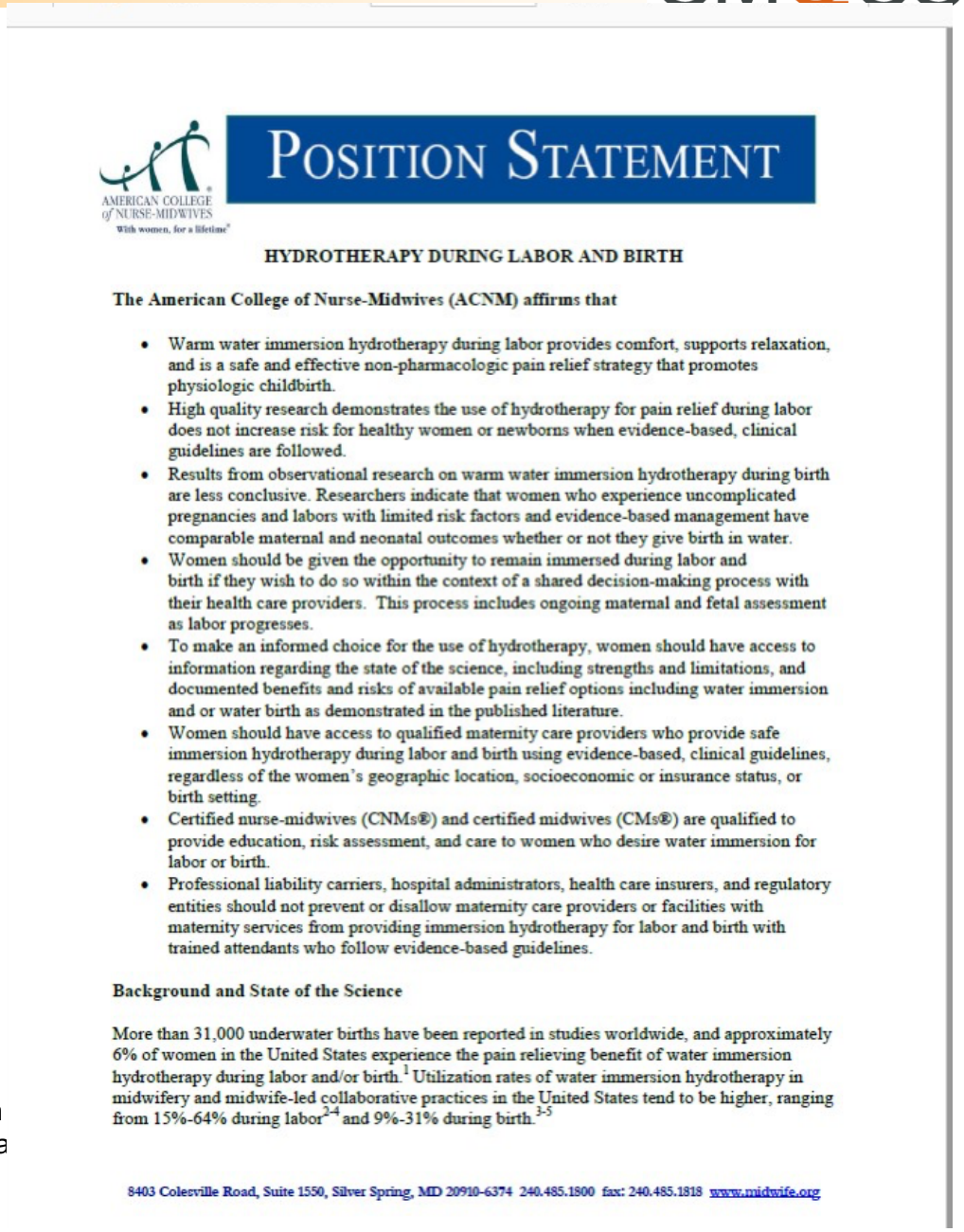
Slide courtesy of Lisa Kane Low

Evidence to support our activities

Comfort from shower or tub

Hydrotherapy

- The safety and efficacy of immersion hydrotherapy are well established for the first stage of labor. While pain relief is the only certain effect of immersion hydrotherapy in labor at this time, immersion may also hasten cervical dilation, resolve labor dystocia, and contribute to postpartum maternal satisfaction with childbirth.



AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime®

POSITION STATEMENT

HYDROTHERAPY DURING LABOR AND BIRTH

The American College of Nurse-Midwives (ACNM) affirms that

- Warm water immersion hydrotherapy during labor provides comfort, supports relaxation, and is a safe and effective non-pharmacologic pain relief strategy that promotes physiologic childbirth.
- High quality research demonstrates the use of hydrotherapy for pain relief during labor does not increase risk for healthy women or newborns when evidence-based, clinical guidelines are followed.
- Results from observational research on warm water immersion hydrotherapy during birth are less conclusive. Researchers indicate that women who experience uncomplicated pregnancies and labors with limited risk factors and evidence-based management have comparable maternal and neonatal outcomes whether or not they give birth in water.
- Women should be given the opportunity to remain immersed during labor and birth if they wish to do so within the context of a shared decision-making process with their health care providers. This process includes ongoing maternal and fetal assessment as labor progresses.
- To make an informed choice for the use of hydrotherapy, women should have access to information regarding the state of the science, including strengths and limitations, and documented benefits and risks of available pain relief options including water immersion and or water birth as demonstrated in the published literature.
- Women should have access to qualified maternity care providers who provide safe immersion hydrotherapy during labor and birth using evidence-based, clinical guidelines, regardless of the women's geographic location, socioeconomic or insurance status, or birth setting.
- Certified nurse-midwives (CNMs®) and certified midwives (CMs®) are qualified to provide education, risk assessment, and care to women who desire water immersion for labor or birth.
- Professional liability carriers, hospital administrators, health care insurers, and regulatory entities should not prevent or disallow maternity care providers or facilities with maternity services from providing immersion hydrotherapy for labor and birth with trained attendants who follow evidence-based guidelines.

Background and State of the Science

More than 31,000 underwater births have been reported in studies worldwide, and approximately 6% of women in the United States experience the pain relieving benefit of water immersion hydrotherapy during labor and/or birth.[1] Utilization rates of water immersion hydrotherapy in midwifery and midwife-led collaborative practices in the United States tend to be higher, ranging from 15%-64% during labor[2-4] and 9%-31% during birth.[3-5]

8403 Colesville Road, Suite 1550, Silver Spring, MD 20910-6374 240.485.1800 fax: 240.485.1818 www.midwife.org

Cluett E, Pickering R, Getliffe K, St. George-Saunders N. Randomised controlled trial of labouring in water compared with standard of augmentation for management of dystocia in first sta of labour. *BMJ*. 2004;328(7435): 314.
7. Cluett E, Burns E. Immersion in water in labour and birth. *Cochrane Database Syst Rev*. 2009;2:CD000111.

Patient Education

- It is OK to come in
- When to return to L&D
- Latent labor can last 20 hours
- Strategies to support delayed admission until active labor

From CMQCC's *"Supporting Vaginal Birth and Reduce Primary Cesareans"* Toolkit

- 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

Conclusion

- Supporting the progress of physiologic labor is an evidence based practice
- Nurses provide essential components of assisting women to make care decisions, provide information, facilitate physical activities that support progress of labor

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Thank You!

Recorded webinar will be available on the website at cmqcc.org

Slides will be available for CMQCC members on the SHARE site.