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Abstract

Purpose: The purpose of this scoping review was to synthesize the literature on nursing support during the latent phase of the first stage of labor. In 2014, the definition of the beginning of active labor changed from 4 centimeters (cm) to 6 cm cervical dilation. More women may have an induction of labor based on results of recent research showing no causal increase in risk of cesarean birth with elective induction of labor for low-risk nulliparous women. Therefore, in-hospital latent phase labor may be longer, increasing the need for nursing support.

Design: Scoping review of the literature from 2009 to present.

Methods: We conducted the review using key words in PubMed, CINAHL, and Scopus. Search terms included different combinations of “latent or early labor,” “birth,” “support,” “nursing support,” “obstetrics,” and “onset of labor.” Peer-reviewed research and quality improvement articles from 2009 to present were included if they had specific implications for nursing care during the latent phase of labor. Articles were excluded if they were not specific to nursing, focused exclusively on tool development, or were from the perspective of pregnant women or providers only.

Results: Ten articles were included. Results were synthesized into six categories; support of physiologic labor and birth, the nurse’s own personal view of labor, birth environment, techniques and tools, decision-making, and importance of latent labor discussion during the prenatal period.

Clinical Implications: Support for physiologic labor and birth is an important consideration for use of nonpharmacological methods during latent labor. The nurse’s own personal view on labor support can influence the support that laboring women receive. Nurses may need additional education on labor support methods.

Key Words: Birth; First labor stage; Nursing care.

NURSING SUPPORT DURING LATENT PHASE LABOR: A Scoping Review

Rachel Blankstein Breman, PhD, MPH, RN, and Carrie Neerland, PhD, APRN, CNM

In 2010, the Friedman (1955, 1978) labor curve was revisited and the amount of time that could be expected and encouraged for labor within normal limits was extended based on more recent evidence (Zhang et al., 2010). This was the beginning of many new clinical recommendations for labor management. In March 2014, the American College of Obstetricians and Gynecologists (ACOG) revised definitions of latent and active labor by defining active labor as typically starting at 6 centimeters (cm) cervical dilation with contractions causing cervical change, instead of the traditional definition of 4 cm (ACOG, 2014). This change in definition occurred along with publication of Obstetric Care Consensus *Safe prevention of the primary cesarean delivery* (ACOG & Society for Maternal-Fetal Medicine [SMFM], 2014). These findings have significant implications for nurses in maternity care because the range for duration of normal limits for latent phase labor during induction of labor is longer than previously accepted (Harper et al., 2012).

In 2018, the ARRIVE trial was published (Grobman et al., 2018). This was a randomized trial of elective induction of labor at 39 weeks gestation versus expectant management up to 42 weeks and 2 days, comparing adverse perinatal outcomes in low-risk (singleton, vertex fetus and no condition that could be an indication for birth before 40 weeks 5 days) nulliparous women (Grobman et al.). Results of the ARRIVE trial support safety of expectant management because there were no significant difference between groups on the primary outcome, a composite measure of perinatal death or severe neonatal complications. A secondary aim was to evaluate risk of cesarean birth with elective induction of labor in this low-risk group of nulliparous women. Cesarean births were significantly



Support of physiologic labor and birth was a major category across the articles in this review.

Within this potentially shifting clinical landscape, there is increasing importance of person-centered care. There is no standard definition of person-centered care; however, we define it as care that is holistic in its approach and aligned with nursing values in that it involves understanding a person's unique needs, culture, values, and care preferences (Institute of Medicine, 2001). To achieve person-centered care, the health care team, person (patient), and family members work together and share power over clinical decision-making and care. In a recent survey of mothers, findings indicate that 58.4% of respondents believed the birth process should only be interfered with when medically necessary, and 21.5% of respondents felt pressure for either labor induction or cesarean birth women (Jou et al., 2015). Black women in California more frequently reported unfair treatment from healthcare providers (11% vs. 1%) and pressure to have a cesarean (18% vs. 9.5%) more often than white women (National Partnership for Women & Families, 2018). This information is essential for nurses in maternity care settings because nurses can advocate for patients and provide education on options. Nurses provide the majority of hands-on care during labor and birth.

