

Title:

Barriers to the Implementation of Mobility and Upright Positioning During the First Stage of Labor

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References:

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Abstract Summary:

This review investigated barriers to the implementation of mobility and upright positioning during the first stage of labor. Barriers presented in recent literature centered around two themes: 1) medicalization of birth and 2) lack of education and professional consensus on the benefits of mobility during labor.

Learning Activity:

| LEARNING OBJECTIVES | EXPANDED CONTENT OUTLINE |
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| The learner will be able to identify current barriers to mobility and upright positioning during the first stage of labor in hospital settings. | The learner will be educated on the medicalization of birth and lack of patient education/professional consensus on the benefits of mobility during labor. |
| The learner will be able to identify methods by which nurses can help patients and other staff overcome these barriers. | The learner will be educated on promoting spontaneous birth, helping reduce cesarean deliveries, improving interdisciplinary communication, and facilitating lateral integration of care. |

Abstract Text:

Background and Significance

Although recent research has made a strong case for normalizing labor and birth, a dissonance continues to exist between the evidence and actual obstetric clinical practices in many hospital settings. For instance, traditionally, many women have labored in mobile and upright positions, especially during the first stage of labor. Yet, many women today who choose to give birth in a hospital setting remain in their bed, are restricted in their movement, and remain in recumbent positions throughout the majority of their labor and birth experience. This is problematic considering that mobility and upright positioning during labor have been shown to decrease the length of the first stage of labor, the need for epidural analgesia and other pharmacological pain relief, and the risk for cesarean delivery, all of which can increase the risk of both maternal and infant morbidity and mortality. Thus, this project aims to determine the factors in a hospital setting that serve as barriers to implementation of mobility and upright positioning during the first stage of labor.

Evidence Review

A literature search was conducted on EBSCOhost Interface using the MEDLINE and Cumulative Index to Nursing and Allied Health Literature (CINAHL) databases to summarize the recent literature on the use of mobility and upright positioning during the first stage of labor. After the application of inclusion and exclusion factors, seven final articles remained. The five quantitative articles included in this review only briefly or indirectly discussed barriers. One article indirectly mentioned barriers in the discussion section and one article directly addressed barriers, but did not discuss them in depth. In two of the articles, barriers were inferred within the underlying purpose of the study and in one article, barriers were inferred through the outcomes of the study. The two qualitative articles included in this review were excellent in directly identifying barriers.

The barriers that were addressed within recent literature on this topic centered on two themes: 1) the over-medicalization of birth and 2) lack of education and consensus on the benefits of mobility during labor. Six of the seven articles in this review identified at least one barrier that related to the over-medicalization of birth, citing electronic fetal monitoring, maternal obesity, and use of epidural analgesia as reasons for the lack of mobilization women experience during labor. Three of the seven articles in this review identified a barrier relating to lack of consensus on the benefits of mobility in labor or a lack of education on the topic, both within healthcare professionals and patients. For instance, one article identified that nurses believed aiding patients with mobility and repositioning put them at an increased risk for injury. If nurses believe that a certain action can cause injury to them, it can be inferred that this would decrease the frequency of this action.

Implications for Nursing Practice

Nurses need to help create a culture of support for physiologic birth, establish interdisciplinary teams to achieve specified goals, and collect and analyze data to show evidence of outcome improvement. Doing so will hopefully help reduce use of EFM, use of epidural analgesia, maternal obesity, and intralabor complications, thus increasing the implementation of mobility and upright positioning during the second stage of labor. Considering that mobility during labor can decrease length of labor and that one of the main indications used for cesarean sections is labor dystocia, cesarean section rates may be decreased through these efforts as well.

In order to create a culture of support for spontaneous birth, educational programs should be created to assure that all labor and delivery nurses are knowledgeable in the proper techniques to aid with mobility and repositioning during labor, especially with obese patients. By encouraging safe and ergonomic methods for nurses to assist with mobility and repositioning during labor, nurses may be less likely to see this intervention as a risk of injury, thus reducing that barrier. Nurses should also be adequately trained in low-intervention methods of caring for women during labor and in the benefits of mobility and upright positioning during labor. With that being said, many of these methods require adequate staffing, thus these types of changes must be supported by administration and the overall mission of the facility/hospital.

