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* ADDENDUM *
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HACKETTSTOWN COMMUNITY HOSPITAL

Division of Nursing

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TITLE: **CHILDBIRTH EDUCATION COURSE**

I. THE LABOR PROCESS

A. Labor is the work done to accomplish the birth of your child.

B. The experience is unique to each woman and pregnancy.

C. Length of labor - wide variation of normal (2-24 hours) Average 14-16 hours.

D. Unknown why it starts. Theories:

1. Uterus stretches to a certain size and can stretch no more and, therefore, contracts.
2. Hormone changes (decrease in progesterone).
3. Pressure on the cervix from presenting part.
4. Prostaglandin produced from mom and fetus.

E. Contractions are caused by oxytocin.

II. SIGNS OF LABOR (See Handout on Signs of Labor)

A. Increase in Braxton Hicks contractions.

B. Lightening

C. Pelvic Pressure

D. Diarrhea or flu-like symptoms

E. Possible 1-3 lb weight loss due to hormonal changes.

F. Increased vaginal discharge.

G. Energy spurt "nesting."

H. Cardinal signs of labor:

1. Loss of mucus plug.
2. Rupture of membranes.
3. Regular contractions.

III. THE STAGES OF LABOR

A. Stage I - Cervix dilates 0-10cm; 100% effaced

1. Preliminary Phase (Early)

   a. Cervix dilates to 3cm; becomes fully effaced.
   b. Contractions come every 5-20 min.
   c. Contractions last 30-45 seconds.
   d. Average length 8 hours primips, 4 hours multips.
   e. Contractions mild.
   f. Coaches role:

      1) Be supportive.
      2) Provide diversion.
      3) Encourage her to focus and relax.
      4) Time contractions.
      5) Remind mom to empty her bladder.
      6) Remind mom to eat only clear liquids.
      7) Encourage rest during the night; activity during the day.
      8) Check for relaxation.
      9) Remind mom to use the first breathing technique (slow paced) when she no longer can focus and relax.

2. Active Labor

   a. Cervix dilates 4-7cm.
   b. Average length of active phase - 3-5 hours primips/2-4 multips.
   c. Contractions -> stronger
   d. Contractions last 60 seconds.
   e. Contractions come every 3-5 minutes
   f. Mom becomes more serious, usually becomes quiet and often will be dependent on the coach.
   g. Coaches Role:
      1) Emotional support.
      2) Check for relaxation.
      3) Act as a liaison.
      4) Provide comfort measures: i.e., ice chips, massage, cool washcloth, dim lights.
      5) Time contractions and talk her through them.
      6) Encourage her to use another breathing pattern only when she can no longer focus and relax with current pattern.
      7) Remind her that pain medication may be available should she needs it.

3. Transition

   a. Contractions q 2-3 min.
   b. Contractions may last 90 seconds.
   c. Cervix dilates 8-10 cm.
   d. Nausea, vomiting, shaking, gas, hiccups and belching common.
   e. Rectal and bladder pressure
   f. Personality changes.

g. May feel the urge to push.
h. Coaches role:

1) Be supportive and encouraging.
2) Do breathing exercises with her if needed.
3) Provide comfort measures.

B. Stage II - From 10cm to the birth of the baby

1. The child descends through the birth canal and is born.
2. Begins at 10cm.
3. Usually accompanied by a strong urge to push.
4. Contractions remain strong, follows the characteristics of active labor contractions.
5. You may push for 30 minutes to two hours.
6. Usually will have a surge of energy to push.
7. Coaches role:

a. Coach mom with pushing technique.
b. Encourage and check for relaxation between contractions.
c. Provide encouragement and praise her efforts.
d. Provide physical comfort (position changes, cool cloth, ice, massage).

8. Perineum burn and stretching sensation.
9. The head will present first; must stop pushing so the airway can be cleared; then push shoulders and remainder of the baby out.

C. Stage III - Expulsion of the Placenta

1. Usually within 15-30 minutes of delivery.
2. Contractions will resume.
3. Mom must again push to expel the placenta.
4. An injection of Pitocin may be given following expulsion to decrease post-partum bleeding. May be given IV or IM.

