

KINGSBOROUGH COMMUNITY COLLEGE
of
The City University of New York
Department of Nursing
Family Centered Maternity Nursing

Nursing 19

Summary Guide to Nursing Care in Labor

First Stage: Dilation, begins with the onset of true labor and ends with complete effacement and dilation of cervix.

Nursing Assessment (Normal process and psychologic characteristics)

Early (Latent) Phase - Duration approx. 6-8 hrs.

- A. Cervical dilation - 0-3 cm
- B. Cervical effacement - 0-100% Nullipara - complete before dilation begins
Multipara - occurs simultaneously with dilation
- 3. Descent - Nullipara - 0 station
Multipara -0, - 2 station
- D. Contractions - Intensity - mild to moderate
Frequency - q 5-30 mm
Duration - 30 - 45 seconds
Rhythm - irregular
- E. Fetus - Heart rate between 120 -160 beats/min
Normal baseline variability
No abnormal decelerations
- F. Show - Color - brownish mucous plug or pale pink mucus amount - scant

Nursing Orders

- 1. Complete admission procedure and H as swiftly as possible.
- 2. Explain routine care procedures before initiating them.
- 3. Apply external monitor.
- 4. Assess and document:
 - a. Contractions q 30 mi - 1 hr.
 - b. FHR q 30 - 60 min.
 - c. B/P, P, R, vaginal discharge & psychological response q. 30-60 mm.
 - d. Temp q4h, unless otherwise indicated.
note (hospital policy for variations)
- 5. Establish good rapport with patient and family:
 - a. remain with patient
 - b. listen to expressions of fear/anxiety.
 - c. give positive reinforcement.
 - d. explain labor process, relaxation and breathing techniques.
- 6. Encourage partner participation and support.
 - a. allow couple time together alone.

Nursing Assessment – con't (Early Labor)

- G. Vital Signs - B/P - remains within normal limits, may be elevated during contraction or if excited.
Temp. - does not increase above 37.2 C (99 F).
Pulse - 60-90 beats/mm.
Resp. - 6-24/mm., changes with breathing techniques and discomfort.
- H. Behavior and - Appearance:
Excited, usually happy, talkative or silent and eager to be in labor. Alert, follows directions readily, seeks information, open to instructions. Some apprehension, discomfort controlled very well. May have backache or low abdominal discomfort.

Nursing Orders – con't

7. Provide or encourage distraction and attention focusing on conversation, music, T.V., reading, games, touch.
8. Encourage ambulation according to hospital policy for active labor/ruptured membranes.
9. Maintain hydration:
a) record I & O, dipstick urine.
b) encourage voiding q 2-3 h.
c) monitor IV @ 125 ml/hr or as ordered.
d) provide mouth care, ice chips prn.
10. Assist with relaxation & breathing techniques:
a. focus eyes on focal point.
b. alert patient to: beginning of contraction, time called out @ 15 sec, 30 sec etc., end of contraction.
c. concentrate on breathing technique: begin contraction with a breath in through nose and out through mouth; end contraction with a breath in through nose and out through mouth.
d. use effleurage.
11. Report any deviation from norm.

Nursing Diagnoses for Consideration:

1. Anxiety r/t unknown outcome of labor
2. Comfort, alteration in r/t contractions, fear, lack of preparation.
3. Knowledge deficit: admission procedures, coping mechanisms, unfamiliar setting
4. Impaired gas exchange, (utero/placental) rt. maternal position, contractions, maternal hypotension

Nursing Assessment (Normal progress and psychological characteristics)

Active Phase - duration approx. 3-6 hrs. More rapid dilatation and descent of presenting part.

- A. Cervical dilation - 4-7cm
- B. Cervical effacement - usually complete
- C. Descent - Nullipara - about +1 to +2 station
Multipara - about +1 to +2 station
- D. Contractions - Intensity - moderate, to strong
Frequency - q 3-5 mm.
Duration - 40-70 seconds
Rhythm - more regular
- E. Fetus - as in early phase
- F. Show - Color - pink to bloody mucus
amount - scant to moderate, increasing, becoming thicker and bloodier
- G. Vital Signs - as in early phase
- H. Behavior and - Appearance:
Becoming more serious, growing apprehension.
May experience feelings of helplessness.
Exhibits increased fatigue and may begin to feel restless and anxious as contractions become stronger.
Doubtful of control pain, desires companionship and encouragement. Has some difficulty following directions, becomes more dependent. May experience increased backache. M.D. may rupture membranes.