lower in the induction group (18.6%) than in the expectant management group (22.2%; Grobman et al.). In the ARRIVE trial, length of stay in the intrapartum setting averaged 20 hours for the elective induction group compared with 14 hours for the expectant management group (Grobman et al.). The rate of induction of labor in the United States in 2018 was 27.08%, an increase of ~5% from 2017 when it was 25.75% (Martin et al., 2019). These data are likely underreported. If the rate of elective induction of labor will potentially increase given results of the ARRIVE trial and normal length of latent phase labor may now be extended many hours, supportive nursing care during the latent phase should be an important focus of research and practice.

Because of the recent recommendations from ACOG and SMFM (2014) on labor management and information on outcomes with elective induction at 39 weeks gestation, women could be spending more time in the hospital during labor, thus requiring increased demand for nursing time and support during latent phase labor (Grobman et al., 2018; Souter et al., 2019). However, the impact of these shifts in clinical recommendations on nursing care have not been fully explored.

Purpose of the Review

We conducted a scoping review (Levac et al., 2010) to synthesize information about nursing support in the

latent phase of the first stage of labor including both spontaneous and induced labor. The purpose was to provide nurses with the most recent information on nursing support during latent phase labor. We used the Association of Women’s Health, Obstetric and Neonatal Nurses’ (AWHONN, 2018) statement on continuous support during labor as a guideline to define nursing support. Key aspects of the role of the nurse are: assessment of physiologic and psychologic labor processes; facilitation of normal physiologic processes, for example, allow movement in labor; provision of physical comfort measures, emotional support, information, and advocacy; instruction on labor process and comfort and coping measures; and role modeling to facilitate participation of family and companions during labor and birth (AWHONN). Of note, AWHONN did not specifically define physiologic birth in this statement.

clusively related to doulas, physicians, nurse-midwives, or midwives were excluded because our focus was specifically on nursing care.

After review at the abstract level, we discussed conflicts and decided to exclude articles before 2009 because their relevance was not as applicable given changes in clinical recommendations for beginning of latent phase labor. Many of these articles had defined active labor as less than 4 cm cervical dilation. Once the conflicts were resolved and publications updated to 2009, full-text review of the 100 remaining articles was conducted independently by each author. Notes were taken on articles in Covidence® to document reasons for inclusion or exclusion. The search was updated in November 2019, and two articles were added. After conflicts were discussed and resolved, 10 articles were included for the review (Figure 1 as per Moher et al., 2009).

These articles were synthesized into the following categories based on their results and implications for nursing

