Use of an Early Labor Lounge to Promote Admission in Active Labor

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Professional maternity care organizations within the United States are aligned in the goal to prevent the first cesarean birth in nulliparous women with a term, singleton, vertex fetus. Currently, one in 3 women are at risk for having a cesarean birth. The most common reason for cesarean in the United States is labor dystocia. The evidence supports delaying admission to the birthing unit until active labor is established, thereby minimizing the inadvertent diagnosis of labor dystocia. Providers are familiar with the rationale supporting delayed admission to the birthing unit until active labor is established; however, there is very little evidence on how to effectively promote this delay. Provider apprehension and the lack of early labor support are challenges to sending women home to await the onset of active labor. Maternal anxiety, fear, pain, and unpreparedness also play a part in this reluctance. To address these obstacles, South Shore Hospital created an early labor lounge with stations aimed at instilling confidence in the birth team, promoting teamwork, facilitating relaxation, and reducing anxiety for laboring women. A literature review focusing on women's perceptions of promoting admission in active labor, maternal anxiety, and nonpharmacologic strategies for managing early labor are discussed within the context of the creation, implementation, and evaluation of an early labor lounge.

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INTRODUCTION

A pregnant woman in the United States has a one in 3 likelihood of having a cesarean birth. In 2013, the overall US cesarean rate was 32.7%, an increase of nearly 60% from 1996 to 2009. For US women, prevention of the first cesarean birth in women who are nulliparous, at term, with a singleton vertex fetus is the highest priority in reducing the overall cesarean rate because the vaginal birth after cesarean (VBAC) rate is approximately 10%. The American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine issued a 2014 consensus statement for Safe Prevention of the Primary Cesarean Delivery that provides multiple evidence-based practices including a change in the clinical definition of active labor onset to 6 cm cervical dilation. To further the goal of primary cesarean birth prevention, there are several simultaneously occurring initiatives. These initiatives include the California Maternal Quality Care Collaborative toolkit, Support Vaginal Birth and Reduce Primary Cesareans, and the interprofessional effort of the Alliance for Innovation on Maternal Health.

Early labor management is a critical time for cesarean birth prevention because pregnant women are admitted to the hospital in early labor their risk for cesarean birth and medical intervention increase. There is unanimous support from professional organizations including the American College of Nurse-Midwives (ACNM) and ACOG for delaying admission of women at low risk of complications until they are in active labor. In addition, the Joint Commission endorses the goal to “reduce[d] admission of women in latent labor and [the] elimination of non–medically indicated elective labor induction before 41 weeks” to decrease cesarean birth.

Since approximately 98% of births occur in the hospital setting in the United States, triaging pregnant women who come to the hospital in early labor and sending them home when they are not in active labor is an option. However, once women arrive but are found not to be in active labor, they are often reluctant to return home. Addressing this conundrum, South Shore Hospital created an early labor lounge aimed at instilling confidence, providing education, and reducing anxiety for women in early labor, thereby promoting a later admission in active labor. This article describes a multidimensional approach to this issue designed by an interprofessional team.

BACKGROUND

Recent studies have concluded that among nulliparous women early admission to the labor unit is associated with an increase in cesarean birth. Labor dystocia is one of the most common reasons for cesareans. Delaying admission to the labor unit until active labor is established has had some success in reducing dystocia. McNiven and colleagues conducted a randomized controlled trial aimed at reducing the cesarean birth rate in women who are nulliparous and at low risk of complications. These authors developed an early labor assessment program that provided criteria for the diagnosis of active labor. Women who were not in labor were sent home with “advice and encouragement.” If the women were not able to go home, they were sent to a room with armchairs and magazines. The study’s findings demonstrated a significant reduction in length of labor, labor augmentation, and
The evidence supports promoting admission in active labor, yet this goal can be challenging to implement for both laboring women and maternity care providers.

Many women have difficulty managing early labor at home because they are unprepared for the realities of labor.

A hospital space was created for women to engage in labor-promoting activities with the goal of supporting labor progression and vaginal birth.

