Champlain Maternal Newborn Regional Program
Programme régional des soins à la mère et au nouveau-né de Champlain

LABOUR SUPPORT WORKSHOP

Optimizing Labour and Birth Care

2021

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LABOUR SUPPORT WORKSHOP

ACKNOWLEDGEMENTS

We thank the many people who have contributed their passion and work to this resource.

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In particular, we acknowledge **Penny Simkin**, Childbirth Educator and Doula, for her significant contributions. Her wisdom and expertise were reflected in the original version of this resource and continue to be referenced in this edition.

Labour Support Workshop

TABLE OF CONTENTS

SUPPORTIVE CARE – WHERE DO I STAND?

With every woman I care for, to what extent do I:

NEVER	SOMETIMES	MOST OF TIMES	ALWAYS
1	2	3	4

1. **Make her feel cared about as an individual?** **1 2 3 4**
   Example: acknowledge her feelings, give her my undivided attention.
2. **Praise her and tell her that she is doing a good job?** **1 2 3 4**
3. **Appear calm and confident in giving care?** **1 2 3 4**
4. **Assist her or instruct her in breathing and relaxation methods?** **1 2 3 4**
   Example: remind her how to relax, help her with self-directed pushing.
5. **Treat her with respect?** **1 2 3 4**
   Example: introduce myself, allow her to have some privacy.
6. **Explain hospital routines and procedures: what is going to be done** **1 2 3 4**
   and why? *Example: fetal monitoring, vaginal examinations.*
7. **Answer her questions truthfully in an understandable language?** **1 2 3 4**
8. **Provide her with a sense of security?** **1 2 3 4**
   Example: check on her frequently, answer hr call light quickly.
9. **Accept what she says and does in labour without judging her?** **1 2 3 4**
10. **Find out about her wishes and plans for her labour and delivery, indicate that I understand and support her birth plan, and try to carry them out as much as possible?** **1 2 3 4**
11. **Attempt to lessen demands on her?** **1 2 3 4**
12. **Provide information about what happens in labour and keep her informed about how her labour is going?** **1 2 3 4**
13. **Touch her?** *Example: hold her hand.* **1 2 3 4**

14. Help make her physically comfortable? **1 2 3 4**
Example: provide a cool washcloth, help with positioning

15. Recognize when she is anxious, and listen to her concerns? **1 2 3 4**

16. Include her in the decision-making during her labour? **1 2 3 4**
Example: inform her of alternatives and give her a choice.

17. Spend time in the room with her, even if I don't have a specific job to do? **1 2 3 4**

18. Communicate her needs and wishes to the nurses relieving me, the physician and other hospital workers? **1 2 3 4**

19. Encourage her partner's involvement? **1 2 3 4**

20. Help her become familiar with her surroundings? **1 2 3 4**
Example: show her where things are.

21. Provide friendly and personal care? **1 2 3 4**
Example: call her by name, make her feel welcome, provide distractions by talking and using humour

22. Support and reinforce the way she and her partner work together? **1 2 3 4**

23. Provide for the needs of her partner? **1 2 3 4**
*Example: relieve him/her for breaks***.**

24. Ask myself: *"HOW WILL SHE REMEMBER THIS BIRTH EXPERIENCE?"* **1 2 3 4**

Adapted from Kintz (1987); Byanton, Fraser-Davey, & Sullivan (1993)

LABOUR SUPPORT – TEST YOUR KNOWLEDGE!

1. The type of support provided by family members is similar to the type of support provided by health care providers.

   TRUE or FALSE

2. Providing labour support is only possible with one-to-one nursing care.

   TRUE or FALSE

3. It has been found that nurses have their own cesarean birth rates, i.e. caesarean rates vary between nurses.

   TRUE or FALSE

4. According to Canadian research, intrapartum nurses spend the majority of their time providing labour support.

   TRUE or FALSE

5. Which of the following is not a form of support during labour:
   a) Physical comfort;
   b) Emotional support;
   c) Information-giving;
   d) Directional support.

6. Labour support is thought to be effective for all of the following reasons, *except*:
   a) it helps to decrease maternal anxiety and stress;
   b) it leads to increased maternal perception of control and confidence;
   c) it reduces the number of nociceptors (pain receptors);
   d) it reduces dissatisfaction with the childbirth experience.

7. Which of the following is ***NOT*** associated with continuous labour support?

   a) decreased use of intrapartum analgesia/anaesthesia;
   b) decreased operative vaginal deliveries;
   c) decreased spontaneous vaginal births;
   d) decreased caesarean births.

