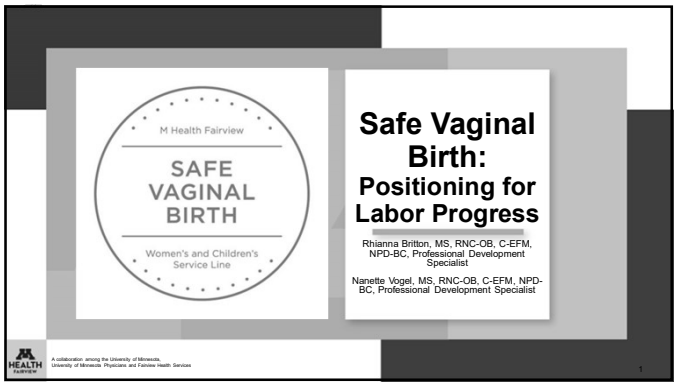
M Health Fairview
SAFE VAGINAL BIRTH
Women's and Children's Service Line
Safe Vaginal Birth:
Positioning for Labor Progress
Rhianna Britton, MS, RNC-OB, C-EFM, NPD-BC, Professional Development Specialist
Nanette Vogel, MS, RNC-OB, C-EFM, NPD-BC, Professional Development Specialist
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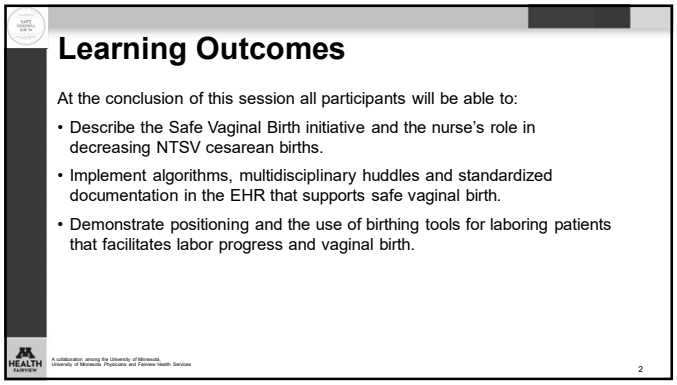
Learning Outcomes
At the conclusion of this session all participants will be able to:
• Describe the Safe Vaginal Birth initiative and the nurse's role in decreasing NTSV cesarean births.
• Implement algorithms, multidisciplinary huddles and standardized documentation in the EHR that supports safe vaginal birth.
• Demonstrate positioning and the use of birthing tools for laboring patients that facilitates labor progress and vaginal birth.
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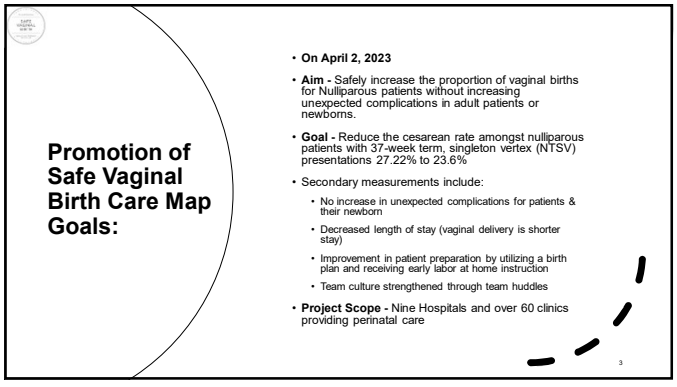
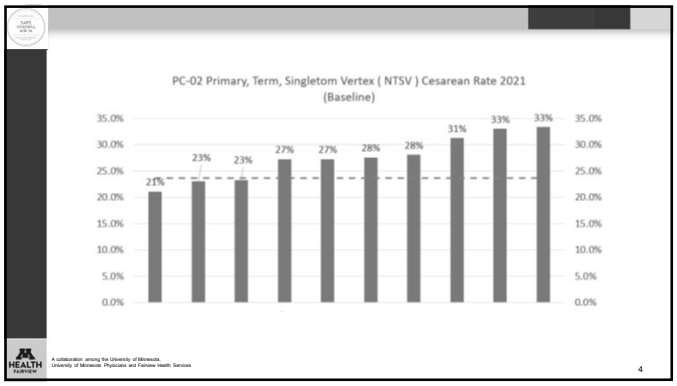