Perceptions of Early Labor

Women's perceptions of labor onset and when to seek care are subjective and often premature. Many women have difficulty managing early labor at home because they are unprepared for the realities of labor. Perception of care among women sent home from the hospital in early labor was the premise of a qualitative study of 100 low-income women. Many women indicated unease with going home and were unclear on when to return to the hospital. Others were afraid they would birth at home, while others just did not want to go home. Most of the women (86%) stated they would have benefited from a follow-up telephone call after discharge. A review of 8 qualitative studies about the experiences of early labor established that most women were surprised by how uncomfortable labor was; many women were worried something was amiss; and women sought care while still in early labor. These findings suggest that interprofessional efforts directed at disseminating information about early labor to women earlier in their pregnancies may aid in increasing a woman's confidence in coping with early labor. Prenatal care should include education for women regarding early labor management and delaying admission to a birthing unit until the active phase of labor. In addition, if a woman is unable to remain at home, she would likely benefit from an environment that includes elements that women in these studies identified as important for their satisfaction with care, such as comfortable spaces conducive to rest, relaxation, and pleasant distractions; nutrition; and a home-like atmosphere.

Another study identified factors that predict women's perceptions of their childbirth experiences. These authors concluded that women value education, relaxation, control, and partner support in early labor. These results mimic the themes of other studies that perceptions of early labor may be improved by empowering women in early labor through education, support, and relaxation.

Maternal Anxiety

Maternal anxiety and confidence affect women's perceptions of labor. Anxieties cause fear, and confidence instills trust in the ability to cope with childbirth. Fear and anxiety in labor can lead to medical interventions and less optimal birth outcomes. Women's negative predispositions may impact their anxiety levels in labor and their subsequent control needs. If women can identify and describe the type of coping strategies that have been successful for them in the past, they can better manage their pain and anxiety in labor.

Employing a variety of both mental and physical strategies to assist with coping during early labor is essential.

Women may come to obstetric triage because the contractions are painful, they are unsure whether their labor has actually begun, are anxious, or may wish to hand over control. Normalizing the presenting situation and reassuring women this is a normal part of labor can help reduce anxiety and allow for informed decision making about whether labor is active and if they need to stay at the hospital or go home.

Support is invaluable as a way to decrease anxiety. Women want their partners to be present with them as prepared, informed, and participating support persons. Partners' presence is not only crucial to women's trust but also important for the birth experience. Therefore, creating an environment that fosters teamwork between a woman and her partner should be a central theme for managing early labor.

Nonpharmacologic Strategies for Managing Early Labor

Strategies for managing early labor such as ambulation and positioning, therapeutic shower, mindful meditation, acupuncture, partner support and massage, rebozo use, and nutrition in labor have been studied individually. However, no single intervention, by itself, has been successful in reducing the cesarean birth rate in low-risk pregnant women except for doula support. Conversely, the techniques listed above have been demonstrated to decrease pain and anxiety in women as well as increase patient satisfaction. The consensus derived from all the studies is that more reliable research is needed on all of these strategies to determine their individual effectiveness in lowering the cesarean birth rate. However, a package or bundle of such interventions to decrease pain and anxiety and empower women may be helpful in early labor. Therefore, an interprofessional team decided to create an early labor lounge to address this.
THE EARLY LABOR LOUNGE

The early labor lounge is an innovative outpatient strategy offered to women presenting in early labor to help deter early admission. Ideally, women will be encouraged to labor at home for as long as possible. The lounge is available for low-risk healthy women in early labor who cannot or will not go home. The purpose of the lounge is to instill confidence in the birthing woman and her support person(s), promote teamwork, facilitate relaxation, educate, reduce anxiety, and offer strategies to be successful in early labor.

Development of the Program

An interprofessional team consisting of midwives, physicians, nurses, and other key stakeholders conceptualized, created, and implemented an early labor lounge to reduce early labor admission among nulliparous women and to lower the institution's 32% cesarean birth rate. Over a 2-year period, the team worked collaboratively to review the evidence on cesarean birth and cesarean birth reduction. The early labor lounge was created with a plan for implementation and evaluation, including education for providers and pregnant women. The purpose of the lounge is to prepare pregnant women to manage early labor and provide them with labor-promoting and comfort strategies in the hospital preadmission, thereby promoting admission in active labor.