IV. BREATHING PATTERNS TO BE USED IN LABOR

A. Use focal point with each technique.

B. Begin and end each contraction with a cleansing breath.

C. Start with the simplest technique, advancing only when necessary.

D. Use relaxation during each contraction; coaches remember to check for relaxation.

E. Be sure to exhale and inhale at equal rates to maintain 0_2 balance.

F. Types of Breathing/Relaxation

1. Relaxation

a. Relaxation is important: tense muscles cause other muscles to tense; too much tension will increase overall pain.

b. Consider your environment: i.e., lighting, sound, temperature, position.

c. Suggested positions - side lying, leaning back on support person.

d. Ask couples to relax.

e. Instruct couples to contract one body part at a time and then relax it. Start with the feet and work toward the facial muscles, being sure to tense (contract) only one body part at a time.

f. Focal Point - One item to look at, a comfortable distance from you so your eyes will remain relaxed. A focal point will deepen concentration on relaxation and breathing technique. It also will provide a way for the coach to know if she is in control - if she is not focusing, she may not be relaxed or in control.

g. Coaches assess relaxation - limbs should be limp, forehead smooth, mouth slightly opened, eyes are focused.

h. Think of pleasant thoughts and places - visualize comfortable surrounding, may also visualize your cervix as a flower opening petal by petal or the baby descending to its birth.

2. Slow Paced Breathing

a. Assume comfortable position.

b. Breath in through your nose and out through mouth at a slow pace (6-9 times/minute excluding cleansing breaths). May use all mouth breathing or nose breathing if it is more relaxing.

c. Start and end with cleansing breath.

d. Keep breathing technique slow, even and deep.

3. Combined Paced Breathing

a. Use when mom is coping well with most of the contraction but needs additional distraction at the contraction peak.

b. Start with slow paced breathing for the first 15 seconds (or as the contraction builds up) - switch to modified paced breathing at the peak, then return to slow paced breathing.

4. Modified Paced Breathing

a. Breathe with the mid/upper portion of the chest.
b. Ideal rate is double your normal respiratory rate.

c. Breathe in and out through the mouth with jaw relaxed and partly open.
d. Be sure to have inhalation and exhalation equal.
e. Breathing should be relaxed rather than forced.

5. Patterned Paced Breathing

a. Use modified paced breathing for 2-5 breaths, then do a soft blow, then 2-5 modified breaths, then blow - repeat ratio of breathing throughout contractions.
b. Suggested ratio is 3:1.
c. Use this technique least as it expends the most energy.
d. If urge to push comes with full dilation, blow to avoid pushing.

6. Pushing Technique

a. Keep chin toward the chest.
b. Perineum must be relaxed.
c. Start with two cleansing breaths.
d. Third breath hold and push to the count of 8-10, release breath, quick breathing in, push and hold 8-10 - repeat cycle for the length of the contraction.
e. End contractions with two cleansing breaths.
f. Pushing is very hard work.
g. May make grunting noises - that is normal.
h. Push with abdomen and diaphragm, not your head and neck.
i. Aim push to the front as if you were trying to urinate, rather than toward the rectum.

V. CESAREAN SECTION - Delivery of baby via abdominal incision

A. Indications for Cesarean

1. CPD
2. Malpresentation
3. Fetal Distress
4. Prolapsed Cord
5. Placenta Previa
6. Placental Abruption
7. Maternal Illness (Toxemia, Diabetes, Herpes)
8. Failure to Progress

B. Procedures to Expect Before Surgery

1. Signing consents for the surgery, blood in case it is needed and pediatrician.

2. IV

3. Abdomen is shaved (including most of the pubic hair).

4. Additional blood is taken.

5. Foley catheter to drain urine.

6. Medications to decrease secretions and to neutralize stomach contents.

C. Procedures to Expect During Surgery

1. Two surgeons (birth attendant included) participate.
2. Pediatrician will be present.
3. Abdomen is cleaned with an antiseptic.
4. The support person stays out of the O.R. until the anesthesia is given and is effective.
5. The incision is usually a "bikini" type but may be vertical (classical). This is provider choice.
6. A classical up and down incision on the uterus prevents a future VBAC and is rarely done.
7. Delivery of the newborn is usually 7-10 minutes after the initial incision is made.
8. Fundal pressure is used to assist in delivery.
9. The newborn is assessed by a pediatrician.
10. A brief bonding period is provided in the OR, then the newborn is taken to the nursery.
11. The coach leaves the O.R. when the newborn goes to the nursery.
12. The surgical repair takes approximately 45 minutes.