Promotion of Safe Vaginal Birth Care Map Goals:
• On April 2, 2023
• Aim - Safely increase the proportion of vaginal births for Nulliparous patients without increasing unexpected complications in adult patients or newborns.
• Goal - Reduce the cesarean rate amongst nulliparous patients with 37-week term, singleton vertex (NTSV) presentations 27.22% to 23.6%
• Secondary measurements include:
• No increase in unexpected complications for patients & their newborn
• Decreased length of stay (vaginal delivery is shorter stay)
• Improvement in patient preparation by utilizing a birth plan and receiving early labor at home instruction
• Team culture strengthened through team huddles
• Project Scope - Nine Hospitals and over 60 clinics providing perinatal care
3

3



4

Promotion of Safe Vaginal Birth Steering Team Members

Performance Dimension: Safety & Quality	**Strategy Deployment Team(s):** Optimal Care
A3 Owner: Laura France, Becky Gams	**Steering Team Members:** Dr. Rauk, Ann Forster Page, Adele Clobes, Tony Pelzel, Suzin Cho, Melissa Hasler, Mary J Johnson, Nancy Misurek, John T Smith, Rebecca Jensen, Rhianna Britton, Nanette Vogel, Jeanne Moore, Jane Sublette
A3 Coach: Jeanne Moore	

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Opportunities – Pre Implementation

- Early labor admission
- Intermittent Auscultation use
- Category 2 fetal heart rate documentation
- Documentation of team communication for Category 2 fetal heart rate tracings
- Positioning for labor progress
- Second stage labor management

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Promotion of Safe Vaginal Birth: Phases of Care

Prenatal

- Outpatient mechanical cervical ripening
- 3 NEW Pt Ed documents
  - My Labor & Birth
  - Any Day Now
  - What to expect in hospital

Admission/Triage

1. Reduce rate of latent labor admissions (<5 cm dilation)
   - Discharging patients in early labor
2. Utilize intermittent auscultation for all eligible patients
3. Arrival and triage discharge notes standardization

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Promotion of Safe Vaginal Birth: Phases of Care

1st Stage of Labor

1. Freedom of movement
   - Upright positioning & position changes
2. Minimize early amniotomy prior to 6 cm
3. Increase Intermittent Auscultation
4. Cat. 2 Algorithm use
5. Birthing tools use
   - Labor Partogram use (the new labor curve)
   - 5 Ps (position, passageway, passenger, psyche, power)

2nd Stage of Labor

1. Second stage huddle
   - Hourly documentation of station
2. Ongoing upright positioning & position changes
3. Ongoing Intermittent Auscultation
4. Ongoing Cat. 2 Algorithm use
5. Ongoing Birthing tools use
   - Labor Partogram use (the new labor curve)
   - 5 Ps (position, passageway, passenger, psyche, power)
   - Smartphrase Huddles (Cat 2 / Dystocia / 2nd Stage)

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Early Labor Admission – Why do we care?

- Patients admitted with cervical dilation greater than or equal to 4 cm were less likely to have epidural anesthesia, oxytocin augmentation, or a cesarean birth than those admitted with cervical dilation less than 4 cm (Kaufman et al. 2016)

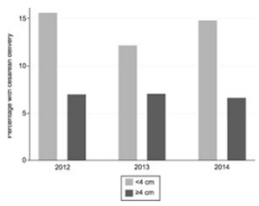

Fig. 3: Cesarean delivery rate, in percentage, by year of delivery and cervical dilation on admission. *Kauffman. Cervical Dilation on Admission and Outcome. Obstet Gynecol 2016*

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Early Labor Discharge Criteria

- Greater than 37 weeks
- Singleton
- Vertex
- Category 1 FHR
- Less than 5 cm
- Intact membranes or ruptured less than 24 hours with clear amniotic fluid
- Normotensive
- Afebrile (<100.4)
- GBS negative
- Normal fetal growth
- No serious patient health conditions
- No previous uterine scar
- Absence of vaginal bleeding
- Coping well with pain

Changes will include updated definition for active labor (6 cm), potential discharge of patient with ruptured membranes, mechanical ripening, definition of ripened cervix as a Bishop score ≥6 regardless of parity

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Intermittent Auscultation Promotion

- Pre-checked mode of monitoring on intrapartum order set
- Indications for continuous fetal monitoring when ordered
- Raising awareness of benefits and techniques for IA
- Improved hand-held doppler availability
  - Reinforced that IA is completed utilizing doppler only
- Fetal monitoring policy updated to promote IA as preferred monitoring mode

