Workshop Report

SHAPING PRACTICE TO PROMOTE VAGINAL BIRTH IN BC

FEBRUARY 28, 2018

SURREY MEMORIAL HOSPITAL

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Shaping Practice to Promote Vaginal Birth in BC

Report on workshop presented by Optimal Birth BC, hosted by Fraser Health Authority
and funded by the Michael Smith Foundation for Health Research
February 28, 2018, Surrey Memorial Hospital

Objectives

1. To review rates of cesarean section stratified by Robson criteria (categories of risk) over the previous five years among hospitals represented at the meeting;
2. To identify broad categories of clinical practice that clinicians from these hospitals believe have promoted vaginal birth among healthy women;
   - 2.1. To detail specific protocols that have been developed to support these changes;
   - 2.2. To discuss transferability of these protocols to other settings in BC;
   - 2.3. To identify resources needed in hospitals to support these changes;
   - 2.4. To develop a plan for health authorities to standardize practice in relation to targeted areas;
   - 2.5. To identify an evaluation strategy for targeted areas of change.
3. To agree on a forum for ongoing mentorship within health authorities by practice leaders in hospitals that have successfully initiated change with sustained results;
4. To develop key research questions arising from the discussion of promising practice change strategies that will form the basis of a vaginal birth research program.

Morning Session (Open to the Public)

Welcoming remarks by Loraine Jenkins, Executive Director, Maternal, Infant, Child and Youth Health, Fraser Health Authority, who noted the challenges faced by Fraser in addressing rising cesarean section rates. She stated that the contributors to the rising cesarean section rate are complex and difficult to understand. She indicated that the workshop would provide an opportunity to gain insight from the hands-on experiences of colleagues.

Dr. Patricia Janssen presented overall cesarean section (CS) rates, planned vaginal birth after cesarean (VBAC) rates and CS rates among nulliparous women eligible for vaginal birth, stratified by hospital size. Invited representatives from hospitals that have demonstrated high vaginal birth rates during the previous five years presented their recommendations for promoting vaginal birth.

Terrace – *Successes in Vaginal Deliveries: Obstetric services in Terrace, BC*

Dr. Jaco Strydom, MB, ChB, M.Fam.Med, MCFP

Maternity Care Service

- Primary care obstetrics provided by a group of 4 family practice physicians (FPs)
- High risk obstetric coverage (including CS) provided by 1 ObGyn and 1 FP
- Dedicated and experienced nurses (RNs) in Labour/Delivery
- Prenatal clinic
- Primary care nursing team from Public Health and Chronic Disease Management Programs

	2015/16	2016/17	2017-
Total Deliveries	292	323	246
C/Section Rates	19.2%	21.9%	18.7%
Elective	25 (8.5%)	42 (13%)	14 (5.7%)
Emergent	31 (11.6%)	29 (10%)	32 (13%)
Planned VBAC	19	13	15
Successful VBAC	13 (68%)	9 (69.7%)	14 (93.3%)

Why Are We Successful in Promoting Vaginal Birth?

- Vaginal delivery is the ultimate goal regardless of previous experience – the staff are passionate about this and set the tone to sustain this culture
- Use of narcotics early in labour
- Low epidural rate (used only when all other methods of pain relief exhausted)
- Admission delayed until in true active labour
- True 1:1 nursing care
- Use of non-pharmacological pain relief techniques, including use of gravity and positioning
- For women eligible for VBAC, information provided at initial visit but final decision made at around 28 weeks (sometimes as late as 36 weeks). If not suited for our facility – option for referral to bigger centre
- Clear communication about plans
- Teamwork and collegiality between physicians and nurses
- Women-centred care – involved in every step of decision making

Richmond – *Shaping Practice to Promote Vaginal Birth: Richmond Hospital*

Dr. Brenda Wagner (Obstetrics) and Kara Thompson (Nursing)

	2013/14	2014/15	2016/16-
C/Section Rates (Total)	27.9%	30.6%	30.3%
CS - Eligible Nullips	16.8%	16.9%	24.7%
CS Eligible Multips planning VBACs	52.3%	53.3%	66.9%

Why Are We Successful?

