

SUBJECT : OBSTETICS & GYNECOLOGY NURSING

SYSTEM : OBSTETICS

TOPICS : INTRAPARTUM DOWNLOADABLE NOTES

Intrapartum Care: Comprehensive Nursing Notes

LABOR STAGES AND PHASES

First Stage: Labor Progression

Phase	Duration	Cervical Changes	Contraction Pattern	Key Nursing Actions
Latent	6-8h (nullipara)	0-6 cm dilation	Mild, irregular	Admission assessment
	4-6h (multipara)	0-40% effacement	5-30 min apart	Comfort measures Hydration/nutrition
Active	3-5h (nullipara)	6-8 cm dilation	Moderate, regular	Frequent assessments
	2-4h (multipara)	40-80% effacement	3-5 min apart	Pain management options Position changes
Transition	30 min-2h (nullipara)	8-10 cm dilation	Strong, frequent	Emotional support Breathing techniques
	15 min-1h (multipara)	80-100% effacement	2-3 min apart	Avoid pushing urges

Second Stage: Delivery

Nullipara: 30 min-3 hours

Multipara: 5-30 minutes

Nursing Management:

- Coach pushing efforts (open glottis)
- Monitor fetal heart rate continuously
- Prepare delivery equipment
- Support birth partner involvement
- Document delivery time and findings

Third Stage: Placental Delivery

Duration: 5-30 minutes

Signs of Placental Separation:

- Sudden gush of blood
- Lengthening of umbilical cord
- Uterus becomes globular and firm
- Uterus rises in abdomen

Active Management:

- Controlled cord traction
- Uterine massage after delivery
- Oxytocin administration
- Inspection of placenta completeness

Fourth Stage: Immediate Recovery

First 1-2 Hours Postpartum

Critical Assessments (Q15min x 1h, then Q30min x 1h):

- Vital signs
- Uterine fundus (firm, midline)
- Lochia (amount, color, clots)
- Perineum (edema, hematoma)
- Bladder distention
- Bonding initiation

FETAL MONITORING AND INTERPRETATION

Fetal Heart Rate (FHR) Assessment

Baseline Parameters:

- Normal: 110-160 bpm
- Bradycardia: <110 bpm for ≥ 10 min
- Tachycardia: >160 bpm for ≥ 10 min

Variability:

- Absent: Amplitude undetectable
- Minimal: >0 but ≤ 5 bpm
- Moderate: 6-25 bpm (normal)
- Marked: >25 bpm

Deceleration Patterns

Type	Shape	Timing	Cause	Nursing Actions
Early	Mirror contraction	Onset early, nadir at peak	Head compression	Normal, no action

Type	Shape	Timing	Cause	Nursing Actions
Late	Uniform shape	Onset after contraction begins	Uteroplacental insufficiency	Position change, O2, IV fluids, notify provider
Variable	Variable shape	Variable timing	Cord compression	Position change, O2, consider amnioinfusion

LABOR DYSTOCIA AND COMPLICATIONS

Abnormal Labor Patterns

Prolonged Latent Phase:

- 20 hours (nullipara)
- 14 hours (multipara)
- **Management:** Therapeutic rest, oxytocin if no progress

Protraction Disorders:

- Slow dilation (<1.2 cm/h nullipara, <1.5 cm/h multipara)
- Slow descent (<1 cm/h nullipara, <2 cm/h multipara)
- **Management:** Oxytocin augmentation if no CPD

Arrest Disorders:

- No dilation for ≥ 2 hours with adequate contractions
- No descent for ≥ 1 hour in second stage
- **Management:** Evaluate for CPD, consider C-section

Obstetric Emergencies

Umbilical Cord Prolapse:

- **Presentation:** Cord palpated before presenting part, FHR decelerations
- **Management:** Knee-chest position, manual elevation of presenting part, emergency C-section

Shoulder Dystocia:

- **Presentation:** Turtle sign, head retracts
- **Management:** McRoberts maneuver, suprapubic pressure, consider other maneuvers

Uterine Rupture:

- **Presentation:** Severe abdominal pain, fetal distress, loss of station
- **Management:** Emergency laparotomy, possible hysterectomy

PAIN MANAGEMENT STRATEGIES

Non-Pharmacological Methods

- Position changes (walking, rocking, hands/knees)
- Hydrotherapy (shower, tub)
- Massage and counterpressure
- Breathing techniques
- Acupressure
- Visualization and distraction

Pharmacological Options

Systemic Medications:

- Opioids (fentanyl, nalbuphine)
- Sedatives (promethazine - for nausea/anxiety)
- **Monitoring:** Maternal respirations, fetal heart rate

Neuraxial Anesthesia:

- Epidural (most common)
- Combined spinal-epidural
- **Nursing Care:** Pre-load IV fluids, monitor BP, assess motor function

HIGH-RISK INTRAPARTUM SCENARIOS

Preterm Labor Management

Tocolytics:

- Nifedipine (calcium channel blocker)
- Indomethacin (NSAID - <32 weeks)
- Terbutaline (beta-agonist - short term)

Antenatal Corticosteroids:

- Betamethasone 12mg IM x 2 doses 24h apart
- Dexamethasone 6mg IM x 4 doses 12h apart
- **Benefit:** Fetal lung maturation 24h-7d after administration

Post-term Pregnancy

Definition: ≥42 weeks gestation

Risks: Macrosomia, meconium, oligohydramnios

Management: Induction at 41+0 to 42+0 weeks

Multiple Gestation

Special Considerations:

- Continuous electronic monitoring of both fetuses
- Increased risk of malpresentation
- Need for additional personnel at delivery
- Higher incidence of postpartum hemorrhage

DOCUMENTATION ESSENTIALS

Labor Progress Documentation

- Cervical exams (dilation, effacement, station, position)
- Contraction pattern (frequency, duration, intensity)
- Fetal heart rate pattern
- Maternal vital signs
- Pain management interventions
- Patient response to labor

Critical Communication

SBAR Reporting:

- Situation: Current status and concern
- Background: Relevant history
- Assessment: Clinical findings and interpretation
- Recommendation: Suggested actions

CASE STUDIES

Case 1: Normal Labor Progression

- 26-year-old G1P0 at 39 weeks, spontaneous labor
- Admitted at 4 cm/80%/0 station, vertex presentation
- **Management:** Continuous support, position changes, hydrotherapy, epidural at 6 cm
- **Outcome:** Vaginal delivery after 12 hours labor, healthy newborn

Case 2: Fetal Distress

- 32-year-old G2P1 at 8 cm with recurrent late decelerations

- FHR baseline 150s, variability minimal, decels to 100 bpm
- **Management:** Position change, O2 at 10L, IV bolus, notify provider
- **Outcome:** Emergency C-section for fetal distress, Apgars 3/7

Case 3: Shoulder Dystocia

- 29-year-old G1P0, macrosomic infant (4500g estimated)
- Head delivers, then retracts (turtle sign)
- **Management:** McRoberts maneuver, suprapubic pressure, delivery of posterior arm
- **Outcome:** Live birth with transient Erb's palsy