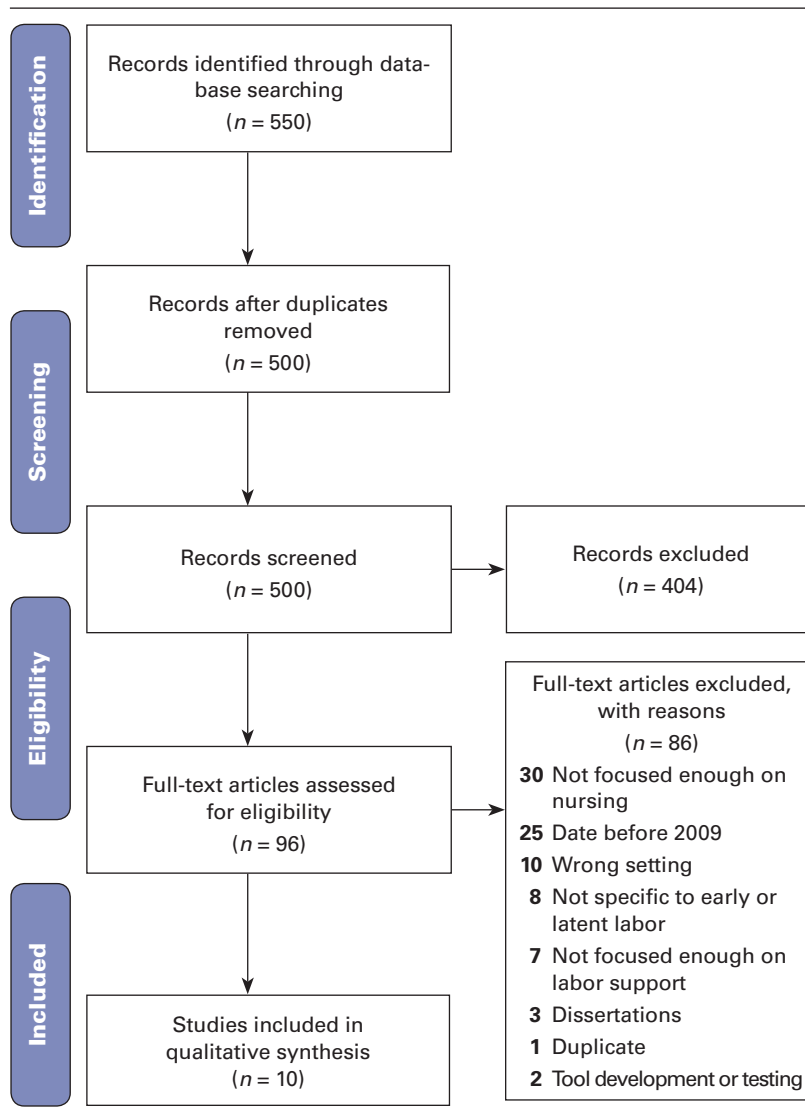
Methods

Search Strategy

In July 2019, we conducted a literature search using PubMed, CINAHL, and Scopus. Search terms included different combinations of the following terms: “latent or early labor,” “birth,” “support,” “nursing support,” “obstetrics,” and “onset of labor.” Boolean phrases such as “latent labor AND nurs* support AND birth” were used in the search; 500 records were returned for peer-reviewed journals. Limitations during the search were publications over the past 20 years (1999–present) and English language. All search results were uploaded into Covidence®, an online software that assists with managing and organizing data for systematic reviews. Covidence® was accessed online by both authors for evaluation of titles and abstracts.

Inclusion criteria for the title and abstract review were articles that specified or had a strong implication for nursing support during latent labor. Original research and quality improvement articles were included. Articles that focused on length of labor and birth outcomes, but did not include labor support, were excluded, as were studies conducted outside of the United States because the context of care differs greatly. Other exclusion criteria were studies that focused on instrument development and testing, small or large for gestational age infants, preterm birth, or other subpopulations of women or fetuses considered high risk, and those on induction methods or epidural medication for pain management. Articles ex-

FIGURE 1. PRISMA FLOW DIAGRAM





A nurse's personal perspective on latent labor and use of nonpharmacological methods is clinically important.

practice: support of physiologic labor and birth, the nurses' own view, techniques and tools, the birth environment, decision-making, and the importance of latent labor discussion during the prenatal period. For physiologic labor and birth, we used ACOG's definition. "Spontaneous labor and birth at term without the use of pharmacologic and/or mechanical interventions for labor stimulation or pain management throughout labor and birth" (ACOG, 2014, p. 4), which excludes use of any induction methods.

Results

Table 1 contains a description of each article and the information most pertinent to nursing practice. See Table 2 for synthesis of results. Many articles were placed in more than one category due to their content.