Consistent Approach to Early Labour Management

- All patients are encouraged to call the unit before coming to the hospital
- Early labour support and teaching done by RNs
- Labour assessment done by an RN in triage
- Patients are only admitted once they are in active labour

Constant Labour Support by Nurses

- All woman in active labour are provided 1:1 labour support by an RN
- Non-pharmacological pain management techniques are ALWAYS offered first
- Patients are encouraged to ambulate and use the bath or shower. Liberal use of birthing balls
- Patients do not labour in bed. Telemetry allows for increased mobilization in labour when continuous fetal monitoring is indicated
- Adherence to the 6 cm rule for active labour, i.e. don't intervene prior to 6 cm to establish labour
- Evaluating labour progress through change rather than pre-defined time limits

Creative Approach to Second Stage

- Pushing starts when women have a strong urge
- Women push in multiple different positions: supine, side lying, hands and knees, toilet, birthing stool, birthing ball, on the bed in hands and knees, in the tub, etc.
- Minimize epidural use to maximize ability to push in different positions
- No intervention until pushing in multiple positions

Culture

- Started with a negative culture that was not evidenced-based
- Change occurred with:
    - Multidisciplinary rounds and open respectful discussion
    - Multidisciplinary education sessions (e.g. midwives teaching doctors)
    - Having fun together
    - Respecting what everyone brings
    - Acknowledging that all questions are good questions
    - Knowing we need each other
    - Holding one another accountable for providing evidence-based practices
    - Trauma-informed approach for patient care and among staff
    - Collaboration between junior and senior nurses
    - Normal labour champions
    - Celebrating our success

Nanaimo Regional General Hospital

Dr. Jeffrey Somerville (Obstetrics)

Maternity Care Service

- Average 1,200 births/year
- Combined LDRP unit with 15 beds
- Complement of maternity care providers and specialists
- On-site pediatricians, anesthesia, as well as unit-specific operating room (OR) with use of the main OR for perinatal patients requiring general anesthetic
- Level 2 NICU

Caesarean Delivery Rate within Robson Groups, NRGH: April 1, 2011 - March 31, 2016

Robson Groups	2011/12	2012/13	2013/14	2014/15	2015/16
TOTAL	*26.1%*	*25.9%*	*25.9%*	*24.1%*	*26.3%*
1. Nulliparous women with a single vertex pregnancy at 37+ weeks in spontaneous labour	14.8%	12.5%	13.5%	17.5%	16.8%
2. Nulliparous women with a single vertex pregnancy at 37+ weeks with induced or no labour	27.3%	41.8%	37.2%	32.9%	33.3%
5. Parous women with a uterine scar with a single vertex pregnancy at 37+ weeks	78.2%	77.1%	75.0%	75.4%	73.9%

Why Are We Successful?

- Practice is multidisciplinary and collaborative among obstetricians, registered midwives (RM), and FPs
- Structured prenatal classes available in the community
- Avid use of oxytocin with epidurals
- OBs skilled at assisted vaginal births
- OBs' scope of practice includes primary maternity care as well as specialty consults
- Prior to 34 weeks gestation, women who wish to pursue a VBAC are referred for an obstetrical consult by the woman's primary maternity care provider (FPs and RMs)
- Communication processes to support collaboration:
    - Call-out process for notifying Pediatrics
    - Perinatal emergency call-out tree to alert Pediatrics and the main OR
- Culture improved significantly with introduction of MORE^{OB} and clinical champions – promoted a culture of learning together
- OB collaborative group (developed by the Department of Family Practice) improved discussion and debate related to evidence-based practice and shifted to patient-centered focus

- Increased rate of trial of labour attributed to RMs sharing practice philosophy and techniques with physicians – this has increased comfort level with VBACs among the team
- Active quality improvement committee that reaches out to colleagues – midwives regularly attend

Fort St. John – *Healthy Mothers and Healthy Babies: Working together to improve perinatal outcomes*

Dr. Glen Hamill (Family Practice), Kathleen Julian, RN (Birthing Centre Lead) and Danielle Quiring RN (former Birthing Centre Lead)

Maternity Care Services

- Fort St. John services a population of +/- 47,000
- Average deliveries in Fort St. John = 650/year
- There are 10 physicians working in the prenatal clinic/birthing centre (3 who have advanced OB skills), 1 OBGYN, 1 pediatrician, and 5 FP anesthetists

Cesarean Birth Rates at Fort St. John Hospital Birthing Centre

- Pre-clinic: 26-32%
- 2014 (first year of clinic): 27.8%
- 2015: 20.8%
- 2016: 19.7%
- 2017: 18.5 %

Induction rates have decreased by 38% since the prenatal clinic opened

Why Are We Successful?

