



## Perinatal Nurses Respond To Shared Decision-Making Education: A Quasi-Experimental Study

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### Abstract

Women describe a loss of autonomy during childbirth as a contributing factor to labor dissatisfaction. Shared decision-making with choice, option, and decision talk may improve satisfaction. Nurses ( $n = 29$ ) received education on supporting women's autonomy with a standardized communication tool (SUPPORT) to facilitate shared decision-making and create an evolving birth plan. This quasi-experimental pre-/post-test design evaluated participant responses to the education module. Participants supported the use of the SUPPORT tool for shared decision-making and developing evolving birth plans. Most recommended initiation between 13- and 26-weeks' gestation. Nurses' willingness to advocate for women's autonomy increased significantly after education ( $p = .022$ ). Shared decision-making with standardized perinatal communication may support a woman's perinatal education and her satisfaction with labor. Women enter the hospital birthing center with expectations for their labor experience (Cook & Loomis, 2012). Postpartum women report greater satisfaction with their labor and birth experience when their goals are met; they have a voice in their care and they participate in shared decision-making (Reed et al., 2017). Additionally, evidence suggests that mothers and their newborns have better mental and physical outcomes when the mother's labor expectations and goals are achieved (Hidalgo-Lopezosa et al., 2017). Shared decision-making benefits from facilitated communication between the laboring woman, nurses, and others involved in her care. The SUPPORT tool was created to involve the expectant mother in shared decision-making. Any women's health-care provider can use the SUPPORT tool to facilitate communication in preparation for labor and birth. Specifically, a registered nurse (RN) can use the SUPPORT tool to discuss and educate pregnant women about interventions commonly used during labor by the health-care team and laboring women. To promote shared decision-making with the use of the SUPPORT tool, an educational module designed for women's health nurses was developed. This pre-/post-test quasi-experimental research study reports on the women's health nurses' responses to the education module and the nurses' recommendations for the use of the SUPPORT tool in practice.

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## ABSTRACT

Women describe a loss of autonomy during childbirth as a contributing factor to labor dissatisfaction. Shared decision-making with choice, option, and decision talk may improve satisfaction. Nurses ( $n = 29$ ) received education on supporting women's autonomy with a standardized communication tool (SUPPORT) to facilitate shared decision-making and create an evolving birth plan. This quasi-experimental pre-/post-test design evaluated participant responses to the education module. Participants supported the use of the SUPPORT tool for shared decision-making and developing evolving birth plans. Most recommended initiation between 13- and 26-weeks' gestation. Nurses' willingness to advocate for women's autonomy increased significantly after education ( $p = .022$ ). Shared decision-making with standardized perinatal communication may support a woman's perinatal education and her satisfaction with labor.

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**Keywords:** pregnancy, personal satisfaction, shared decision-making, labor, obstetric, communication

Women enter the hospital birthing center with expectations for their labor experience (Cook & Loomis, 2012). Postpartum women report greater satisfaction with their labor and birth experience when their goals are met; they have a voice in their care and they participate in shared decision-making (Reed et al., 2017). Additionally, evidence suggests that mothers and their newborns have better mental and physical outcomes when the mother's labor expectations and goals are achieved (Hidalgo-Lopezosa et al., 2017). Shared decision-making benefits from facilitated communication between the laboring woman, nurses, and others involved in her care. The SUPPORT tool was created to involve the expectant mother in shared decision-making. Any women's health-care provider can use the SUPPORT tool to facilitate communication in preparation for labor and birth. Specifically, a registered nurse (RN)

can use the SUPPORT tool to discuss and educate pregnant women about interventions commonly used during labor by the health-care team and laboring women.

To promote shared decision-making with the use of the SUPPORT tool, an educational module designed for women's health nurses was developed. This pre-/post-test quasi-experimental research study reports on the women's health nurses' responses to the education module and the nurses' recommendations for the use of the SUPPORT tool in practice.