Triage Process

All pregnant women after 20 weeks’ gestation who come to the hospital for an assessment are seen in the obstetric triage unit. The triage process assesses the maternal and fetal health status and evaluates for labor (early or active labor). Women in active labor are admitted. If a woman is not in labor, she is sent home. Women in early labor are offered the options of being discharged home or sent to the early labor lounge. The institution uses the ACOG definitions of early labor and active labor (Table 1).\(^2\) To aid in decision support, a guideline was developed that outlines the labor assessment process as well as the inclusion and exclusion criteria for the lounge (Table 2). In general, women who require close monitoring are not eligible to use the lounge. Women who are not admitted in active labor are triaged upon return until the criteria for admission are met or they are sent home.

The Lounge

The early labor lounge is a 20 ft by 12 ft room located just outside the obstetric triage unit. It is a relaxing, comfortable space consisting of lounge chairs, yoga mats, labor balls, nutrition supplies, instructional posters, video disc and compact disc players, and media showing relaxation techniques, as seen in Figure 1. The lounge provides instruction and structured activities for the laboring woman and her support person(s) (the birth team) on how to effectively utilize the lounge. There are 6 stations strategically placed throughout the lounge and the adjoining maternal-child unit to promote ambulation. The different stations allow for privacy if more than one birth team is utilizing the early labor lounge. No health care provider is assigned to the early labor lounge. If a woman requires assistance, the obstetric triage nurse resumes care. The pregnant woman remains on outpatient status until she is either discharged home or admitted.

The early labor lounge stations include: mindful meditation, therapeutic shower, acupressure, ambulation, partner-supporting positions, and partner massage. Each station is designed to educate and support the birth team in early labor as well as reduce stress and promote relaxation.

The mindful meditation station is in a space separate from the labor lounge. It consists of a media player, disposable headphones, and a compact disc with a guided meditation. Based on feedback from previous birth teams, a television was made available for women who do not wish to use headphones. The television is programmed to stay on a station that only plays relaxation music with guided imagery.

A private therapeutic shower room with towels and bath-mats is available for birth teams in early labor; this room is also separate from the labor lounge. The shower has a seat as well as handheld shower wand for increased comfort. In case of emergency, there is a call light available. Once the birth team has finished using the shower, they are provided with a number to call for the room to be cleaned and prepared for the next birth team.

The remaining 4 stations are located in the early labor lounge. Posters in the lounge facilitate the birth teams with partner support and positioning, proper usage of labor balls and rebozo, and instructions for providing acupressure. Lounge chairs, massage tools, and yoga mats are placed strategically inside the lounge to aid with comfort and relaxation. A privacy screen is available for birth teams who desire additional privacy.

Cost of Program

The cost to start this program was minimal because the institution was in the process of redesigning the labor unit, and a dedicated space for the early labor lounge was incorporated in the renovation. The total cost of supplies was approximately US$500, which included the cost of the posters, labor balls, rebozos, media players, massage tools, and lighting. Nutritious drinks and snacks are provided by the nutrition department.

DISCUSSION

This project aims to provide support and education to women about early labor, reduce premature admissions, and increase the confidence of the birth team to manage labor. Interventions are based on current professional guidelines and evidence-based research and are intended to promote labor progression and increase satisfaction with care.

The early labor lounge can be replicated in other birth settings. Each institution will need to assess its space and determine what will work best and adapt to its patient population and culture. In addition to the dedicated early labor lounge, our program also accessed underutilized spaces and repurposed them into the different stations. If space constraints are an issue, purchasing labor balls, rebozos or draw sheets, massage tools, and posters and placing these tools in the triage rooms is another low-cost option. Currently, the
Table 1. Definitions of Labor and Birth

<table>
<thead>
<tr>
<th>Type of Labor</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous onset of labor</td>
<td>Labor without the use of pharmacologic and/or mechanical interventions to initiate labor.</td>
</tr>
<tr>
<td>Spontaneous onset of labor does not apply if there is artificial rupture of membranes before the onset of labor</td>
<td></td>
</tr>
<tr>
<td>Latent phase of labor</td>
<td>From the onset of labor to the onset of the active phase</td>
</tr>
<tr>
<td>Active phase of labor</td>
<td>Accelerated cervical dilation typically beginning at 6 cm</td>
</tr>
<tr>
<td></td>
<td>Can be either spontaneous or induced</td>
</tr>
</tbody>
</table>

Source: American College of Obstetricians & Gynecologists, 2014.