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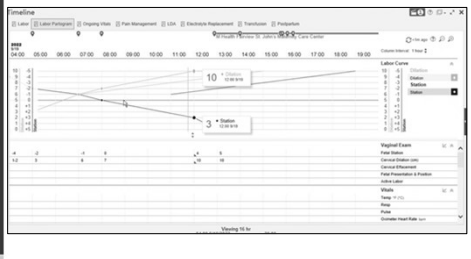
Labor Partogram



- Includes FHT documentation, meds, vaginal exams (dilation/effacement/station), vital signs, uterine activity, induction/augmentation interventions
- Provides the same view of information for providers and RNs

Zhang (2010)

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Category 2 Management

- Improve utilization of Category 2 algorithm
- Implement standardized Category 2 note
  - Nurses
  - Providers
- Promote use of Category 2 huddles

Provider: *** CNM / MD / DO was notified at *** regarding: a persistent Category II fetal heart rate tracing for *** minutes. Category II Algorithm

Fetal heart rate and uterine activity reviewed with provider.

EFM interpretation suggests: EFM Concern / Absence of Concern

Interventions to improve fetal oxygenation for a Category II tracing include

After discussion with provider:
Provider coming to bedside / Plan reassessment / Plan team huddle

Plan per provider / orders received (Optional)

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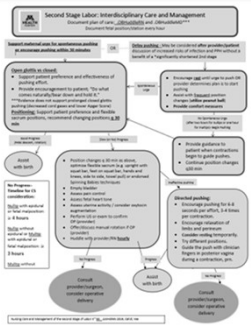
Second Stage of Labor



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One year later...

Location	Q3 Rate Jul-Sept	Q4 Rate Oct-Dec	2024 Jan-Feb	Change in Rate Q4 to Jan/Feb
Hospital 1	30.4%	28.1%	36.51%	8.41%
Hospital 2	25.8%	25.5%	31.94%	6.44%
Hospital 3	37.3%	25%	34.48%	9.48%
Hospital 4	47.9%	35%	37.5%	2.5%
Hospital 5	30.7%	37%	22.22%☆	14.8% ☆
Hospital 6	29.4%	21.9% ☆	25.81%	3.91%
Hospital 7	29.1%	27.7%	23.53%☆	4.17%
Hospital 8	26.7%	21.7% ☆	33.33%☆	11.63%
Hospital 9	42.2%	46.2%	16.67%	29.53% ☆
System	29.1%	27.67%	28.59%☆	.92%

Goal - Primary Cesareans (PC-02) **Target=23.6%**

2023 rate decreased in quarter 2 and 3 for a System Rate at the end of **Q4 = 27.67%** to end the year

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"5 Ps"

How do you as a nurse promote physiological birth?

16

The 5 Ps Include

Let's take a look at how impacting the 5Ps can positive influence labor progress

Psyche
Power
Passageway
Passenger
Position

17

Psyche

- Birth preparation
- Patient education
  - In the prenatal period and continuing throughout all phases of care
- Empowering our patients to complete early labor at home

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The 5 Ps

- Psyche
- **Power**
- Passageway
- Passenger
- Position

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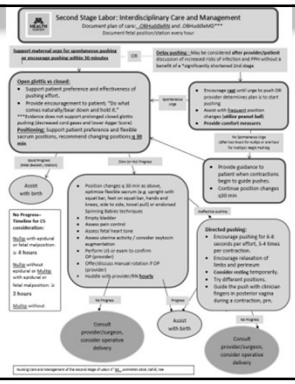
Power of Labor



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The 5 Ps

- Psyche
- Power
- **Passageway**
- Passenger
- Position

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Passageway

Bones- Gynecoid, Android, Anthropoid and Platypelloid pelvises

Joints- Pubic symphysis, sacroiliac joints, sacrococcygeal joint

Soft Tissues- Pelvic floor, psoas muscle, piriformis muscle, broad ligament, round ligament, sacroiliac ligament, sacrotuberous ligament, uterosacral ligament, pubocervical ligaments, cardinal ligaments, fascia