Furthermore, unit meetings or daily huddles should also be modified to include time for nurses to share methods that have been working for them and what specific barriers they have faced. This may unearth further modifications to the educational programs that need to be made as well as further encourage a culture of mobility and repositioning during labor. In order to assure continuity of the above education, however, there must also be buy-in from hospital administration so that a sufficient amount of funds are provided for educational workshops, mobility aids, and equipment that nurses can utilize to meet each patient's individual needs.

An interdisciplinary team of nurses, physicians, midwives, and anesthesiologists should also be created and tasked with creating specific policies and procedures that standardize fetal heart rate interpretation. They should clarify which patients and patient conditions warrant the use of EFM as a means to decrease overuse of this intervention and redefine anesthesia informed consent protocols to assure that patients are first educated on and provided with adequate opportunities for non-pharmacologic approaches to pain management. Only once other options have been fully expended should the patient be presented with the option for epidural analgesia, as long as the informed consent protocol assures the patient is truly educated on the negative outcomes that could result from the use of this intervention (i.e. lack of mobility and positioning, increased length of labor, etc.). Lastly, guidelines should be prepared to aid nurses and other healthcare staff in how to support "best possible care" of obese patients as opposed to "normal" birth due to the unique complications common in this patient population.

Once the aforementioned interdisciplinary team has completed writing their assigned policies, procedures, and protocols, they could transition into serving as an interdisciplinary communication team. Led by nurses, this team would meet regularly to discuss hospital- and unit-specific barriers to mobility and upright positioning during labor. These meetings would allow the team to track progress with the implemented interventions and make adjustments as needed. This could specifically help continue to decrease the barrier of lack of education and consensus on the benefits of mobility during labor.

Nurse-led lateral integration of care could help assure that care across the spectrum of a pregnant woman's experience is patient-centered and focused on shared decision-making. For instance, a clinical nurse leader could be tasked with establishing connections with offices that provide prenatal care or primary care to their patient population, educate them on the benefits and techniques of mobility during labor, and offer classes to their patients that educated them on their choices regarding mobility and positioning during labor. This same information and education could be provided to patients who visit the hospital's center for advanced fetal care and similar facilities in or near the hospital. The clinical nurse leader would also assure that in labor and delivery triage, education about and support of mobility is maintained.

As a woman moves from triage to the labor and delivery unit, the clinical nurse leader would then assure that this woman receives as continuous of labor support as possible. This is of increased importance because continuous labor support, which often includes non-pharmacologic methods such as mobility and upright positioning, can promote spontaneous labor, decrease analgesia use, and decrease cesarean delivery. Nurses engaging in continuous labor support should encourage women's choice of positions during labor, provide advice as to how to implement different positioning and mobility options, and reasonably discourage anything that may limit a woman's access to positions they find comfortable. With these multiple opportunities for education and the consistency of care provided across the spectrum, patients would likely be more empowered to engage in shared decision-making and communicate their personal values and choices during their labor. This engagement, in turn, can promote positive health outcomes and improve patient satisfaction.

Summary and Conclusions

It is clear from the diversity of studies included in this review that barriers to mobility and upright positioning during the first stage of labor are multifaceted. Furthermore, since many of the themes that emerged spanned across countries and research methodologies, it can be assumed that many of the barriers present in today's healthcare systems may be universal across the U.S. and its peer countries. With that being said, more research in this area is direly needed. The literature supports the safety and benefits of this intervention and yet, this is not reflected in practice. If we are to solve this problem, we must first determine where the source of the problem is. Lastly, nursing could greatly benefit from research that investigates the way we structure nursing school curriculum and how this impacts use of low-tech interventions, such as mobility and upright positioning, during labor.