## LITERATURE REVIEW

### *Statement of the Problem*

In an ideal situation, a laboring woman would present a set of goals or expectations for her birth experience and recovery to the health-care team. The

health-care team would discuss her goals before labor. Together, the woman and health-care team would address and evaluate these goals on an ongoing basis. When conditions surrounding her labor changed, education on available therapies would be provided, and the woman and health-care team would work together to determine what is the best evidence supported decision for her care.

In reality, many women are not effectively involved in the decision-making process surrounding their care in labor, and these women report feeling as though they suffered a loss of control or lack of involvement in their care (Henriksen et al., 2017). Nurses and physicians have reported believing that birth plans lead to poor outcomes (Carlton et al., 2009; White-Corey, 2013). However, researchers report that women whose birth plans are adhered to may have better birth outcomes (Hidalgo-Lopezosa et al., 2017).

Through a process of discussing evidenced based labor options and considering the woman's opinion in conjunction with the expertise of the health-care team, shared decision-making can lead to better outcomes and improved maternal satisfaction (Byrne et al., 2017; White-Corey, 2013). Participating in shared decision-making may reduce the loss of autonomy some women feel during labor and childbirth.

### ***Birth Experience***

The birth of a child is one of the most substantial moments in a woman's life, and therefore, it is one of the most memorable (Cook & Loomis, 2012; Lundgren et al., 2009). It is important that women's health nurses do not only provide care to women for the physical changes that the body experiences during labor, but also care for the emotional challenges as well. Lundgren et al. (2009) report on the impact of the childbirth experience on women's identity. They state that women's self-confidence and ability to trust is formed either positively or negatively by their birth experience. When a person is likely to remember every detail of an experience for the rest of their life, it is the responsibility of the health-care team to try to make those memories as positive as possible. According to the Association of Women's Health, Obstetric and Neonatal Nurses (Association of Women's Health, Obstetric and Neonatal Nurses [AWHONN], 2010), evidence that nurse staffing levels improve outcomes for people admitted to intensive care units and surgical settings likely transfers to the inpatient birthing context as these are

also intensive care settings. The American College of Obstetricians and Gynecologists (American College of Obstetricians and Gynecologists [ACOG], 2019) recommends that continuous labor support be provided in the form of "... 1 nurse to 1 woman in labor to promote shorter labor, decreased use of analgesia, and anesthesia, decreased risk of operative vaginal birth or cesarean birth, decreased need for oxytocin, and increased patient satisfaction" (pp. 166–167). Women's health nurses must ensure the needs of the woman are met by encouraging her to be directly involved in her care when one to one staffing is not feasible. A woman who feels she is losing control of her body and the circumstances surrounding her labor may be traumatized (Hollander et al., 2017). The health-care team can work with the woman to support her during these potentially traumatic events. Women's health-care nurses who take the time to explain the changes occurring during labor and options surrounding intervention can support the woman while collaboratively adjusting to the woman's new circumstances. The process of remaining flexible, as changes occur, differentiates the evolving birth plan from the more commonly identified static birth plan.

### ***Birth Plans***

Autonomy is one of the most significant factors in determining the level of satisfaction a woman has in the postpartum period (Cook & Loomis, 2012; Reed et al., 2017). The act of creating a birth plan or using a communication catalyst provides an educational opportunity for women (Aragon et al., 2013). This education allows a discussion between the health-care team and the expectant mother about the unplanned scenarios that commonly develop during labor. By discussing these events, women can make informed decisions leading to feelings of empowerment (Aragon et al., 2013). Active participation in shared decision-making with the health-care team can result in overall feelings of satisfaction by the woman, even if expectations are not fully met (Hauck et al., 2007).