Support of Physiologic Labor and Birth

Nearly all of the articles discussed support of physiologic labor and birth; however, none explicitly defined physiologic labor and birth. Each of these articles included in this category discussed physiologic, "normal" or "natural" birth and the importance of nonpharmacological methods to promote physiologic labor processes. Nonpharmacological methods included continuous supportive nurse presence, doula care, use of intermittent auscultation, promoting mobility, and calming spaces. A number of articles described delaying admission until active labor to support

physiologic labor and minimize interventions (Bell et al., 2017; Breman, Iobst, et al., 2019a; Breman, Storr, et al., 2019b; Gams et al., 2019; Hosek et al., 2014; Simpson & Lyndon, 2017). Providing education to women about early labor and physiologic birth processes was often mentioned for improving outcomes (Bell et al.; Breman, Iobst, et al., 2019a; Breman, Storr, et al., 2019b; Carlton et al., 2009; Hosek et al.; Simpson & Lyndon). Authors expressed importance of evidence-based education for nurses to support physiologic labor and birth (Aschenbrenner et al., 2016; Bell et al.; Carlton et al.; Murn, 2019).

Nurses' Own View

Of the five articles in this category, two specifically explored nurses' personal view on birth and the impact this has on laboring women. Nurses' perspectives greatly impact the care, decision-making, and culture surrounding labor and birth. Nurses expressed that support, advocacy, and communication are important aspects of the care they provide (Carlton et al., 2009; Lyndon et al., 2017; Murn, 2019; Simpson & Lyndon, 2017). Personal birth experiences and length of time as a labor nurse were associated with intention to provide labor support (Aschenbrenner et al., 2016). Nurses also viewed their care as critical to avoiding cesarean birth including advocacy to not admit too early and providing informational support in triage (Simpson & Lyndon). Physicians believe that nursing has considerable influence on unit culture and birth outcomes (Lyndon et al.). Unit culture was cited as a determinant in the provision of care, care variation, and support (or lack of support) for physiologic labor (Aschenbrenner et al.; Carlton et al.; Lyndon et al.; Simpson & Lyndon). Numerous barriers were identified including views of birth as risky, nurse staffing, requirements for frequent documentation, lack of experience in supporting physiologic labor, technological interventions, negative attitudes toward birth plans, and nurse-provider relationships (Aschenbrenner et al.; Carlton et al.; Lyndon et al.; Murn; Simpson & Lyndon). Provision of education for novice nurses in labor support and understanding their role in continuous labor support was recommended (Murn).

Techniques and Tools

Although nonpharmacological support during labor is not new, innovations in how to implement them have been emerging from the literature. Use of an Early Labor Lounge (ELL) was a tool described by Gams et al. in 2019 and evaluated from the patient's perspective by Breman, Storr, et al. (2019b). Individuals using the lounge were considered on observation or triage status and were not admitted. The purpose of the lounge in the hospital was to assist with promoting admission in active labor to reduce the low-risk cesarean birth rate. Two articles evaluated women's perceptions related to early labor support activities. Breman, Storr, et al. found that women felt these activities were helpful in providing support to them during the latent phase. Mobility, hydration, and eating are important to the physiologic labor process; women indicated a desire to have these options available in early