Nursing Orders

1. Assess and document:
 - a. Contractions, FHR & psychological responses q 15 minutes.
 - b. Vaginal discharge q 30 mm.
 - c. B/P, P,R, q 30 mm.
 - d. Temp q4h, unless otherwise indicated.
2. Decrease environmental stimulus (lights, noise, etc.).
 - a. provide privacy.
3. Keep explanations & instructions short and simple.
4. Encourage patient to rest between contractions:
 - a. do not ask irrelevant questions.
 - b. keep voice well modulated.
5. Encourage position change q 20-30 mm
 - a. elevate top of bed 45.
 - b. use pillows/blanket rolls to support dependent body parts.
6. Provide comfort measures:
 - a. mouth care and ice chips.
 - b. cool washcloth to face.
 - c. counterpressure to sacrococcygeal area.
 - d. encourage pelvic rock exercise.
 - e. place small rolled towel in small of back.
 - f. apply heat or cold to lower back.
 - g. change linen & gown pm.
 - h. encourage partner to participate in care.
7. Keep patient & partner aware of progress.
8. Encourage and praise both.
9. Assess bladder, IV and hydration.
10. Consult with M.D. or nurse - midwife for analgesics/anesthesia.

Active Labor con't

Nursing Orders con't

11. Assist with relaxation & breathing techniques:
 - a. remind to use focal point.
 - b. encourage voluntary relaxation of muscles of back, buttocks, thighs and perineum.
 - c. use effleurage.
 - d. begin contraction with breath in nose, out mouth, then slow chest breathing until contraction intensifies, then shallow, effortless mouth breathing @ moderate pace through peak of contraction; slow chest breathing as contraction subsides.
 - e. encourage breathing that feels right for patient.
12. Provide support to partner (refreshments, breaks) and reinforce appropriate behavior.
13. Report any deviations from norm.

Nursing Diagnoses for Consideration:

1. Possible urinary elimination, alt, patterns of r/t pressure of fetal descent, effects of anesthesia/analgesia.
2. Tissue perfusion, alt. (utero/placental) rt. contractions, maternal position.
3. Infection, high risk for rt. bacterial invasion 2 R.O.M., vaginal exams, invasive lines (IV, monitor).

Nursing Assessment (Normal progress & psychologic characteristics)

Transition Phase - Duration approx. 20 to 40 minutes

- A. Cervical dilation - 8-10 cm
- B. Cervical effacement - complete
- C. Descent - Nulli & Multipara - +2 to +3 station
- D. Contractions - Intensity - strong to expulsive
Frequency - q 2-3 mm.
Duration - 45-90 sec.
Rhythm - regular
- E. Fetus - May experience early decelerations
- F. Show - Color - bloody mucus
Amount - copious
- G. Vital Signs - As in early phase
- H. Behavior and Appearance: Mood changes, difficulty in coping. Acute sensitivity & irritability, feelings of frustration, fear of loss of control. "Don't touch me" "Leave me alone" Vague in communications, difficulty in carrying out directions. Restless, exhausted, amnesia between contractions, writhing with contractions. Horror of being left alone but little desire for interaction. May be easier to be "put to sleep". May experience leg cramps, shaking and chills, perspiration on forehead and upper lip, nausea, vomiting, hiccoughing, pulling and stretching sensations low in pelvis, severe backache, feeling of need to defecate and pressure on anus.

Transition con't

Nursing Orders

1. Stay with woman & provide constant support:
 - a. make eye contact.
 - b. repeat directions firmly.
 - c. reassure regarding normalcy of sensations and closeness to delivery.
 - d. breathe with patient.
2. Assess and document:
 - a. contractions, FHR & psychologic responses q 15-30 minutes.
 - b. vaginal discharge q 10-15 mm.
 - c. B/P, P, R, q 15-30 min.
 - d. Temp. q4h, unless otherwise indicated.
3. Assess perineum with every contraction. Observe for bulging, caput.
4. Perform orders #2 through 9 as in active phase.
5. Accept behavior.
6. Assist with relaxation and breathing techniques:
 - a. remind to use focal point.
 - b. encourage voluntary relaxation of muscles of back, buttocks, thighs and perineum.
 - c. may refuse effleurage.
 - d. begin contraction with breath in nose and out mouth, then use puff-blow pattern in 4:1 ratio - breath, breath, breath, breath, puff (as though blowing out a candle). Ratio may be increased to 6:1 or 8:1, end contraction with breath in nose and out mouth.
 - e. observe for S & S hyperventilation.
 - f. have patient "blow out" whenever she feels urge to push.