Some women develop a formal birth plan that facilitates communication with the health-care team, improves women's satisfaction, and promotes

participation in shared decision-making during the birthing process (Hidalgo-Lopezosa et al., 2017). Other women do not create or are unable to articulate a formal birth plan, but these women still have expectations of labor and childbirth. Women who have many requests on a birth plan can experience dissatisfaction if many of the requests are not met. It becomes challenging to meet a woman's goals and ensure she is satisfied with her birth when she develops a more static birth plan with extensive detail. In Olmstead's (2017) published interview with Afshar, MD, the necessity of flexibility in the birth plan was identified as a common theme from both the woman and the health-care team's perspective. Positive health outcomes for the mother and infant occur when a woman's autonomy is maintained alongside a focus on evidence-based decision-making for a good physical birth outcome. Achieving this goal is more likely when the health-care team and the woman participate in an ongoing discussion about the birth plan (Cook & Loomis, 2012). According to Hidalgo-Lopezosa et al. (2017), adherence to a birth plan can improve both outcomes and satisfaction. The nurse who communicates about the events that may occur during labor, discusses the birth options, and educates the laboring woman may help her to feel satisfied while maintaining a culture of safety through the evolving birth plan.

### ***Clinician Perspectives***

In an online survey of 600 obstetricians, 30% felt like a birth plan would lead to a poor outcome (Olmstead, 2017). Carlton et al. (2009) identified that most nurses believe that having a written birth plan causes a "jinx" on the labor. A 2017 study by Hidalgo-Lopezosa et al. analyzed the cord pH of infants born to mothers with birth plans. Infants born to mothers in the low compliance to birth plan group showed a cord pH less than 7.20 at a rate of 14.6%, which is much higher than the compliance group at only 2% ( $p = .024$ ; Hidalgo-Lopezosa et al., 2017). Women with a birth plan were 28% less likely to receive oxytocin ( $p < .01$ ), 29% less likely to undergo artificial rupture of membranes ( $p < .01$ ), and 31% less likely to have an epidural ( $p < .01$ ) (Afshar et al., 2018). Thus, using shared decision-making

and considering the woman's evolving birth plan may lead to improved infant outcomes as well as increased maternal satisfaction.