TABLE 1. TYPE OF ARTICLE, DESIGN, OUTCOMES, AND IMPLICATIONS

First Author and Year	Type of Article	Design/ Intervention	Participants	Outcomes	Implications
Aschenbrenner (2016)	Research	Cross-sectional, mixed-methods, descriptive, guided by Theory of Planned Behavior	<i>N</i> = 60 Nurses	Nurses' own birth experiences are related to planned labor support they offered. Barriers to labor support included nurse staffing, documentation, high technology interventions, and subjective norms.	More experience with physiologic birth is needed for novice nurses. Nurses should examine own experiences of continuous labor support.
Bell (2017)	Quality Improvement	Quality improvement project at 3 hospitals using the Council on Patient Safety in Women's Health Care: Patient Safety Bundle on the Safe Reduction of Primary Cesarean Births	<i>N</i> = 434 Births preimplementation; <i>N</i> = 401 Births postimplementation	Reduction in primary cesarean birth rate from 27.9% to 19.7%. Cesarean birth rate of those admitted in labor decreased, whereas rate of induction of labor increased. Increased provider compliance with labor management guidelines. Increased use of labor support techniques.	Engagement of key leaders is essential. There can be decreases in hospital charges associated with decreasing cesareans. Sustainability depends on systematic education of providers and nurses about labor management guidelines and support techniques.
Breman (2019a)	Research	Qualitative study using semistructured interviews and inductive approach	<i>N</i> = 25 Clinicians including nurses, midwives, and physicians	Triad of decision-making identified (client, nurse, provider). Major theme: many factors exist when admitting low-risk pregnant individuals in labor. Four subthemes: expectations and knowledge about birth, perceived coping with labor, care variation, and concern for maternal/fetal safety.	Many nonclinical factors come into play when making decisions about women who present to obstetric triage. Shared decision-making should be used by triad of stakeholders. Nurses educate women about labor process and admission. Nursing support in early labor increases coping ability.
Breman (2019b)	Research	Cross-sectional design with survey	<i>N</i> = 67 Low-risk nulliparous women	Those who received information about early labor lounge were more likely to use it.	Nurses may use early labor lounge to provide supportive care to individuals in early labor.

TABLE 1. TYPE OF ARTICLE, DESIGN, OUTCOMES, AND IMPLICATIONS (*CONTINUED*)

First Author and Year	Type of Article	Design/ Intervention	Participants	Outcomes	Implications
Breman (2019b) <i>(continued)</i>					Offering nutrition and acupressure are satisfiers. Prenatal information may lead to higher uptake and may promote admission to labor unit when labor more active.
Carlton (2009)	Research	Qualitative study, semistructured interviews with nurses	<i>N</i> = 18 Nurses	Four themes: aversion to birth plans, barriers to provision of supportive care (system, provider, language barriers, personal birth preferences, maternal), differences in caring for those who are medicated and those who are unmedicated, rewards of caring for birthing individuals	Nurses face challenges in providing labor support including staffing, acuity, and time. Unit culture has an impact on ability to support physiologic birth. There is disparity between nurse and provider levels of support.
Gams (2019)	Evidence-based Practice Change/ Quality Improvement	Quality improvement, evidence-based practice change incorporating Promoting Labor Progress Bundle from ACNM's Reducing Primary Cesareans project	NA, data reported as percent change for different implementation activities	Multiple initiatives to support early labor and physiologic birth including DNP midwife student project to develop early labor lounge, early labor guideline, using intermittent auscultation, upright positioning in labor, use of white boards to communicate pertinent information and stage of labor. Increases in continuous labor support, use of intermittent auscultation, and upright positioning were noted. Those who used labor lounge would recommend it to others. Decreased primary cesarean birth rate.	Interdisciplinary team working to change and sustain unit culture to support physiologic birth is important. Nurse champions are needed to sustain culture change.
Hosek (2014)	Research	Descriptive survey study of women discharged in early labor	<i>N</i> = 100 Pregnant women at term presenting for care in latent labor	Majority of women would have liked a follow-up phone call and written instructions about what to do at home to stay comfortable. Many women were not happy with decision to be sent home due to pain or distance from home to hospital.	Hydration, eating, and mobility are important comfort measures to women in early labor. Women desire clear instructions about home comfort measures and when to return.

TABLE 1. TYPE OF ARTICLE, DESIGN, OUTCOMES, AND IMPLICATIONS (*CONTINUED*)