Table 2. Assessment Criteria and Eligibility for Use of the Early Labor Lounge

<table>
<thead>
<tr>
<th>Assessment Criteria</th>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal status</td>
<td>Ability to ambulate with partner safely</td>
<td>Inability to walk independently or unsteady gait or dizziness</td>
</tr>
<tr>
<td></td>
<td>Afebrile</td>
<td>Maternal temperature &gt; 100.4 °F</td>
</tr>
<tr>
<td></td>
<td>At low risk of obstetric complications</td>
<td>Uncontrolled gestational hypertension or preeclampsia</td>
</tr>
<tr>
<td>Assess the frequency, duration, and intensity of contractions</td>
<td>Normal contraction pattern</td>
<td>Abruptio contraction pattern or fetal intolerance to contractions</td>
</tr>
<tr>
<td>Confirm fetal position</td>
<td>Term, vertex, singleton</td>
<td>Nonvertex, multiple pregnancy, gestation &lt; 37 weeks</td>
</tr>
<tr>
<td>Obtain reactive nonstress test</td>
<td>NICHD Category 1 fetal heart tracing</td>
<td>NICHD Category II or III fetal heart rate tracing</td>
</tr>
<tr>
<td>Evaluate status of fetal membranes; if ruptured, determine GBS status</td>
<td>Intact membranes or ruptured membranes if GBS negative</td>
<td>Ruptured membranes and GBS positive</td>
</tr>
<tr>
<td>Patients will be reevaluated by a provider at least every 2 hours in obstetric triage or as needed</td>
<td>A patient utilizing the early labor lounge will remain in outpatient status until she is either admitted or discharged home.</td>
<td>Thick meconium amniotic fluid</td>
</tr>
</tbody>
</table>

Abbreviations: NICHD, Eunice Kennedy Shriver National Institute of Child Health and Human Development; GBS, group B streptococcus infection.

early labor lounge materials are only in English. However, this program could benefit diverse populations.

Possible Barriers

Six barriers were identified that could potentially affect how this concept is replicated in other hospitals. These barriers include infection control and housekeeping concerns, legal issues surrounding admission status, buy-in from hospital staff and administration, space constraints and privacy concerns, lack of research to support the model, and resistance to change. Prior to development, our institution created an interprofessional team consisting of physicians, midwives, nursing, administration, unit clerks, doulas, and patients. Ancillary services were invited to monthly meetings to address the barriers identified. For example, to address the concerns for infection control, housekeeping cleans the early labor lounge daily. The rebozo is washed after use, or staff members are encouraged to use draw sheets as replacements.

Each hospital should develop its own admission policies surrounding early labor management. For example, in this institution, concern was expressed regarding pregnant women walking the halls in early labor without an admission status. Hospital policy now states that the pregnant woman will remain in an outpatient status until labor is established, at which time she will be admitted. This policy provides women the opportunity to utilize the lounge without the need for constant supervision or monitoring.

The largest barrier encountered at this institution is buy-in from hospital staff. Changing the culture and providers’ practice is a challenge. Change can often take years for adoption to take hold. There is a daily struggle to normalize and routinize this practice. To support this process, regular interprofessional team meetings and education sessions are held. Each institution has a unique culture and will need to determine which strategies will work best.

Space constraints and privacy concerns may be encountered when trying to implement an early labor lounge. Our institution accessed underutilized spaces and repurposed them into different stations. We also added privacy screens to the lounge in the event that more than one birth team is utilizing the space at once.
Finally, there is a lack of research on early labor lounges and their effectiveness for promoting admission in active labor. This institution is in the process of conducting research to evaluate if this measure is an effective strategy to promote admission in active labor and/or lower the cesarean birth rate among women who are nulliparous, at term, and with a singleton vertex fetus.

**CONCLUSION**

There have been numerous studies addressing why we need to lower the cesarean birth rate in nulliparous women at term but very little research demonstrating how this can be done. The early labor lounge described above provides a potential approach. The labor lounge is innovative in that it takes into consideration the contemporary labor definitions supported by a number of professional organizations, previous studies discussing delayed admission until active labor, women’s perceptions of early labor, maternal anxiety, and nonpharmacologic strategies for managing early labor. Each strategy, in and of itself, has been unsuccessful in lowering the cesarean birth rate in the United States, but perhaps the multifaceted approach described here will be successful in promoting the delay of admission until active labor, which may subsequently aid in decreasing the cesarean birth rate.

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**CONFLICT OF INTEREST**

The authors have no conflicts of interest to disclose.

**REFERENCES**


