**PROTOCOL FOR:** Labor and Delivery: Care of the Laboring Patient in Labor & Delivery

**PURPOSE:** To delineate nursing care and responsibilities for the laboring patient admitted to the MFICU.

**DESIRED PATIENT OUTCOMES:**

1. Patient will verbalize an understanding of the physiological/emotional changes related to labor and delivery.
2. Patient will verbalize anxieties and have fears minimized during labor and delivery.
3. Patient and fetus will be free of or demonstrate minimal evidence of injury or infection during the labor process.
4. Patient will demonstrate effective coping related to physical discomfort related to labor and delivery.

**PATIENT ASSESSMENT:**

1. Assess patient's and support person's knowledge regarding the physiological and emotional changes related to the labor and delivery process.
2. Assess patient's knowledge regarding pain management during labor and delivery.
3. Assess patient's vital signs, uterine activity and fetal heart rate and variability at the time of admission. Refer to Patient Care section for guidelines on reassessment and evaluation.
4. Assess status of membranes (color, odor and amount of amniotic fluid) at time of admission and throughout labor.
5. Assess patient's coping mechanisms and support network.
6. Assess discharge planning needs, if applicable.
7. Assess urinary output. Palpate bladder at least every hour during labor if epidural in place and at least every 2 hours without epidural anesthesia.

**PATIENT TEACHING:**

1. Provide anticipatory guidance for the applicable stages of

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labor.

2. Assist with and reinforce breathing and relaxation exercises. Reinforce positive coping mechanisms.

3. Teach the patient pain scale.

4. Discuss use of analgesics/anesthetics for pain relief and control during labor and delivery.

5. Provide emotional support as needed.

6. Keep patient informed of general status and progress.

PATIENT CARE:

1. Provide safety measures, especially for those who are agitated or anxious.

2. Encourage ambulation with physician order.

3. Formulate and initiate pain management plan which might include the following:

   a. diversional activity
   b. effleurage
   c. pelvic rocking
   d. analgesic/antiemetic as ordered
   e. breathing and relaxation exercises
   f. massage
   g. application of heat/cold
   h. epidural anesthesia (see Epidural Anesthesia Protocol)

4. Assist with position changes.

5. If patient is unable to void, catheterize patient as ordered.

6. Provide hydration with clear liquids/ice chips if physician permits, and/or IV fluids as ordered.

7. Decrease risk of infection by:

   a. pericare
   b. keeping linen clean and dry
   c. limiting vaginal exams

8. Telemetry is available for patients requesting ambulation.

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Intermittent monitoring may be considered at the discretion of the physician following a minimum of a 20 minute reassuring fetal heart rate tracing.

9. If implemented, fetal monitoring by fetal scalp electrode will be continuous. The scalp electrode will be reapplied by the MD if it becomes dislodged or the tracing is uninterpretable. External fetal monitoring should be re-instituted until scalp electrode is reapplied. (See Procedure for: Internal Fetal Heart Rate Monitoring.)

10. Uterine contractions will be monitored continuously while the external fetal monitor is in use. The nurse should assess strength and duration of contractions intermittently by palpation during the use of external uterine monitoring.

    Uterine contractions will be continuously monitored by an internal pressure catheter, if implemented (see Procedure for Monitoring: Internal Uterine Activity).

11. Vital signs:

    a. Temperature: with intact amniotic membranes, at least every 4 hours, with ruptured amniotic membranes; at least every 2 hours.
    b. First Stage:
        (1) Latent Phase (0-4cms)
            (a) Pulse, respirations and blood pressure at least every two hours.
            (b) FHR and UA evaluated and documented at least every two hours.

        (2) Active Phase (4cm - fully dilated)
            (a) Pulse, respirations and blood pressure at least every hour.
            (b) FHR and UA evaluated and documented at least every hour or more frequently as changes are noted.

    c. Second Stage: (Complete dilatation to expulsion of infant):

            (a) Pulse, respirations, and blood pressure at least every 30 minutes.
            (b) FHR and UA evaluated and documented at least every 30 minutes or more frequently as changes are noted.

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**Note**: Patients receiving certain medications or with high-risk obstetrical conditions, may warrant more frequent vital signs. Please refer to associated standards for the care of these patients.

**Note**: If the patient is not being continuously monitored by electronic fetal monitor, the FHR should be auscultated and recorded at least every 30 minutes in the active stage of labor and at least every 15 minutes in the second stage of labor.

12. Assist MD with amniotomy as needed (see procedure).
13. Assist with or conduct vaginal exams to assess progress.
14. Transfer to delivery room if patient is < 36 weeks gestation unless otherwise agreed upon by Neonatal personnel.
    a. Primipara transferred when perineal bulging is noted.
    b. Multipara is transferred when cervical dilation is complete (see Delivery Room Protocol for Care of the Patient during Delivery).

REPORTABLE CONDITIONS:

1. Non-reassuring fetal heart rate patterns.
2. Uterine hyperstimulation or other abnormal labor pattern.
3. Spontaneous rupture of membranes.
4. Meconium stained amniotic fluid.
5. Foul odor of amniotic fluid.
6. Abnormal vital signs.
7. Patient's severity of pain/need for pain relief.
8. Adverse reaction to pain medication.
9. Unusual vaginal discharge and heavy or unusual vaginal bleeding.
10. If applicable, notify anesthesia if patient’s condition changes requiring
    anesthesia assessment or attendance.

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**DOCUMENTATION:**

1. **Document assessments and interventions in the appropriate unit flow sheet, Fetal Heart rate Tracing, MAR and Infusion Record.**
2. **Document patient response to care in patient progress notes per unit/department documentation standards.**

**CREDENTIALS:** **RN**

**EFFECTIVE DATE:** **5/91**

**REVISION DATE:** **8/91, 3/93, 6/93, 6/02, 8/03**