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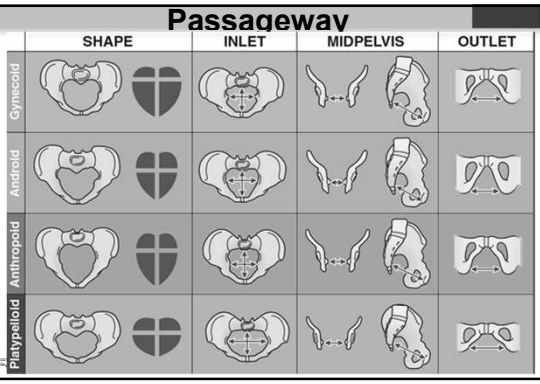
Passageway



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The 5 Ps

- Psyche
- Power
- Passageway
- **Passenger**
- Position

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Passenger

Bony plates

Fontanels

Sutures

Where is the fetal occiput?

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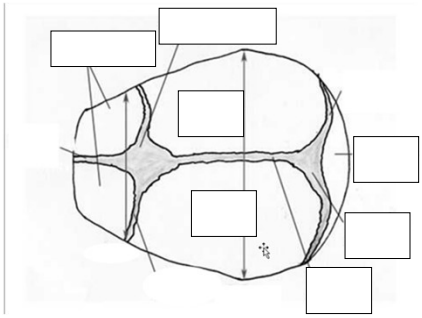
PASSENGER



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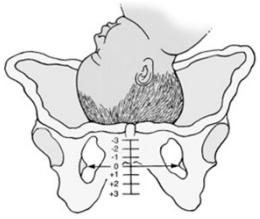
Fetal Station

- Inlet (top of pelvis)
  - Goal - head puts pressure on cervix
  - Rotation to LOA or ROA position is easiest as baby is not engaged
- Mid-Pelvis (middle of pelvis near ischial spines)
  - Goal - baby passes through ischial spines
  - Positions focus on increasing this narrow space
- Outlet (bottom of pelvis)
  - Goal - open the bottom of the pelvis
  - Manipulate the top of the pelvis to cause the bottom to open



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The 5 Ps

- Psyche
- Power
- Passageway
- Passenger
- **Position**

28

Why don't patients walk around?

What is the practice at your site?

29

Mobility is treated as an intervention. Let's flip the script and treat lying in bed as the intervention.

30

Physiologic Positions for each level of the Pelvis

- **Inlet**: -2, -3, -4
- **Mid-pelvis**: -1, 0, +1
- **Outlet:** +2, +3, +4

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Physiologic Positions

Inlet (-2, -3, -4)

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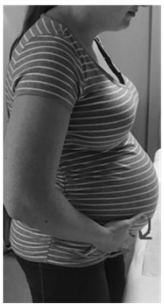
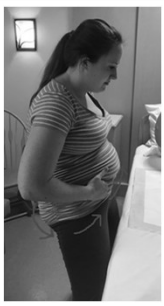
Abdominal Tuck & Lift

Abdominal Abdominal Lift and Tuck





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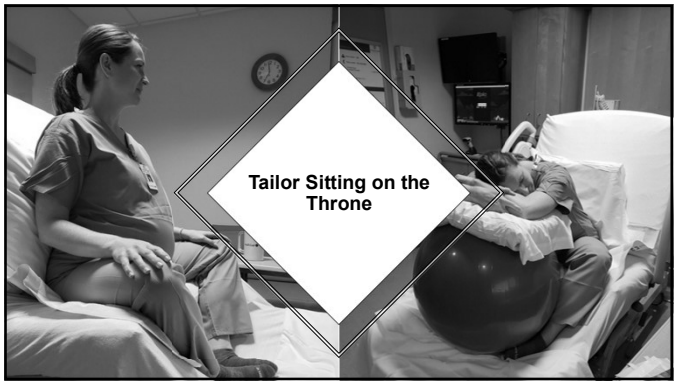
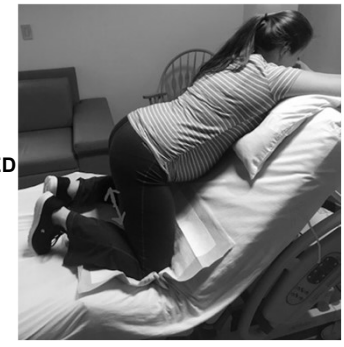