PAIN-MEDICATION PREFERENCE SCALE

Adapted from Penny Simkin (www.pennysimkin.com)

You and your partner may use this scale to determine your preferences regarding your use of pain-relief measures in labour. Begin with each of you choosing the number that best matches your feelings. Then compare. If you are not in close agreement, discuss why and come to an agreement. The woman's preferences are more important and must prevail if you cannot agree. The right-hand column describes what help you need.

NUMBER	WHAT IT MEANS FOR THE WOMAN	HOW THE CAREGIVER & PARTNER CAN HELP
+ 10	**A desire to feel nothing; a desire for anesthesia before labour begins.**	• An impossible extreme. • If the woman is a + 10, she has no interest in helping herself in labour. • Help her accept that she will have some pain, and begin discussing ways to deal with the pain.
+ 9	**Fear of pain; lack of confidence that I/she will be able to cope; dependence on staff for pain relief.**	• Follow recommendations for + 10. • Suggest she discuss fears with caregiver or childbirth educator.
+ 7	**Definite desire for anesthesia as soon in labour as possible, or before labour becomes painful.**	• Be sure the caregiver is aware of her desire for early anesthesia; learn whether this is possible in your hospital. Inform staff when you arrive.
+ 5	**Desire for epidural anesthesia before transition (7-8 cm dilation). Willingness to cope until then, perhaps with narcotic medications.**	• Encourage her in breathing and relaxation. • Know comfort measures. Suggest medications to her in labour as she approaches active labour.
+ 3	**Desire to use pain medications, but would like as little as possible. Natural childbirth is not a goal.**	• Plan to be active as a birth partner to help her keep medication use low. • Use comfort measures. • Help her get medications when she wants them. Suggest reduced doses of narcotics or a "light" epidural block.
0	**No opinion or preference. This is a rare attitude among pregnant women; not uncommon among birth partners.**	• Become informed. • Discuss medicated and unmedicated pain-relief measures. • Commit yourself to helping her decide her preferences. If she has no preference, let the staff manage her pain.
- 3	**Would prefer that pain medications be avoided, but only if labour is short or easy. Wants medication otherwise.**	• Do not suggest that she take pain medications. Emphasize coping techniques. Do not try to talk her out of pain medications.
- 5	**Strong preference to avoid pain medications, mainly for baby's benefit. Is actively preparing (practicing labour coping skills and reading outside childbirth class) and learning comfort measures, but will accept medications for difficult labour.**	• Prepare yourself for a very active role and, if possible, invite or hire an experienced labour support person to accompany and help the two of you. • Practice together in advance. Thoroughly learn how to help her relax and breathe. • Know the comfort measures. • Do not suggest medications. If she asks, try other alternatives. Have her checked for progress. Ask her to try 5 more contractions without medication. • Be firm, confident and kind. Maintain eye contact and talk her through each contraction. Get help from others.
- 7	**Very strong desire for natural childbirth, for sense of personal gratification as well as to benefit baby. Will be disappointed if she uses medications.**	• Follow the recommendations for -5, but with even greater commitment. • Interpret requests for pain medication as an expression that she needs more help. • Use the "Take Charge Routine". Only if that does not work do you stop trying to help her cope without medications.
- 9	**Wants medication to be denied by staff, even if she asks for it.**	• Very difficult • Promise to help all you can, but the final decision is not yours. It is hers.
- 10	**Will not use medication even for cesarean delivery.**	• An impossible extreme. • Encourage her to learn of complications that require painful interventions. Help her get a realistic understanding of risks and benefits of pain medications.

SAMPLE BIRTH PLAN (Hôpital Montfort, 2013)

Hôpital Montfort

BIRTH PLAN

Introduction

Hôpital Montfort's Family Birthing Centre (FBC) values compassion, best practices and family-centred safety. Accordingly, Montfort has instituted a service model unique in the Ottawa region, allowing you and your family to experience the birth of your child in a luxurious room where your comfort and peace of mind are assured. We are committed to providing attentive, state-of-the-art services in relaxed and inviting surroundings.

Hôpital Montfort's birth plan explains the various options available to you during labour and delivery. The companion guide will help you make informed decisions for an even more memorable birth experience.

It is important to remember that although your healthcare team will make every effort to respect your wishes, unforeseen complications or changes could alter the original plan. In such cases, you will be informed and included in the decision-making process. Also bear in mind that your birth plan is not a contract and you are free to change your mind at any time.

www.infosbebes.com

SAMPLE BIRTH PLAN (Hôpital Montfort, 2012) (Cont'd)

What Hôpital Montfort has to offer you…

The Family Birthing Centre (FBC) healthcare team includes nurses, doctors, midwives and various other health professionals and support staff. Hôpital Montfort is proud of being a teaching hospital, and your birthing team will therefore include students and medical residents.

We look forward to having you with us and working with you to make your baby's birth a positive and memorable experience!