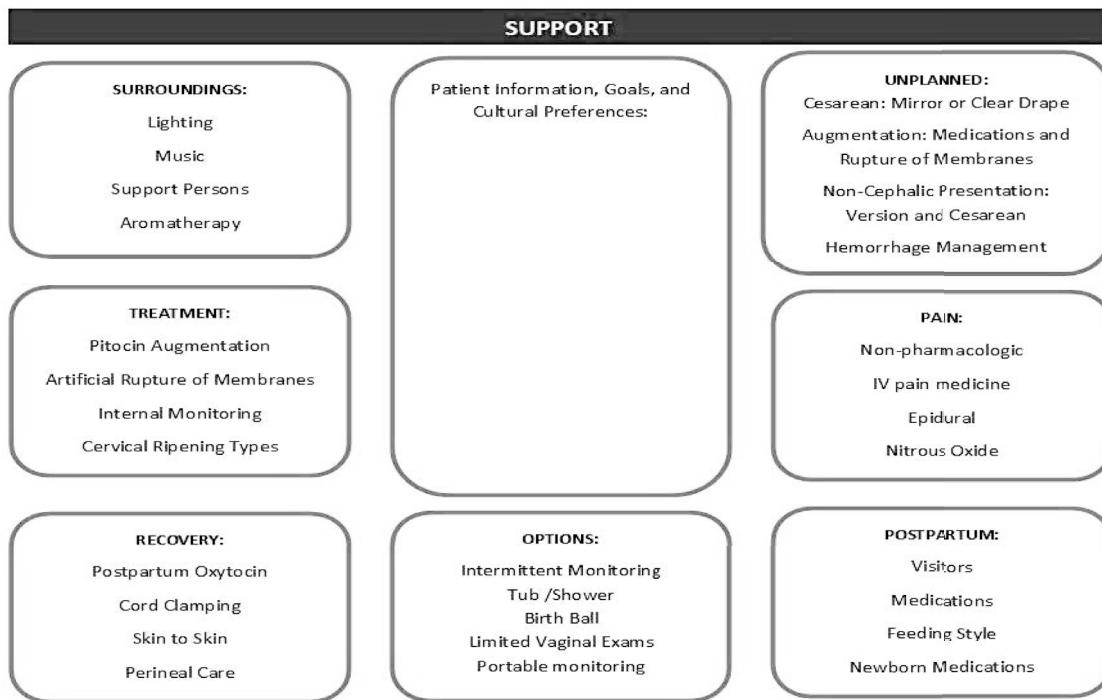
### ***Shared Decision-Making***

Shared decision-making upholds the ethical imperative of respect for patient autonomy and engagement (Elwyn et al., 2016). Actively discussing the plan of care on a continuum is a necessary component of patient engagement (Waller-Wise, 2016). Elwyn et al. (2012) proposed an Interprofessional Shared Decision-Making (IP-SDM) model for clinical practice and identified three key components to successful integration of shared decision-making into patient care. The three identified components are choice, option, and decision talk (Elwyn et al., 2012). To facilitate a conversation about the plan of care, the woman must first be presented with the concept of choice. Then they should be provided evidence-based options. After the woman has been educated on their choices and options, an open line of communication should occur, in which questions about risks and benefits are weighed and answered. This process leads to the decision talk component in the IP-SDM. Ultimately, a safe decision, based on the woman's wishes, that is well informed and supported by the health-care team is made (Elwyn et al., 2012). A standard communication tool should be used to establish the line of communication and provide women with consistent, evidence-based options.

### ***Development of the SUPPORT Tool***

Divall et al. (2017) explained it well saying that there is no one size fits all birth plan, and every individual must discuss their personal needs and preferences with their health-care team. The topics for development of the communication tool were established with review of the available birth templates and consulting with content experts including certified and experienced labor nurses, obstetricians, certified nurse midwives, and hospitalized pregnant women for content validity. SUPPORT, is an acronym for the following labor and childbirth care categories: Surroundings, Unplanned, Pain, Postpartum, Options, Recovery, and Treatment.

The SUPPORT tool (Figure 1) is a single page form where the health-care team and the laboring woman can identify goals and view common options and interventions in one place. Together they can discuss what the woman desires and the



**Figure 1.** SUPPORT communication tool; sample design for standardized communication

health-care team anticipates for the plan of care. The SUPPORT tool, as a visual aid, will encourage open communication and support shared decision-making that assures safety of the mother and baby while allowing the woman to actively participate in her care (Waller-Wise, 2016). According to Afshar et al. (2017), birth plans could be used as a quality improvement tool. The SUPPORT tool is an evolving birth plan designed with common birth plan themes to improve communication and subsequent women's care with shared decision-making.

## METHODS

### Participants

A university institutional review board (IRB) reviewed the study procedures and determined this study to be of low risk and exempt from ongoing oversight. All responses were managed with REDCap software and only a participant number, as assigned by the software, identified participants. Participants were recruited from the *Labor and Delivery Nurses Rock* Facebook group with a link to the online survey and educational module. No incentives for participation were offered. Participants were informed of the purpose of the educational research and agreed to participate prior to accessing the survey and educational content. Participants who agreed to continue with the study were included in data analysis if they

were over 18 and answered 95% of the survey questions. Nurses ( $n = 29$ ) participating ranged from age 25 to 62 ( $n = 36.28$ ) years with a mean experience of 9.02 years and a range of 1–32 years of experience in obstetrics. Slightly less than half (48.3%) of participants reported being members of AWHONN. Participants were given four options to describe their nursing style to which 75.9% described their style as “anything goes.”

### Instruments and Procedures

The online survey and educational module collected both qualitative and quantitative data. Participants evaluated agreement with five survey statements (Table 1) using a 5-point Likert scale as follows: 1—strongly disagree, 2—disagree, 3—neutral, 4—agree, and 5—strongly agree. The post-education analysis assessed (a) if changes occurred in the participant perspectives regarding birth plans and (b) if participants believed that a communication tool could benefit their ability to advocate for women's wishes. Following the education participants answered one open ended question, “How would you use the SUPPORT tool in Practice?”