D. Post-Operative and Post-Partum Recovery

1. Recovery of C/B is done in the OR or in the client’s room.
2. Mom, baby and coach bond in the recovery area.
3. Pulse, BP and resp. are monitored every 15 minutes x one hour.
4. A small clip on the finger or ear lChild Birth Family Centere will monitor blood oxygen content.
5. The fundus is palpated each time the vital signs are checked.
6. IV and catheter are left in from 12 – 24 hours.
7. Diet will go from NPO - Clear - Regular.
8. Pain medication is available either PCA or IM for 24 hours, then oral meds. If duramorph used in epidural often no other painmedication is requried.
9. Post-operative gas prevention exercise is available and will be demonstrated following C/B.

10. Wound Care.

VI. ANALGESIA/ANESTHESIA DURING LABOR

A. Ask your provider which options are available to you.

B. Medications are given with the baby's well-being in mind.

C. Don't feel like a failure if you choose to use medication.

D. Use relaxation, massage and breathing techniques prior to and along with pain medication.

E. There are several types that may be available:

1. Sedatives - To induce sleep while client in early labor.

   a. Side effects - Prolonged sleepiness, may slow labor, may decrease sensory perception, possible sleepy baby.

   b. Usually given p.o, IM or IV.

2. Tranquilizers - Given to lower tension and apprehension.

   a. Women who are tense are more apt to experience pain; therefore, if she is more relaxed, she will cope better.

   b. Side effects: drowsiness, decreased BP, dizziness, possible CNS depression in baby.

   c. Often given in conjunction with analgesics to help analgesics work more effectively.

   d. Usually given IM or IV.

3. Analgesics - Given to increase pain threshold, therefore, decreasing pain.

   a. Usually given in active labor
   b. Side Effects - Possible mild respiratory and circulatory depression, sleepiness, possible infant CNS depression.

   c. Usually given IM or IV

   d. May speed labor.

4. Paracervical Block - Relief of uterine pain but not perineal pain during labor.

   a. Usually given at 4-7 cm's.
   b. Given into each side of cervix.
   c. Effective for 60-90 minutes.
   d. May be repeated.
   e. Side Effects - Possible transient depression of contractions, possible fetal

bradycardia, irritability, CNS depression.

5. Pudental Block - Anesthesia given for second stage of labor.

   a. Medication injected into pudental nerve up to 30 minutes prior to delivery.

   b. Possible Side Effects - Loss of the urge to push, pain of contractions is still felt.

6. Epidural - Anesthesia injected into epidural space in the spine resulting in complete relief of pain in pelvic area, perineum and legs.

   a. Client remains awake.

   b. Client retains the ability to push and participate in delivery.

   c. Possible Side Effects - Maternal hypotension, prolonged labor, increased use of forceps, decreased FHR.

7. Local - Numbs the perineum for the episiotomy and repair.

   a. Given just prior to episiotomy.

   b. Most people will have local given.

8. General Anesthesia – Client asleep

   a. Given via IV or mask.

   b. Given when epidural can't be used during cesarean birth.

VII. TOUR OF CHILD BIRTH FAMILY CENTER UNIT

A. Method

1. Have client phone Child Birth Family Center to arrange tour.

2. Part of Prepared Child Birth Class

3. RN/Case Manager may provide tour pointing out the following:

   a. Explain entrance used will vary based on the time of day.

   b. Have client visit LDRP room.

   c. Explain admission procedure.

d. Explain I.V.
e. Explain monitor.
f. Point out miscellaneous items such as 0_2 mask, bed being on wheels, clock.
g. Demonstrate birthing bed and stirrups.
h. Describe delivery of baby and discuss after care, suction, identification.
i. Discuss delivery of placenta and repairs, medications in I.V. or given IM.
j. Discuss opportunity for parents to handle baby-bonding.
k. Discuss ID procedures: ID bracelets, finger print of mother, footprint of baby and security system.
l. Mention Cesarean births are done in the surgical suite within the Childbirth Family Center.