First Author and Year	Type of Article	Design/ Intervention	Participants	Outcomes	Implications
Hosek (2014) <i>(continued)</i>				Comfort measures including hydration, nutrition, and mobility were very important to the women.	Comfort measures in latent/early labor can be incorporated in to prenatal teaching. Distance to hospital is a factor to consider when pregnant women present in early labor.
Lyndon (2017)	Research	Qualitative focus groups with nurses, new mothers, and physicians, thematic analysis	<i>N</i> = 73 Nurses; 23 mothers; 9 physicians	The most important aspects of nursing care that have an impact on labor and birth outcomes are support and advocacy. Subcomponents for the RN group included explaining, relationships, caring, advocating, and supporting. Important aspects per the mothers' group: informing, supporting, following wishes, avoiding cesarean, breastfeeding support Important aspects per the physician group: labor support and management, avoidance of cesarean, education, and emotional support	Supportive and relationship building require time at the bedside. Care delivery models should be designed to ensure nursing presence for labor support and advocacy.
Murn (2019)	Quality Improvement	Literature review on continuous labor support and discussion of the implementation of an educational program to enhance nurses' knowledge of continuous labor support	<i>N</i> = 23 Nurses	Continuous labor support has many benefits including increased patient satisfaction and decreased cesarean births. There was an overall significant increase in nurses' knowledge related to continuous labor support.	Education for novice nurses on physiologic birth and nurse-led continuous labor support is vital.
Simpson (2017)	Research	Qualitative focus group interviews, thematic analysis	<i>N</i> = 24 Nurses	Nurses reported routinely taking active steps to help women avoid cesareans. Care that they provide to help women include support, advocacy, and interactions with physicians. In latent labor, nurses offer education about normal labor process and advocate that women not be admitted too early.	Labor nurses use many strategies to promote vaginal birth and avoid cesareans including education, support, advocacy, and encouragement.

TABLE 2. SYNTHESIS OF RESULTS BY CATEGORY

Category	Number of Articles	First Author and Year
Support of Physiologic Labor and Birth	9	Aschenbrenner, 2016 Bell, 2017 Breman, 2019a Breman, 2019b Carlton, 2009 Gams, 2019 Lyndon, 2017 Murn, 2019 Simpson, 2017
Birth Environment	6	Aschenbrenner, 2016 Breman, 2019a Carlton, 2009 Gams, 2019
Nurses' Own View	5	Aschenbrenner, 2016 Carlton, 2009 Lyndon, 2017 Murn, 2019 Simpson, 2017
Techniques and Tools	5	Bell, 2017 Breman, 2019b Gams, 2019 Hosek, 2014 Murn, 2019 Simpson, 2017
Decision Making	4	Aschenbrenner, 2016 Breman, 2019a Carlton, 2009 Murn, 2019
Importance of Latent Labor Discussion During the Prenatal Period	4	Breman, 2019b Carlton, 2009 Hosek, 2014 Simpson, 2017

labor (Hosek et al., 2014). Numerous techniques and tools for support were mentioned in the included articles such as relaxation techniques, massage, labor balls, labor slings, yoga mats, hydrotherapy (tub or shower), and aromatherapy (Bell et al., 2017; Breman, Storr, et al., 2019b; Gams et al., 2019; Hosek et al.; Murn, 2019; Simpson & Lyndon, 2017).

Birth Environment

The birth environment was discussed in four of the 10 articles. The birth environment category encompasses the birth setting (birth center, home, or hospital), the policies and procedures of the birth setting, the responsibilities of the nurses within the birth environment, and unit culture. Specific guidelines for activities to support labor progress created a facilitating environment for use of intermittent auscultation and tools for support during latent labor (Gams et al., 2019). Possible barriers to the provision of

latent labor support within the birth environment included issues related to staffing, relationships with providers, the need for frequent documentation, high technology interventions, doulas, and birth plans (Aschenbrenner et al., 2016; Breman, Iobst, et al., 2019a; Carlton et al., 2009).

Decision Making

Early labor is a time when there are frequent moments for decision-making for laboring individuals, nurses, and providers. Breman, Iobst, et al. (2019a) described a complex multifactorial decision-making process when considering admission for low-risk women in labor. Major factors influencing nursing decision-making included personal beliefs regarding birth, experience with nonpharmacological comfort measures, concerns for safety, and the relationship with the provider (Breman, Iobst, et al.). Clinicians felt that many factors have an impact on a woman's decision-making about early labor including parity, risks, anxiety or fear, support, expectations, knowledge about birth, and coping (Breman, Iobst, et al.). Part of decision-making during latent labor could involve use of a birth plan; yet, nurses do not consistently view the use of birth plans positively (Aschenbrenner et al., 2016; Carlton et al., 2009).