The Goals

- Initially not to decrease caesarean section rates but to ensure patients were receiving comprehensive, evidence-based and appropriate care
- To increase team functioning and support a culture to optimize patient care

Prenatal Clinic

Started in 2014 due to loss of maternity care physicians. Comprised of a unit clerk, primary care RN, dietician, and diabetic educator. Various retrospective chart reviews show that group prenatal care has statistically significant results, including:

- Reduction of preterm births
- Increased birth weights
- Decreased maternal weight gain
- Reduced odds of fetal demise

- Shorter hospital stays
- Increased likelihood to exclusively breastfeed
- Increased patient knowledge
- Increased satisfaction with prenatal care
- Decreased caesarean section rate

Highlights of the RN Position

- Continuity of care and education for each patient
- Prepares all routine lab work, ultrasounds, care plans, prenatal registry (SOGC Guidelines)
- Appropriate and timely referrals for dietician, diabetic educator, anesthetic consult and OB consult
- Mental health referrals, MCFD referrals, and community support connections
- "Watch dog" - a second check for all lab and ultrasound results
- New ideas to streamline and/or improve the clinic

The Rules

- Induction of labour
    - Unit-specific protocol developed
    - Any induction not for post dates (41-42 weeks) needs consultation prior to booking
    - Patient education
- Consults are to OBGYN or OB advanced practice FPs
- If an OB advanced practice FP is working in labour and delivery, a consult is still needed to go to caesarean section
- Elective caesarean sections require a consult, especially if less than 39 weeks
- Consults must be appropriate
- Trial of labour after CS (potential VBAC) require a consult

Financial

- 2 pools of funds: prenatal and labour & delivery units
- Funds divided among the physicians according to how many shifts worked in a 3-month period
- Any OR procedures or consults fall outside of the pool and are paid on an individual basis
- "Special" patient funds go into the pool

Comprehensive Care Plans

- BMI
- Gestational diabetes (patient worksheets included)
- Mental health
- Drug abuse/substance misuse
- Methadone

- Limited supports/<19 years of age

These plans have promoted better health through the antepartum period.

Labour and Delivery & Developing a Culture

Prenatal Clinic attached to labour ward gives numerous advantages:

- Timing of decision making - minutes instead of hours
- Interaction with staff increased making for better culture and team approach
- More interactions with patients, improving the environment, atmosphere, decreasing anxiety, and a more personable approach
- Time for debriefing and discussions

Vaginal Birth

The plan this year is to educate patients, both verbally and in writing at prenatal appointments, about assisted vaginal deliveries and caesarean sections.

- This will allow the patient to give not just informed consent but educated informed consent
- They will be able to ask the right questions

Do the Right Thing Together!

- Everyone has something they know
- Everyone has something to share
- Everyone has something to learn

Langley – *Shaping Practice to Promote Vaginal Birth: The Langley Experience*

Dr. Erica Phelps, (Obstetrics), Dr. Beth Watt (Family Practice), Tina Blaney (Midwifery), Donna Adhemar (Nursing, Patient Care Coordinator) and Tanya Jantzen (Nursing, Perinatal Clinical Educator)

	2013/14	2014/15	2016/16-
C/Section Rates (Total)	21.8%	24.9%	22.7%
CS - Eligible Nullips	21.6%	26.9%	29%
CS Eligible Multips planning VBACs	68.7%	69.7%	60.7%

Why Are We Successful?

TEAM Approach:

T – Together
E – Everyone
A – Achieves
M – More

Principles of Team-Based Health Care:

Shared Goals

- The team – including the patient – works to establish shared goals that reflect patient and family priorities, and that can be clearly articulated, understood and supported by all team members.

