

Practice Guidelines

Safe Reduction of Primary Cesarean Births: National Partnership for Maternal Safety Releases Consensus Bundle

Key Points for Practice

- Health systems should ensure that staff know the value of attaining vaginal birth and acknowledge patient desires.
- Every facility should implement standard admissions criteria for women who present in spontaneous labor.
- Diagnosis and treatment of dystocia are crucial to prevent unnecessary cesarean births.

From the *AFP* Editors

Unnecessary cesarean birth is a preventable cause of maternal morbidity and mortality. It can cause short-term complications such as blood loss, infection, and venous thrombosis, and long-term effects in subsequent pregnancies, including abnormal placentation, increased risk of hemorrhage, and hysterectomy. Because of a high cesarean birth rate in the United States (one in three women), it is a significant maternal health safety issue. A workgroup was appointed to address this issue and is made up of members who represent women's health care organizations, including the American Academy of Family Physicians, the American College of Nurse-Midwives, the American College of Obstetricians and Gynecologists, the Association of Women's Health, Obstetric and Neonatal Nurses, and consumers through the National Partnership for Women and Families.

The National Partnership for Maternal Safety has developed a patient safety bundle that outlines important practices that every maternity

unit should implement to reduce the number of primary cesarean births and improve care to increase the number of vaginal births. The bundle consists of four domains: readiness, recognition and prevention, response, and reporting and systems learning. These components can be adapted to accommodate different facilities, but standardization within the facility is recommended.

Readiness

Developing a culture that supports vaginal birth, as well as articulating the risks and benefits of a cesarean vs. vaginal birth, is one component of readiness. Health systems should ensure that staff know the value of attaining vaginal birth and acknowledge patient desires, and that education, facilities, equipment, and health care professionals maximize the probability of a safe vaginal birth. Patient and family engagement has an important role in shared decision-making that can lead to the likelihood of vaginal birth. Facilities should offer education and training focused on assessing labor, methods to promote labor progress, labor support, pain management (pharmacologic and nonpharmacologic), and shared decision-making.

Recognition and Prevention

It is recommended that every facility implement standard admissions criteria for women who present in spontaneous labor. Research shows that women who present in latent labor have higher rates of cesarean birth. Redefining active labor as dilation of 6 cm rather than 4 cm and

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This series is coordinated by Sumi Sexton, MD, Editor-in-Chief.

A collection of Practice Guidelines published in *AFP* is available at <https://www.aafp.org/afp/practguide>.

CME This clinical content conforms to AAFP criteria for continuing medical education (CME). See CME Quiz on page 203.

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avoiding early admission of women in preactive labor who have not shown any progress are one strategy studied to reduce the chances of a cesarean birth. For women in active labor, standardized pain management techniques promoting labor progress and preventing dysfunctional labor should be offered with shared decision-making (e.g., epidural anesthesia, continuous support during labor).

Improper interpretation of electronic fetal monitoring can cause unnecessary cesarean births. Using standardized methods of fetal assessment developed by the National Institute of Child Health and Human Development can help with interpretation and documentation, and encourages freedom of movement for the patient. No benefit from continuous electronic fetal monitoring has been shown for the uncomplicated, nulliparous, term patient in spontaneous labor with a single fetus in vertex presentation.

It is important to identify specific problems that cause preventable cesarean births, such as herpes simplex virus infection or breech presentation. Suppressive therapy for herpes can be used in women with recurrent flare-ups and can be offered around 36 weeks of gestation in women without flare-ups so that vaginal birth can occur in the absence of lesions or prodromal symptoms. Regular assessment of fetal presentation in the third trimester during each prenatal visit can aid in identifying breech presentation, at which point shared decisions can be made regarding positioning measures.

Response

A consistent in-house team of maternity care providers supports communication about standard practices and provides consistent admission policies for labor. This ensures timely and effective responses to labor problems that could interfere with a primary vaginal birth. Diagnosis and treatment of dystocia are crucial to prevent unnecessary cesarean births. Based on the recommendation that dilation of 6 cm, rather than 4 cm, is the definition for active labor, a prolonged latent phase of labor would not be a reason for

cesarean birth. Following standardized evidence-based labor algorithms allows for prompt recognition and appropriate use of oxytocin. Use of standardized scheduling and execution of labor induction is recommended to guarantee proper selection and preparation of women undergoing induction. The risks and benefits of elective labor induction should be compared in women with low-risk pregnancies without medical complications. All maternity care professionals should have regular continuing education for fetal heart rate assessment and interpretation, and there should be standardized policies and procedures for what to do when an abnormal fetal heart rate is detected. Protocols and expertise for special situations, such as breech version, instrumental delivery, and twin delivery, should be available to lessen the need for cesarean birth.

Reporting and Systems Learning

Evaluation of processes and procedures is important in assessing progress. Open and confidential feedback forms, tools such as checklists and algorithms, and consideration of process measures should all be used to evaluate specific clinical changes. Tracking balancing measures and metrics of safety outcomes for women and infants (i.e., measures of maternal adverse events and newborn well-being) ensures that the program and changes are safely reducing cesarean births.

Guideline source: National Partnership for Maternal Safety

Evidence rating system used? No

Systematic literature search described? No

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Recommendations based on patient-oriented outcomes? Yes

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Jennifer Wilkes

AFP Editorial Coordinator ■