A link to the Research Electronic Data Capture (REDCap) platform, a secure web application for managing online surveys, was distributed to participants via social media and secured the participant

data. After agreeing to participate, each participant completed demographic questions, followed by a survey with a Likert scale (Table 1), education module, repeat of the survey with Likert scale, and answered an open-ended question. The education module consisted of a one-page pdf file detailing shared decision-making and advocacy; the SUPPORT communication tool; and how the nursing role contributes to each portion. Participants also viewed a 5-minute video that explained each component of the SUPPORT tool as described by the developer.

Demographic responses were used to categorize participants. Categories such as years of service in obstetrics, age, and membership to AWHONN were used to form group comparisons for analysis of responses to survey statements. IBM Statistical Package for the Social Sciences (SPSS) software versus 26 was used in all calculations. Additionally, the data was analyzed for correlational differences related to years of service in obstetrics using a frequency analysis as opposed to a chi-square due to a small sample size with a non-normal distribution (Table 2).

### Results

Analysis of the Likert scale difference between pre and post intervention for each of the five statements indicated changes in the expected direction after the educational intervention (Table 3). Each pretest and posttest statement response was compared using a paired samples *t*-test. Statistical significance ( $p = .022$ ) was demonstrated with statement 4, "I advocate for my patient's wishes when the plan of care needs to change from their original wishes." Statement 3, "Patient and fetal safety is more important than a patient's autonomy" did not demonstrate a

statistically significant change. However, the shift in mean was meaningful due to the nature of the relatively high pretest score for this statement. Interestingly, nurses with less than 5 years of experience had no change in their response to question four after education. However, nurses with 15 or more years of experience, had an observed categorical frequency difference. Post education, there were no "strongly agree" responses to statement 3. This outcome demonstrated the effectiveness of the education module in changing attitudes of more experienced RNs.

### DISCUSSION

#### **Statement One: Patient Satisfaction Improves When the Patient Is Involved in the Plan of Care Even With a Negative Birth Outcome**

The statement one mean score prior to educational intervention was 4.66 and 4.69 after intervention. Statement one had the smallest change in mean (0.034) but had one of the highest preinterventions means. Though the mean increased after education, there was only a small margin for improvement since 70.2% of initial responses were "strongly agree" (5). This finding is congruent with findings from Cook and Loomis (2012) who identified "women's positive and negative recollections of their birth experiences are related more to feelings and exertion of choice and control than to specific details of the birth experience" (p. 158).

#### **Statement Two: Fetal Outcomes Improve When the Plan of Care for a Birth Is Discussed**

The mean score prior to education was 4.21. After education, the mean increased to 4.38, a change in mean of 0.172, which was not statistically significant. The initial mean of the nurse's responses was higher than expected based on Olmsted's (2017) survey of nurses reporting on nursing's general belief that a birth plan leads to a "jinx." This higher agreement with statement two is likely a reflection of the characteristics of this convenience sample. The

TABLE 1

**Survey Statements Measured for Agreement/Disagreement Using a 5-Point Likert Scale**

	Survey Statement
1	Patient satisfaction improves when the patient is involved in the plan of care even with a negative birth outcome.
2	Fetal outcomes improve when the plan of care for a birth is discussed.
3	Patient and fetal safety is more important than a patient's autonomy.
4	I advocate for my patient's wishes when the plan of care needs to change from their original wishes.
5	Patient education is essential for satisfaction and shared decision-making

study participants may have been more engaged in this topic than other women's health workers as evidenced by their group affiliation (e.g., AWHONN). However, the scores do indicate a stronger belief in discussion of birth plans for improved fetal outcomes. Discussion of the birth plan provides opportunity for decision talk, an important component of shared decision-making.