Nursing Orders con't

7. Have partner change to clothes for DR. before transition.

8. Breathe with patient – “actions are more effective than words”.
9. Report any deviations from norm.

Nursing Diagnoses for Consideration:

1. Possible communication, impaired r/t anxiety, fear, contractions.
2. Possible fear (partner) r /t woman’s unexpected behavior changes.
3. Infection, high risk for rt, bacterial invasion 2, R.O.M., invasive lines (IV, monitor), vaginal exams.
4. Tissue perfusion, alt. utero/placental rt., contractions, maternal position.

In primigravida, 1st stage lasts average 12 – 14 hrs

In multipara, 1st stage lasts 6 – 1- hrs.

Second Stage: Expulsion, begins with full dilation and complete effacement of the cervix and ends with the birth of the infant.

Nursing Assessment (Normal progress and psychologic characteristics)

- A. Cervical dilation - complete, 10 cm
- B. Cervical effacement - complete, 100%
- C. Duration - 20-60 minutes
- D. Contractions - Intensity - expulsive, 50-70 mm Hg
Frequency - q 2-3 mm.
Duration -90 sec.
Rhythm - regular
- E. Descent - constant (+2 to +4 station)
- F. Fetus - May experience early decelerations.
- G. Show - Color - bloody mucus Amount - copious
- H. Behavior and Appearance:
Increasingly involved in birth process, works with contractions, relief when pushing, desire to bear down or push. May be unable to follow directions readily. Makes grunting sound and expiratory vocalizations. Complete exhaustion after each contraction. Perineum begins to bulge and anal orifice begins to dilate. May feel baby is stuck. Very tired but determined - new burst of energy may appear. May describe "ring of fire."

2nd Stage cont'd

Nursing Orders

- 1. Stay with woman and provide constant support:
 - a. make eye contact.
 - b. repeat directions with each contraction.
 - c. prepare for transfer to delivery room
 - d. encourage and praise client's pushing efforts.
- 2. Assess and document:
 - a. continuously q contraction and fetal response
 - b. perineum with q contraction.
 - c. B/P, P, R & temp as per hospital policy
 - d. bladder, hydration and IV.
- 3. Assist with position for pushing:
 - a. Side-lying - upper leg held by nurse on partner.
 - b. Hands-Knees - provide for safety.
 - c. Semi-Fowler - head and shoulders raised to 45 angle. Thighs flexed on abdomen, hands grasped just below knees. Pull on knees and flex chin on chest.
- 4. Encourage bearing down efforts:
 - a. have her push when she feels like pushing.
 - b. have her take 3 breaths at beginning of contraction
 - c. have her push no longer than 5 seconds at a time.
 - d. push with an open glottis and slight exhale.
 - e. encourage her to "push the baby out of the vagina (or birth canal)."
 - f. remind her to relax pelvic floor.
 - g. have her take 3 breaths at end of contraction.

Nursing Orders- cont'd

- 5. Transfer to delivery room:
 - a. position client on delivery table

- have her move down so that buttocks are at end of table.

- b. place both legs in padded stirrups at same time.
- c. adjust stirrups to be at equal height.
- d. do penineal prep.
- e. prepare warm environment for newborn.
- f. check resuscitation equipment

- g. monitor FHR after q contraction.
- h. encourage client's pushing efforts.
- i. encourage and praise client and partner's efforts.
- j. remind client to "blow out" when M.D. or C.N.M. does not want her to push.
- k. instruct partner in D.R. procedures and policies.
- 6. Provide immediate care for newborn:
 - a. note time of birth.
 - b. maintain clear airway, suction mouth, then nose, place in trendelenburg position.
 - c. provide for warmth, dry head and body well, place in radiant warmer, apply temp probe to abdomen.
 - d. perform apgar score @ 1 & 5 minutes.

 - e. assess cord for anomalies.
 - f. assess infant for obvious anomalies.
 - g. identify infant as per hospital policy.
 - h. assess weight, length and head circumference as per hospital policy.
 - i. perform eye prophylaxis.
 - j. encourage parent-child interaction point out infant's features, explain normal variations.
 - k. observe for inappropriate behaviors i.e. reluctance to touch baby, lack of eye contact, inappropriate remarks.

