Background and Significance

Mobility and upright positioning have been shown to decrease\(^1\):

- The need for epidural analgesia and pharmacologic pain relief
- The risk for cesarean delivery
- The length of the first stage of labor

When the first stage of labor is prolonged, this can result in\(^2,3\):

- More pain and exhaustion for the mother
- Labor dystocia
- Cesarean or instrumental delivery

Increased risk of both maternal and infant morbidity and mortality

Yet, modern hospital practices often restrict laboring women's movement and encourage recumbent positions\(^4\)

Purpose

The purpose of this review is to determine current barriers to mobility and upright positioning during the first stage of labor and propose solutions a Clinical Nurse Leader can implement.

Evidence Search

**Electronic Databases**

CINAHL & MEDLINE

**Duplicates** = 24

**Excluded** = 46

**Reasons for Exclusion at Title Review Level\(^*\)**

- Labor as an economic term (23)
- Cesarean or instrumental delivery (13)
- Insufficient research (12)
- Poster presentations (3)
- Train nurses and other providers on low
- doi

Redefine informed consent protocols for epidural analgesia

- Patients not in the first stage of labor (12)
- Lack of education (7)
- Medicalization of birth (6)
- Lax of patient
- Create educational programs on proper techniques to aid with mobility and
- X

- Increase risk of both maternal and infant morbidity and mortality
- Yet, modern hospital practices often restrict laboring women's movement and encourage recumbent positions

Evidence Synthesis

The five quantitative articles included in this review only briefly or indirectly discussed barriers

- One article indirectly mentioned barriers in the discussion section
- In two of the articles, barriers were inferred within the underlying purpose of the study

The two qualitative articles included in this review were excellent in directly identifying barriers\(^10,11\)

Table 1: Summary of evidence quality and barrier identification

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Level of quality rating: A</th>
<th>Level of quality rating: B</th>
<th>Level of quality rating: C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence</td>
<td>McKnight, V., &amp; Eborn, F.</td>
<td>Singleter &amp; Barber, 2014</td>
<td>DeLander et al., 2014</td>
</tr>
<tr>
<td>Methodology</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Findings</td>
<td>X</td>
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</tbody>
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Implications for Nursing and CNL Practice

- Create a culture of support for physiologic birth
- Create educational programs on proper techniques to aid with mobility and repositioning
- Train nurses and other providers on low-intervention methods of labor support
- Encourage weekly labor mobility huddles

Establish interdisciplinary teams to create policies and procedures that promote physiologic birth

- Standardize fetal heart rate interpretation and use of external fetal monitoring
- Redefine informed consent protocols for epidural analgesia

Create guidelines on how to support “best possible care” of obese patients

Summary and Conclusions

- Barriers to mobility and upright positioning during the first stage of labor are multifaceted
- These barriers may be universal across the U.S. and its peer countries
- Further research is needed that focuses more directly on barriers and their source(s)
- We should investigate the structure of pre- and post-licensure nursing curricula and how this impacts the use of low-tech interventions during labor\(^11\)

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