Importance of Latent Labor Discussion during the Prenatal Period

Four of the articles mentioned prenatal care or childbirth education as important opportunities for individuals to receive information about latent labor. In one study, clinicians including both nurses and physicians noted that prenatal preparation and childbirth education are critical elements that play a role in women's expectations about early labor (Breman, Iobst, et al., 2019a). Hosek et al. (2014) found women may not receive enough support and information to be comfortable staying at home when they are in latent labor. Therefore, these women may prefer to be admitted to the hospital instead of sent home. In five articles, authors discussed inclusion of information about latent labor in prenatal care and childbirth education to increase confidence during early labor in order to delay admission until active labor (Breman, Storr, et al., 2019b; Carlton et al., 2019; Hosek et al.; Simpson & Lyndon, 2017).

Discussion

There are six categories to consider for nursing care given the new context of support of laboring women through possibly longer latent phases of labor. Nurses working in a care environment that promotes physiologic labor and birth may have more nonpharmacological options available for use with those who may have longer latent labors. Having more nonpharmacological options may also benefit women admitted for an elective induction, although this would be an area of future research. These options could include hospital labor lounges or structured walking paths. Barriers nurses face in providing supportive care during the latent phase could be due to their own view on labor or the environment where they work. These differences in environment may be at the

root of the variation noted in different cesarean rates within similar populations (Cáceres et al., 2013; Kozhmannil et al., 2013). Other articles on the birth environment and nursing support for physiologic birth have been published (Adams et al., 2016; Stark et al., 2016), our review adds to this area focusing on latent labor support which is of particular importance in the wake of the ARRIVE trial (Grobman et al., 2018) and the potential for an increase in elective labor induction.

It was noted that although nursing support of physiologic labor and birth was a major category among the articles, none of the authors included a definition of physiologic labor and birth. Several maternity care organizations have developed definitions of physiologic birth including ACOG (2014) and one that was developed by consensus among three midwifery organizations in the United States (American College of Nurse-Midwives, Midwives Alliance of North America, & National Association of Certified Professional Midwives, 2013). Use of a shared definition of physiologic labor and birth provides more standardized guidance for policies, guidelines, and educational programs for nurses and others on the interprofessional team to support the physiologic labor process.

Supporting physiologic labor and birth and honoring an individual's choice are both part of shared decision-making in maternity care. Multiple studies support that when there are decision aids in care, people tend to choose less-invasive options (Stacey et al., 2014). Although these studies were not in maternity care, there is an opportunity for this in maternity care so that people know the benefits of physiologic birth such as reduced maternal and neonatal morbidity (Renfrew et al., 2014), enhanced breastfeeding (Moore et al., 2016), and improved birth experiences (Dixon et al., 2013). In the United States in 2018, 75% of women had an epidural during labor (Martin et al., 2019); however, it is unknown whether this rate is reflective of patient choice and knowledge of physiologic birth or their intention and desire for effective pain relief during labor and birth. Efforts to improve shared decision-making could potentially increase use of nonpharmacological methods, perhaps in environments where that may not be the norm.

Part of the environment is a team-based approach to providing intrapartum care and nurses are an integral part of the team. Ideally, healthcare team members will have the same approach to providing care during labor. The nurse's role on this team cannot be overlooked (Zielinski et al., 2016). One way to increase communication among the team about a pregnant woman's care preferences is a birth plan or birth partnership (DeBaets, 2017). Use of a birth plan could be another strategy to address use of induction in low-risk pregnant women and to reduce the cesarean birth rate. Afshar et al. found that patients who had a birth plan had a 72.6% vaginal birth rate, in part likely due to their motivation to avoid a cesarean (Afshar et al., 2017). The nurse's view of birth and personal experience with birth plays a profound role in the care they provide (Simpson & Lyndon, 2017; Sleutel et al., 2007). This includes encouraging laboring indi-