**Statement Three: Patient and Fetal Safety Is More Important Than a Patient's Autonomy**

Participant responses to statement three changed meaningfully. The statement three mean score prior to education was 3.45 with responses ranging from disagree (2) to strongly agree (5). After education, responses included strongly disagree (1) as well as a reduction in the frequency of strongly agree (5)

response from 10.3% to 3.4%. After education, the mean score dropped to 3.28 a difference of 0.172. Notably, the more years of service in obstetrics, the greater the change in responses after education to the statement three. The nurses with less than 5 years of experience had no change in their beliefs after education. However, nurses with 15 or more years of experience eliminated use of the "strongly agree" responses to statement three (Table 2).

The participants increased in their identification of the maternal right to actively participate in their birth plan. This change in belief is essential for effective shared decision-making. As people, our values differ and for some individuals there are aspects of their childbirth that are essential for their satisfaction, even if that decision does not follow recommended guidelines. Nurses who are willing

TABLE 2

**Frequency of Agreement With Statement 3 Pre-/Posteducation by Experience in Obstetrics**

Statement 3			Years in Obstetrics			Total
			5 or less	5.1–14.99	15 or more	
Patient and fetal safety is more important than a patient's autonomy	Presurvey	Disagree	2	0	1	3
		Neutral	5	6	2	13
		Agree	8	1	1	10
		Strongly agree	0	1	2	3
		Total	15	8	6	29
	Postsurvey	Strongly disagree	0	1	0	1
		Disagree	2	1	0	3
		Neutral	5	4	4	13
		Agree	8	1	2	11
		Strongly agree	0	1	0	1
	Total	15	8	6	29	

TABLE 3

**Comparison of Agreement to Survey Statements Pre-Post Education With Paired Sample t-Test**

Survey Statement	Mean			SD	Std. Error Mean	t	df	Sig. (2-tailed)
	Pre	Post	Change					
Patient satisfaction improves when the patient is involved in the plan of care even with a negative birth outcome	4.66	4.69	.034	.421	.078	-.441	28	.663
Fetal outcomes improve when the plan of care for a birth is discussed	4.21	4.38	-.172	.602	.112	-1.543	28	.134
Patient and fetal safety is more important than a patient's autonomy	3.45	3.28	.172	1.002	.186	.926	28	.362
I advocate for my patient's wishes when the plan of care needs to change from their original wishes	4.21	4.39	-.179	.390	.074	-2.423	27	.022
Patient education is essential for satisfaction and shared decision-making	4.68	4.75	.071	.466	.088	-.812	27	.424

to engage in decision talk demonstrate support for women's autonomy. Women have reported feeling dehumanized through the loss of self during labor and childbirth as the focus is all on the child (Byrne et al., 2017). Nurses may improve both birth outcomes and satisfaction by acknowledging the importance of a woman's autonomy and returning a feeling of control to her through shared decision-making.

***Statement Four: I Advocate for My Patient's Wishes When the Plan of Care Needs to Change From Their Original Wishes***

The participants' mean score on statement four prior to education was 4.21 and 4.39 after education. This was a statistically significant increase in the mean of 0.172 ( $p = .022$ ). Completion of the educational module increased the participant's awareness of the nurse's role in advocating for the woman's wishes as their labor progresses. The first objective of the education module was "The learner will be likely to advocate for the obstetric patient's unfolding labor plan." Although respondents were already likely to advocate for the women, the increase in mean indicates that the educational objective was achieved, and participants were now more likely to advocate for the woman.

***Statement Five: Patient Education Is Essential for Satisfaction and Shared Decision-Making***

The second educational objective, "The learner will value education as a primary component of shared decision-making" is best evaluated using statement five data. The mean response prior to education was 4.68 and post education was 4.75 and mean difference of 0.071. Elwyn et al. (2012) reminds readers that shared decision-making begins with providing education about treatment options. The education module strengthened participants' value of education as an essential component of shared decision-making as demonstrated by the increased mean. This demonstrates the nurses' value of participation in options talk as described by the IP-SDM (Elwyn et al., 2012).

