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EXPERT OPINION

National Partnership for Maternal Safety: Consensus Bundle on Safe Reduction of Primary Cesarean Births—Supporting Intended Vaginal Births

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ABSTRACT

Cesarean births and associated morbidity and mortality have reached near epidemic proportions. The National Partnership for Maternal Safety under the guidance of the Council on Patient Safety in Women's Health Care responded by developing a patient safety bundle to reduce the number of primary cesarean births. Safety bundles outline critical practices to implement in every maternity unit. This National Partnership for Maternity Safety bundle, as with other bundles, is organized into four domains: *Readiness, Recognition and Prevention, Response,* and *Reporting and Systems Learning*. Bundle components may be adapted to individual facilities, but standardization within an institution is advised. Evidence-based resources and recommendations are provided to assist implementation.

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Currently one in three women in the United States gives birth surgically (Martin, Hamilton, & Osterman, 2014), and this high cesarean birth rate can be viewed as a significant maternal health safety issue. Cesarean birth has short-term complications, including blood loss, infection, and venous thrombosis (Bauserman et al., 2015), and long-term effects in subsequent pregnancies and births, including abnormal placentation and increased risk of hemorrhage and hysterectomy (Bauserman et al., 2015; Marshall, Fu, Guise, 2011). Although appropriate intervention with cesarean birth can save the lives of women and newborns, overuse can be viewed as a significant maternal safety issue.

Seeing unnecessary cesarean birth as a preventable cause of maternal morbidity and mortality and reduction of cesarean birth rates as an important strategy to improve women's health, a workgroup of the National Partnership for Maternal Safety within the Council on Patient Safety in Women's Health Care was appointed in April 2015 to address the high cesarean birth rate in the United States. The members of the workgroup, who represent women's health care professional organizations, including the American Academy of Family Physicians, the American College of Nurse-Midwives (ACNM), the American College of Obstetricians and Gynecologists (ACOG), the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), and consumers through the National Partnership for Women and Families, developed a safety bundle of actions focused on lowering the primary cesarean birth rate and improving care to increase the opportunity for a vaginal birth in the hospital setting (Table 1).

Effective initiatives to reduce cesarean birth rates have been described in the literature and include a variety of clinical models, team-based care, and application of new recommendations for labor management. Achievement of the goal to reduce cesarean births was demonstrated by several authors in a wide range of clinical settings

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Table 1: Safe Reduction of Primary Cesarean Births: Supporting Intended Vaginal Births

Readiness

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 nonpharmacologic), 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.

Response

To Every Labor Challenge

- Have available an in-house maternity care provider or alternative coverage which guarantees timely and effective responses to labor problems.
- Uphold standardized induction scheduling to ensure proper selection and preparation of women undergoing induction.
- Utilize standardized evidence-based labor algorithms, policies, and techniques, which allow for prompt recognition and treatment of dystocia.
- Adopt policies that outline standard responses to abnormal fetal heart rate patterns and uterine activity.
- Make available special expertise and techniques to lessen the need for abdominal delivery, such as breech version, instrumented delivery, and twin delivery protocols.

Reporting/Systems Learning

Every Birth Facility

- Track and report labor and cesarean measures in sufficient detail to: 1) compare to similar institutions, 2) conduct case review and system analysis to drive care improvement, and 3) assess individual provider performance.
- Track appropriate metrics and balancing measures, which assess maternal and newborn outcomes resulting from changes in labor management strategies to ensure safety.

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(Chaillet & Dumont, 2007). Specific approaches included the use of multidisciplinary teams of physicians and midwives who provide hospitalist coverage and the use of standardized clinical protocols based on current labor management guidelines that redefine active labor and expectation of labor progress (ACOG & Society for Maternal-Fetal Medicine [SMFM], 2014; Spong, Berghella, Wenstrom, Mercer, Saade, 2012). Much of the focus has been on lowering first-time cesarean births, particularly for those women with single fetuses in vertex presentation, because this group accounts for downstream increased morbidity in subsequent pregnancies and approaches to these are different than preventing the first cesarean birth in multiparous women (ACOG & SMFM, 2014). Continuous labor support has positively affected primary cesarean

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