CLINICAL NURSING IMPLICATIONS

- Based on longer within normal ranges for the latent phase of the first stage of labor, this aspect of intrapartum nursing care warrants attention to promote high-quality supportive care.
- If more women choose elective induction of labor at 39 weeks, extended hours of nursing care during latent phase labor may become routine.
- Nursing care includes use of nonpharmacologic methods for support during latent phase labor.
- Early labor lounges support use of nonpharmacologic methods.
- Nurses should recognize their own personal views on physiologic labor, comfort measures, and be aware of the evidence to best support laboring women.
- Some nurses may need more education about providing nonpharmacologic support during latent phase labor.
- Nurses in antenatal settings can provide education on latent phase labor to patients to increase their knowledge of what type of discomfort or pain they might experience during labor.

viduals to ambulate, eat, and use hydrotherapy. There is a clear clinical implication for nurses. If a nurse does not support use of birth plans or nonpharmacologic methods or does not feel comfortable with their use, then laboring women could have less access to them.

Three articles described programs that were hospital quality improvement projects and also part of an external interdisciplinary collaborative. Hospitals, part of a larger external quality improvement initiative, could have a more supportive hospital environment for physiologic labor and birth. Participation and dedication to these kinds of activities may provide context to the birth environment and specifically the hospitals themselves because not every hospital administration and staff have resources dedicated in this way to improving maternity care. Nurse staffing is also an important consideration because providing support and education to women in labor takes time and may not be the highest priority for nurses when unit census is high and nurse staffing levels are low.

Limitations

Because the focus of the search was narrowed to nurses only, articles related to doulas and nurse-midwives were excluded. Use of doulas varies greatly and the barriers related to use of doulas include cost, hospital policies, and the individual's desire for this kind of support. Although nurse-midwives can also provide support during labor, they are few in numbers and not involved in every birth in every hospital. Nurses, however, are part of every woman's birth experience in the hospital setting and that is why we focused on their support during latent labor. Another limitation is that although most

of the review articles included physiologic birth, none of them defined it. Our review did not specifically explore a major issue in maternity care, implicit bias and racism. None of the articles addressed disparities, yet recent research supports that there are care disparities in different hospitals by race (Howell et al., 2016), and this could extend to nursing care during latent labor. A final concern and limitation is author bias. Both authors have contributed to this field and their works were part of the review. To address this, each manuscript was discussed and had to meet the inclusion criteria, specifically nursing care during the latent phase of labor.

Clinical Implications

Nurses are central to providing care and education to women during the latent phase of labor. There are a growing number of quality improvement initiatives where nurses can be actively engaged in shifting the unit culture in support of evidence-based care practices to support physiologic labor and birth, such as the National Partnership for Maternal Safety (Lagrew et al., 2018) and the ACNM Reducing Primary Cesareans project (Gams et al., 2019). These initiatives also include perinatal quality initiatives at the state level because several states have launched perinatal quality collaboratives or are implementing the Alliance for Innovation on Maternal Health bundles (Simpson, 2018). Nurses need to be self-aware of their own personal views on birth and the support they provide during the latent phase of labor. There is an opportunity for continuing education for nurses on this topic to support clinical practice. Nurses who are not as confident in their skills or who do not fully engage in supporting women during the latent phase should address this gap and seek more opportunities to learn about labor support techniques so they can provide high-quality care during labor. ❖

Dr. Rachel Blankstein Breman is an Assistant Professor and KL2 Scholar Grant #1UL1TR003098-01, University of Maryland, School of Nursing, Baltimore, MD. Dr. Breman can be reached via email at rbreman@umaryland.edu

Dr. Carrie Neerland is an Assistant Professor, University of Minnesota, School of Nursing, Minneapolis, MN.

The authors declare no conflicts of interest.

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