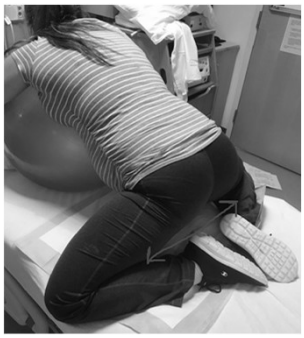
35

EXTERNAL ROTATION
LEANING OVER BACK OF BED



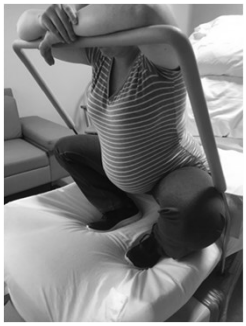
36

EXTERNAL ROTATION WITH BIRTH BALL



37

MODIFIED DANGLE WITH SQUAT BAR



38

STANDING WITH EXTERNAL ROTATION OF THE FEMUR

39

MODIFIED LUNGE IN THE TUB

40

TAILOR SITTING
IN THE TUB

41

EXTERNAL ROTATION
FORWARD LEANING OVER TUB

42

POSTERIOR PELVIC TILT

43

SIDE-LYING WITH EXTERNAL ROTATION USING PEANUT BALL

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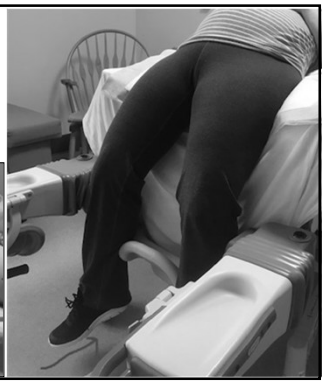
FLYING COWGIRL

www.spinningbabies.com/pregnancy-birth/techniques/other-techniques/flying-cowgirl/

45

45

WALCHERS



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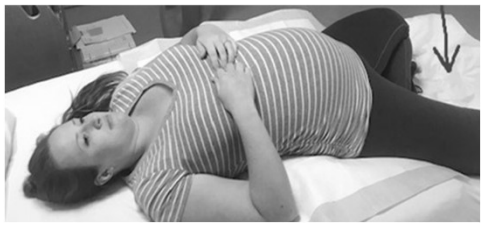

FROGGY WALCHERS

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Physiologic Positions

Mid-Pelvis (-1, 0, +1)

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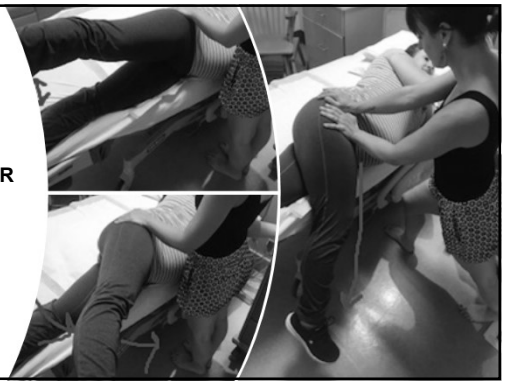
PELVIC FLOOR RELEASE



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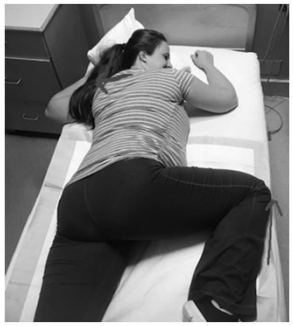
LUNGES

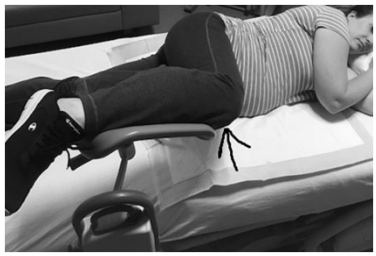
50

“RUNNING MAN”



51

SIDE-LYING USING STIRRUPS



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SIDE-LYING WITH INTERNAL ROTATION USING PEANUT BALL

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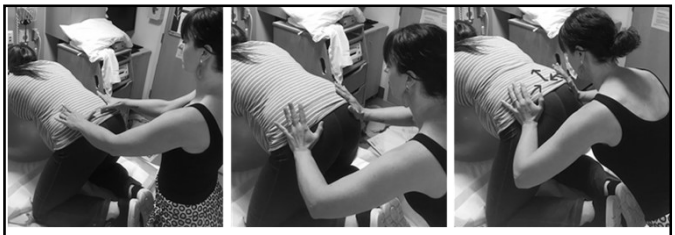
INTERNAL ROTATION WITH PEANUT BALL