Nursing Dx for Consideration:

1. Injury, high risk for (trauma) it material transfer LR □ DR, rapid delivery.
2. Ineffective individual coping.
3. Comfort
4. Fear
5. Tissue perfusion, alt., utero/placental rt. contractions, maternal position, pushing efforts.
6. Newborn:
 - a) High risk for ineffective airway clearance r/t excess mucus.
 - b) Ineffective thermoregulation rt. adaptation to extrauterine environment.

Third Stage: Placenta, begins with birth of the baby and ends with the expulsion of the placenta and membranes.
Duration 2 -30 minutes

Nursing Assessment (Normal progress and psychologic characteristics)

- A. Contractions - temporarily cease with birth.
- B. Uterus - rises upward in abdomen changes from discoid to a globular shape and becomes more firm.
- C. Perineum - umbilical cord lengthening as the placenta gets closer to the introitus.
 - sudden gushing of dark blood from the introitus
 - vaginal fullness (the placenta) on examination
- D. Vital Signs - B/P - returns to normal prenatal levels.
Pulse - bradycardia for approx 7-10 days.
- E. Behavior and Appearance - Exhausted, relieved, excited, may have trembling and experience chilling sensation.
Eager to see and touch baby.

Nursing Orders

- 1. Instruct client to push as contractions are felt.
- 2. Assess B/P, P & R after delivery of placenta.
- 3. Administer oxytocin as per M.D./C.N.M. order
- 4. Assist MD/C.N.M. with inspection of cervix and or repair of episiotomy:
 - a. remind patient to relax pelvic floor muscles.
 - b. assist patient in using comfortable breathing technique.
- 5. Prepare patient for transfer to recovery room:
 - a. remove both legs simultaneously from stirrups.
 - b. apply sterile pen pad.
 - c. change gown and cover with warm blankets.
 - d. raise side rails on stretcher/bed.
 - e. use good body mechanics.

Nursing Diagnoses for Consideration in 3rd & 4th Stages

- 1. Comfort alteration in: pain r/t perineal trauma.
- 2. High risk for infection r/t bacterial invasion & trauma during L&D, episiotomy.
- 3. Possible fluid volume deficit secondary uterine atony.
- 4. Fatigue r/t energy expenditure associated with childbirth.

Fourth Stage: Recovery, begins with delivery of placenta lasts for approximately 2 hours. Critical period for mother and neonate.

Nursing AssessmentNursing Orders

- A. Fundus - firm midline, 2 cm above or at umbilicus 2 hr after delivery.
- B. Bladder - may be distended, check location, maybe seen as a rounded suprapubic bulge.
- C. Lochia - moderate flow; may contain clots.
note color, odor, amount
scant = less than 1 inch stain on peri pad
light = less than 4 inch stain on peri pad
moderate = less than 6 inch stain
- and
heavy - saturated pen pad in 1 hr.
anxious,
- D. Perineum - may be edematous, discolored and sutures intact.
- E. Vital Signs - B/P - slightly elevated from excitement & delivery, returns to normal within 1 hr.
Pulse - normal bradycardia within 1 hr.
- F. Behavior & Appearance Excited, elated, exhausted.
Anxious to touch and hold newborn. Anxious to see partner, mother, May have nausea, vomiting, diaphoresis, diuresis, shaking chill.

1. Assess fundus lochia, perineum & v/s q 15 minutes x 1 h, than q 30 mm x 1 h.
 - a. massage fundus if boggy.
 - b. express clots as necessary.
 - c. check for bladder distention, record time and amount of first voiding. Catheterize as necessary.
 - d. check under buttocks as well as pad for lochia flow
 - e. notify MD stat if patient soaks 2 perineal pads in 15 min, complains of feeling light headed, "seeing stars" or feeling "funny sick to her stomach", begins to act color turns ashen or gray and skin feels cool and clammy.
 - f. apply ice to perineum per hospital policy, assess for hematoma formation.
2. Provide perineal care:
 - a. aseptic technique.
 - b. wash hands.
 - c. remove and apply pad front to back.
 - d. teach principles to patient.
3. Provide for comfort:
 - a. maintain position of comfort.
 - b. give warm dry gown and blanket, back rub.
 - c. provide quiet environment.
 - d. provide light nourishment as per hospital policy.
 - e. answer questions.
4. Assess family interaction
 - a. allow to ventilate feelings.
 - b. clarify when necessary.