Clear Roles

- Clear expectations for each team member's functions, responsibilities, and accountabilities, which optimize the team's efficiency and often makes it possible for the team to take advantage of division of tasks – team is greater than the sum of its parts. Holding each other accountable for the care that we deliver together.
- Dedicated team that supports clients through the birthing journey. The unit culture is to cross monitor and give and receive support and advice from each other.
- Focus is on evidence-based labour management:
    - Strong advocacy for intermittent auscultation (IA) for fetal health surveillance. The use of IA promotes mobility/position changes during labour and hydrotherapy as a coping strategy. Only IA is used in low risk deliveries. Regular, multi-disciplinary workshops on fetal health surveillance promote IA as a standard of care in normal low risk pregnancies.
- Use of Baby Pause is expected to encourage team discussion throughout patient's care and promote patient safety
- Establishment of accurate EDCs for postdates inductions with thorough discussion of risks/benefits
- Experienced maternity nurses provide prenatal classes. Strong nursing leadership. Staff engage the leadership team in regard to difficult situations, including escalation, trigger tools, and quality review. Nurses empowered to collaborate more effectively with the entire team after implementation of the MORE^{OB} program. Nurses are proactive in advocating for active management of labour for their patients. Labour support is a priority; continuous 1:1 nursing care in active labour.
- Midwifery-supported births have increased substantially as a result of the strong partnerships that have developed with the obstetrical and nursing groups where respect for each other's expertise is paramount. Midwives undertake home labour assessments that keep women in early labour at home. Midwives attend quality review meetings.
- Leadership from obstetricians support evidence-based practice, home births and informed maternal choice.
- Obstetric team is located just down the street and members share same office so are constantly communicating with one another regarding practice and care challenges
- Group of Family Practice physicians have created a "new" sustainable model for maternity care at the Langley Maternity Clinic where the focus is on excellence in primary maternity care. The patient population has high social risk, including recent immigration, mental health issues, and

poverty. The clinic is down the hall from the birthing unit. The clinic has adjacencies to social work for seamless integration of care. Strong collaboration with obstetrics, pediatrics, anesthesia, midwifery and social work. The FP head of the clinic also acts as lead for the Division of Family Practice, enabling closed loop communication and easy rounding**.** Leadership from family practice is provided through perinatal rounds, MORE^{OB} meetings, quality improvement rounds and Langley Maternity Clinic meetings, for which attendance from family practice physicians is required. The family practice group works together as a team in the office, not just individuals sharing a physical location. Sharing patients allows for multiple views and input. Physicians support each other and hold each other accountable to best practice.

Mutual Trust

- Team members earn each other's' trust, creating strong norms of reciprocity and greater opportunities for shared achievement
- Strong, well-attended quality improvement meetings, such as mortality and morbidity rounds, perinatal committee meetings with participation from the interprofessional team on a monthly basis
- The team members work together through MORE^{OB} program activities, Take Five sessions and social events
- All team members encouraged to escalate concerns, nurses comfortable escalating concerns through hierarchy

Effective Communication

- The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings. These include CHAT/SBAR Maternal/Fetal Classification Communication Tool and Walking the Cube tool for learning conversations as well as MORE^{OB} workshops.

Measurable Processes and Outcomes

- The team agrees on and implements reliable and timely feedback on successes and failures in both functioning of the team and achievement of the team's goals – used to track and improve performance immediately and over time.

Afternoon Session (By Invitation)

Discussants

The morning session was reviewed by discussants Dr. Michael Klein, Professor Emeritus in the Department of Family Practice Physician, and Saraswathi Vedam, Professor of Midwifery, UBC.

Dr. Klein made the following observations:

- The increasingly important role played by midwives in helping to alter the culture of practice, including keeping women out of hospital until labour is well established, and the increasing acceptance of midwives by all provider groups.
- The ability of hospitals to maintain low CS rates with and without regular use of epidurals. It means that if the care is sophisticated and team-based, epidurals can be used without leading to adverse outcomes. On the other hand, as in Richmond Hospital, keeping epidural use low and support high can lead to outstanding results.
- Team-based care is key. If there is a coherent philosophy of care and care is collaborative, good results follow.
- Langley has the first OB group using group prenatal care. This is the essence of coherent care. They have the same philosophy and will have a strong positive influence on their institution and on perinatal outcomes.

The Maternity Care Discussion Group (MCDG) is a multidisciplinary discussion group with 1,700 members who discuss clinical practice, research, self-help and analysis of the maternity literature. To join, just email: mklein@mail.ubc.ca and state your discipline and location.

Professor Vedam summarized the morning's discussion of strategies as follows:

- Team culture: shared goals, trust, communication
- Intentional data collection (measurable outcomes)
- Leadership
- Individualized evidence-based care
- Debriefs, accountability, constructive feedback
- Multi-disciplinary rounds, QI/QA, and education
- Harmonized approach and messaging
- One-to-one care
- Prenatal preparation & informed decision making
- Safety broadly defined (psycho-emotional and physical)

She noted the following clinical components of care to promote vaginal birth:

- Hydrotherapy
- Mobility and position changes (telemetry, balls)
- Judicious use of epidurals (need for oxytocin, forceps)
- High touch, low technology skills
- Stay on call
- Cross consultation
- IA vs. electronic fetal monitoring
- Delayed admission with anticipatory guidance

Professor Vedam asked the following questions:

- What is the impact of care on women's catecholamines, comfort, psyche, and transition of their newborn?
- What is the impact of environment through lighting, privacy, appearance and layout of the birth setting?
- Should there be a Mama Pause in addition to Baby Pause?
- What is the impact of relationship-based care/continuity of care?
- Does presentation of risk include both absolute risk and risk in the context of culture and as defined by the patient?
- How does individual skill level and philosophy affect success in a shared call model?