54

STANDING WITH INTERNAL ROTATION

55

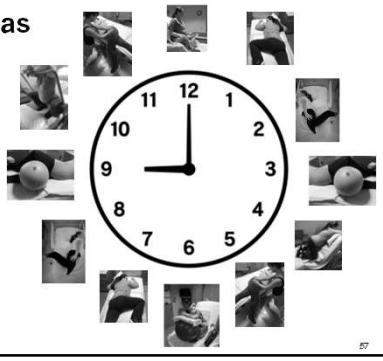


PELVIC PRESS

56

But my Patient has an Epidural

- For patients who are in bed (epidural) and the fetus is at the inlet or mid-pelvis, there are a multitude of positions (other than right and left) to facilitate labor progress and descent
- We like to refer to this as **Bed Gymnastics!**



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Physiologic Positions

Outlet (+2, +3, +4)

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How does the patient position change the pelvic outlet?

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Pushing Positions

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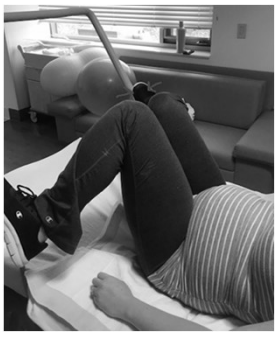
PUSHING WITH ANTERIOR PELVIC TILT

61

DOUBLE HIP SQUEEZE
*** GOOD FOR OUTLET WORK

62



PUSHING WITH INTERNAL ROTATION USING SQUAT BAR

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SQUATTING BAR

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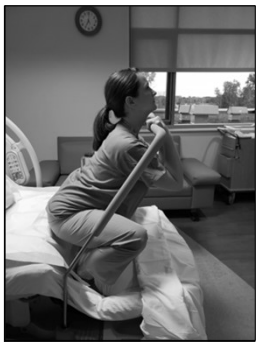

ANTERIOR PELVIC TILT WITH SQUATTING BAR

65

Tools to Support Labor Positioning

- Bony Pelvis
- Soft baby
- Squat bars/Birth stools/Peanut balls
- Position "Menu" for patient education

66

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3 Simple Take-aways

- Position the patient based on the fetal station and position
- Knees apart = opens pelvic inlet
  - Baby enters pelvis and begins descent
- Ankles together = opens pelvic outlet
  - Allows continued rotation and descent

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Where are we now?

- Intermittent Auscultation Provided rate= 44%
- OB Triage Nurse Note Compliance rate= 28.1 %
- Position Change Count (second stage) per hour, Median=2, Mean=3.45
- Active Labor Indicated rate= 28%
- Stage 2 Huddle Nurse Note Compliance = 1.2%

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Conclusion

- The goal of this project is to reduce cesarean births and promote safe vaginal birth. While not every patient situation is going to allow for a vaginal birth, our goal is to change the culture on the unit to encourage early labor at home, promote upright positioning, intermittent auscultation and enhanced bedside presence to the laboring patient
- A commitment can be made by the multi-disciplinary team including providers, nurses and operations leaders to implement these best practices making this model of care the standard and priority to improve patient and fetal outcomes

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A Special Thank You to:

- Amber Tharp (the awesome pregnant person in our pictures) for demonstrating positions to optimize Safe Vaginal Birth.
- And Elizabeth Hursh (Woodwinds Birthplace RN) for being the support person in our pictures, for providing content for this presentation, and for educating us, her colleagues and her patients about optimal positions for birth. Your advocacy and passion for birth makes a significant difference in people's lives.

70

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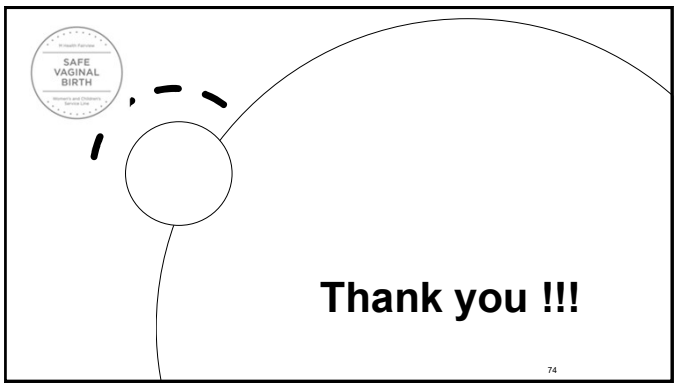

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