***Qualitative Responses***

A third objective of the learning module was, "The learner will identify how and when to implement a childbirth communication tool into their practice." This educational objective was achieved as measured by participants' responses to a short answer question. Nurses (53.6%) identified weeks 13–26 as

an ideal gestational age to implement the use of the SUPPORT tool for improved shared decision-making. Additionally, participants provided qualitative feedback about how they would prefer to implement the SUPPORT tool in practice (Table 4). A response that confirmed Olmstead's (2017) report of health-care professionals' negative view of birth plans and the opportunity for change was as follows: "I would love to see this discussed at prenatal visits; I feel like in general birth plans are looked upon negatively. This helps to create one positively, it is not forcing anything on a patient. It just helps to identify their needs and how we can support them through those choices" (Participant 24).

***Limitations***

Nurses who choose to participate as part of the convenience sample are likely to be intrinsically motivated learners (Knowles et al., 2005). It is unknown if less motivated learners would have a more or less significant response to this educational module. These motivated participants demonstrated an increase in their mean scores after education indicating the effectiveness of this education among these participants. Additionally, the small sample size limits the ability to identify statistically significant change, especially in the presence of data that is not normally distributed.

***Recommendations***

Further study of nurses implementing the SUPPORT tool with the laboring woman is needed to determine her perception of the SUPPORT tool and nurse perception of usability in practice. Involving a larger and more diverse sample may also provide additional insights into the SUPPORT tool's effective implementation and utilization for shared decision-making. Shared decision-making with communication tools could be further developed and studied in other areas of nursing practice. For example, a communication tool could be developed for use in family planning and conception to navigate care options. A modified communication tool could benefit a variety of facilities and situations.

**IMPLICATIONS FOR PRACTICE**

Surveyed nurses responded to an educational module with the belief that guided shared decision-making using an evolving birth plan will support women's autonomy. Educating nurses in the use of a standardized communication tool, such as



TABLE 4

**Participant Responses: “How Would You Use the SUPPORT Tool in Practice?”**

Participant	Response
1	To help a patient make decisions.
11	I would appreciate the reminder to have these discussions every time. I already incorporate ongoing communication and prioritize it in my nursing, but I know I don't do enough every single birth.
20	Working with patients on their wishes and helping them to look back on their birthing experience with happiness and satisfaction that it went the best way possible even if it wasn't exactly how they had planned for it to go. It could also be used for discussion between health-care providers while caring for a laboring mother.
24	I would love to see this discussed at prenatal visits; I feel like in general birth plans are looked upon negatively. This helps to create one positively, it isn't forcing anything on a patient. It just helps to identify their needs and how we can support them through those choices.
26	Education with patients on what interventions and why they are needed.
30	When the patient arrives either in observation or as an admit.
32	Prenatal appointments, induction of labor (IOL) admission, labor admission, in triage—could have a checklist in the electronic health record (EHR) that we check off preferences as patients decide...or "undecided" until they do decide. The earlier the better as we never know when they may present.
40	I would use it during my initial assessment to better understand my patient's wishes. I like how it opens areas for education.
41	I like the idea of having a standardized communication tool for each patient!
46	Yes I love the format! Nice job explaining it as well!!
63	I don't think our docs would pay attention to it.

TABLE 5

**Practice Implications**

Practice Implications
Guide shared decision-making with an evolving birth plan to support women's autonomy.
Educate nurses in the use of a standardized communication tool, such as the SUPPORT tool, to improve shared decision-making and benefit nursing practice.
Initiate the evolving birth plan with the SUPPORT tool between 13- and 26-weeks' gestation to facilitate shared decision-making.
Discuss the evolving birth plan throughout the birth process.
Use a communication tool to facilitate shared decision-making to improve women's care and satisfaction in the labor and childbirth setting.

the SUPPORT tool, may improve shared decision-making and benefit nursing practice. Initiating the evolving birth plan with the SUPPORT tool between 13- and 26-weeks' gestation may facilitate shared decision-making. In addition to this earlier implementation, the discussion with the evolving birth plan should continue through the birthing process. Using a communication tool to facilitate opportunities for shared decision-making may improve women's care and satisfaction in the labor and childbirth setting.

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