She noted that including the patient voice in person-centred care could involve:

- Patient feedback loops – social media
- Patients at QI/QA meetings
- Patient debriefs
- Measuring patient autonomy and respect
- Impact on patient's obstetrical sequelae, especially among women planning large families

General Discussion among Workshop Participants

Prenatal Education

- In Nanaimo, structured prenatal classes available in the community.
- In Richmond, virtual tours are available, incorporating teaching. An important component of care is physician endorsement of prenatal classes – improves uptake.
- Fort St. John and Terrace identified that building community connections are key aspects of prenatal education. They watch social media groups to be aware of the dialogue and appropriateness of information transfer. Prenatal groups for mothers are an important social fabric.

Prenatal Care

- Beginning early in pregnancy, Langley encourages use of doulas.
- In some settings, children are permitted to attend prenatal visits. This occurred after feedback from the community.
- In other settings, education is provided on a 1:1 basis.

Trauma

- Education about trauma from a trauma specialist was beneficial in Richmond. This information is not normally taught to physicians or nurses.

- Education teaches use of language to avoid re-traumatization.
- Education regarding trauma must enhance physician and RN training.

Patient Engagement

- Go to lay websites (administered by pregnant women) and observe how change is adopted.
- Include patients in MORE^{OB} workshops to assist in education of care providers.
- A satisfaction survey is mandated by the College of Midwives of BC – is there opportunity for a standardized survey in BC?

Priority Strategies

Based on morning presentations and afternoon discussions, feasibility, and available evidence, priority strategies were identified as follows:

1. Embedding services such as antepartum clinics and prenatal classes in hospital maternity units, so that practices are aligned with the clinical setting.
2. Linking services across the perinatal course of care so that philosophies are aligned.
3. Mandating a second opinion before elective CS; potentially for emergency CS as well.
4. Implementing consults from experts in normal labour prior to CS.
5. Making available an expert in labour management in labour units.
6. Undertaking peer review of births after CS.
7. Making education interdisciplinary to promote a culture of working together.
8. Provision of resources to support units to develop and implement interprofessional education, including comprehensive education on physiologic birth.
9. Broader access to prenatal education.
10. Promotion of psychological comfort for women with attention to language and environmental factors:
    a. Early pregnancy assessment for trauma history, tools and referrals for treatment
    b. Postnatal debriefing to assess for trauma experienced during labour and birth
    c. Education for perinatal care providers re: recognition and management of trauma to prevent re-traumatizing experiences.
11. Development of Ministry of Health standards for building construction and development of birthing spaces to promote movement and activity during labour.
12. Use of creative non-pharmacological approaches to second stage.
13. Development of standards of care for perinatal nursing education (mentorship, modelling, conveyance of tacit knowledge).
14. Coaching of practitioners on how to promote vaginal birth by interprofessional champions travelling to hospitals around BC.
15. Streamline and simplify workload associated with documentation for point of care staff.

16. Individualize early labour management.
17. Assessment of patients for adverse childhood experiences ACE questionnaire as part of obstetrical risk assessment.
18. Build toolbox of strategies to promote culture change through enhancing trust and promoting multidisciplinary teamwork.
19. Create a debriefing policy with patients after their birth.
20. Undergo a Take Five type of debrief with patient participation:
    a. What went well?
    b. What did we learn?
    c. What would we do differently next time?
    d. Did we have any systems issues?
    e. Who is going to follow up to address problems?

