

Section: Division of Nursing
Approval: _____

* PROCEDURE *

Index: 6160.021a
Page: 1 of 2
Issue Date: October 10, 1989
Revised Date: July 2011

HACKETTSTOWN REGIONAL MEDICAL CENTER

Originator: Beth Van Meter, R.N.C.
Revised by: Catherine Burns RNC BSN

MATERNAL SERVICES
(Scope)

TITLE: PROCEDURE FOR CARE OF PATIENT AT DELIVERY

PURPOSE: To outline procedure to identify nursing responsibilities at a vaginal delivery.

- EQUIPMENT LIST:**
1. EFM
 2. CPN system
 3. Vital signs equipment
 4. Delivery table set up
 5. Chux
 6. OB Maternity kit (blue bag)

CONTENT:

PROCEDURE STEPS:

1. Close LDR door. Position patient according to providers orders, utilizing stirrups, foot rests, **per provider preference.**
2. Adjust light
3. Uncover delivery table
4. Assist patient with pushing. Document contraction quality and FH Q5 min during 2nd stage in QS. Record BP before delivery and after delivery of placenta and every 15 minutes times 4 or until stable.
5. Note delivery time of infant and placenta in CPN system.
6. Give Pitocin/Methergine as ordered.
7. Assist with repair. Obtain suture and sponges as needed.
8. Cleanse perineum after delivery. Apply ice pack and place clean chux under patient.
9. Obtain cord blood from provider. Follow cord blood collection procedure.
10. Reposition patient on full bed and start recovery period.

KEY POINTS:

Position patient's buttocks at break in bed. Assist labor coach/other family member to appropriate area in LDR with providers. Use dimmer as desired per provider, obtain vacuum/forceps if needed from nursery cabinet.

Avoid checking BP during contraction. Report abnormalities to provider.

Pitocin and Methergine may increase a high BP. Verify BP prior to administering. FYI: May be given in the same syringe per provider orders.

Use of vacuum or forceps may predispose patient to lacerations. Document any perineal lacerations, episiotomy. Provide emotional support and answer questions

Check with provider if placenta needs to be sent to pathology.

Maintain IV access if present for recovery.

11. Check fundal firmness and height, bleeding, BP, P&R q 15 min x 1 hr or more frequently if not stable.
Massage uterus if boggy. Check temperature once during recovery. Check bladder and empty if necessary. Keep patient informed and offer emotional support.
12. Offer blankets for comfort
Provide ample time for bonding, breast-feeding, etc.
13. Offer light snack, oral fluids as appropriate.
14. Count and spray delivery table instruments with Klenzyme foam..
Follow CSR policy for disposition.
15. Restock delivery cart with supplies/sutures.
16. Dispose of excess garbage, linens, etc. prior to arrival of visitors.