Priority Strategies Consolidated and Delegated

To continue the discussion of operational issues, feasibility, and resources to facilitate practice change, priority strategies were consolidated and potential agencies with authority to implement those strategies were identified as follows:

Ministry of Health

1. Ensure broader *accessibility* to prenatal education through resources for development of alternative strategies for delivery, including mHealth.
2. Achieve *effective* use of birthing spaces to promote comfort, movement, and activity, through development of evidence-based standards for their design and construction.
3. Resources to support hospitals and health authorities to develop interprofessional education in topical areas *appropriate* to promoting physiologic birth:
    a. A toolbox of strategies to promote a culture of interprofessionalism through enhancement of trust and teamwork
    b. Non-pharmacological approaches to second stage
    c. A standardized approach to early labour management
    d. Standards for continuing education in the workplace (mentorship, modelling, conveyance of tacit knowledge)
    e. Streamlined and simplified point of care documentation.
4. Attain *efficient* use of educational resources through support and endorsement of an interprofessional team of champions/experts who would provide coaching to maternity care provider teams at hospitals regarding implementation of policies, protocols, training, and use of physical space to promote vaginal birth.
5. Promote *acceptability* of services through development of policy for engaging the patient voice in planning change and evaluating experiences.

Perinatal Services BC

1. Ensure broader *accessibility* to prenatal education through implementation and evaluation of alternative strategies for delivery, including use of online technologies and mHealth.
2. Development of training modules *appropriate* for promoting physiologic birth for maternity care providers, including non-pharmacological approaches to second stage, early labour management, and mentorship and modelling for new maternity care professionals.
3. Promote *safety* by establishing guidelines for obtaining a second opinion for elective CS, and potentially for emergency CS.
4. Measure and report on aspects of culture that *effectively* promote interprofessional trust and teamwork.
5. Construct guidelines to support psychological *safety* and comfort for women:
    a. Early pregnancy assessment for trauma history, using the ACE questionnaire and other tools, followed by referrals for treatment
    b. Postnatal debriefing to assess for trauma experienced during labour and birth
    c. Education for perinatal care providers regarding recognition and management of trauma to prevent re-traumatization during labour and birth
    d. Partner with the Faculty of Medicine, Schools of Nursing for development of curriculum for training on trauma-informed care.
6. Attain *efficient* use of educational resources through implementation and evaluation of an interprofessional team of champions/experts who coach maternity care teams at hospitals to develop or promote policies, protocols, training, and physical space to promote vaginal birth. Could involve partnerships with Midwives' Associations of BC and the Doctors of BC.
7. Promote *acceptability* of services to women through development of protocols to engage them in planning and evaluation, including participation in quality improvement exercises, participation in "Take Five" discussions after non-routine events, and routine debriefing after each birth. Could involve partnerships with SPOR networks, the Patient Voices Network and the Institute for Patient- and Family-Centered Care.

Health Authorities

1. Promote *efficiency* and streamlining of services, including collaborative care, by embedding prenatal education classes and antenatal clinics in hospitals.
2. Promote *safety* by implementing protocols for obtaining a second opinion for elective CS, and potentially for emergency CS as well as consults from experts in normal labour.
3. Implement interprofessional education in topical areas *appropriate* to promoting physiologic birth:
    a. Building trust, teamwork, and a positive culture
    b. Early labour management
    c. Standards for continuing education in the workplace (mentorship, modelling and conveyance of tacit knowledge)

d. Non-pharmacological approaches to second stage
e. Use of protocols to streamline and simplify documentation at point of care.

4. Support psychological *safety* and comfort for women by implementing:
   a. Routine antenatal assessment for trauma history, using the ACE questionnaire and other tools, followed by referrals for treatment for all women who need it
   b. Postnatal debriefing to assess for trauma experienced during labour and birth
   c. Education for perinatal care providers regarding recognition, and management of trauma to prevent re-traumatization during labour and birth (i.e. use of language, breathing exercises, supporting/facilitating self-regulation).
5. Promote *acceptability* of services to women through including them in quality improvement exercises, routine debriefing in the postpartum period, participation in the "Take Five" approach to non-routine events, and inclusion in rounds, relevant to promoting vaginal birth.

Final Reflections

Dr. Glenys Webster, Director of Women's, Maternal and Early Childhood Health, BC Ministry of Health noted that although her department is small, she is committed to helping develop approaches to promote vaginal birth, including working with Perinatal Services BC and Optimal Birth BC to work towards some of the changes suggested in this workshop.

Potential Next Steps

- Present findings to PSBC and MOH
- Set up a meeting with workshop organizers and PSBC/MOH with the objective of formulating a strategy to work with health authorities to achieve identified goals
- Set up an informal webinar-based community of practice in which health authorities/hospital representatives meet for support/advice on implementing change
- Evaluation of the outcomes from the workshop, i.e. engage participating sites to share the impact of the conference on practice changes and culture with a follow-up session in 1-2 years. This could link well with a community of practice.
- Publication of workshop findings in peer-reviewed literature

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