In keeping with best practices, the FBC care team assures you that the following guidelines will apply during your stay at Hôpital Montfort:

- ☑ The health of mothers and newborns is our top priority. Fathers and significant others are important members of the team and are encouraged to actively participate in the birthing process and post-natal period.
- ☑ The healthcare team's approach is non-interventionist (no intervention occurs without a medical reason).
- ☑ Any intervention is discussed with you in advance and you are involved in the decision-making.
- ☑ When possible, you and your baby will have skin-to-skin contact immediately after the birth (uninterrupted contact for at least one hour or for as long as you like). Routine newborn care, such as weighing, measuring, vitamin K injections and erythromycin ointment application are delayed to allow for this precious time.
- ☑ If your baby is born by cesarean section and if you and your baby are both well enough, the healthcare team will assist you with skin-to-skin contact in the operating room and recovery room. If medical reasons prevent this possibility, skin-to-skin contact can be provided by your partner or other support person in the recovery room or in your hospital room.
- ☑ You and your baby will stay together in the same room at all times unless any medical complications arise.

The Family Birthing Centre's breastfeeding policy also includes the following:

- ☑ Breastfeeding will begin as soon after birth as possible.
- ☑ Your healthcare team will instruct and support you to initiate and maintain breastfeeding.
- ☑ If medical reasons require that your baby receive a supplement (espressed breast milk or formula), you can choose from a number of methods for delivering it: cup, spoon, syringe, finger feeding or lactation aids, etc.).

If you have questions or comments,
please feel free to discuss them with your nurse, doctor or midwife.

SAMPLE BIRTH PLAN (Hôpital Montfort, 2012) (Cont'd)

MY BIRTH PLAN

My name:_____

Name of my partner / significant other: _____

I am expecting: ☐ a boy ☐ a girl ☐ a surprise???

Baby's name (if you have already decided) : _____

I would like the following people to be present:

Name and relationship*	During labour	During the birth
_____ _____		

* *NOTE: Your partner or other support person is encouraged to stay with you during the entire birthing process. No more than two additional support persons may be present during your labour and the birth if your clinical condition permits.*

My pain management preferences:

____ I want a medication-free delivery.
____ I want a medication-free delivery if my labour goes well.
____ I have no preferences regarding the use of medication.
____ I want medication, but I would like to go as long as possible without it.
____ I want medication as soon as possible.

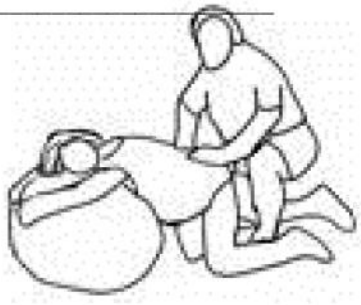
Other pain management options: (you may check more than one box)

☐ Birthing ball
☐ Shower
☐ Bath (with or without jets)
☐ Walking and different positions
☐ Massage
☐ Hot compresses
☐ Cold compresses
☐ Relaxation techniques
☐ Breathing techniques
☐ Pressure points
☐ Counter pressure
☐ Focussing
☐ Visualization
☐ Listening to my own music

Other : _____

Pain management medication options: (you may check more than one box)

□ Narcotics
□ Nitronox (gas)
□ Epidural



SAMPLE BIRTH PLAN (Hôpital Montfort, 2012) (Cont'd)

My baby's birth:

During the pushing stage:

☐ I would like healthcare staff to support me in my preferred positions.

☐ I would like different positions to be suggested to me.

☐ I would like to have a mirror so that I can watch my progress as I push.

☐ I would like to touch the baby's head when it crowns.

In the case of a cesarean birth:

☐ I would like _____ to be with me in the operating room and recovery room.

Feeding my baby:

I want to: ☐ Breastfeed

☐ Bottle feed (commercial formula)

☐ Mixed feed (breastfeeding + commercial formula)*

** Mixed feeding (breastfeeding + bottle feeding) is not recommended during hospitalization or in the early weeks after birth except for medical reasons. Studies show that this type of feeding can affect breast milk production and your chances of successful breastfeeding.*

Your past experience:

☐ I have never breastfed

☐ I have breastfed ____ child(ren): #1 for ____weeks / ____months
#2 for ____weeks / ____months
#3 for ____weeks / ____months

My comments/questions/concerns about feeding my baby:

_____

_____

_____

_____

SAMPLE BIRTH PLAN (Hôpital Montfort, 2012) (Cont'd)

Other general questions…

I would like my healthcare team to be aware of the following **concerns/worries**:

_____

_____

_____

_____

I have special **needs**:

_____

_____

_____

_____

_____

I have **questions**, or I need **additional information** about:

_____

_____

_____

_____

_____

Produced by Vanessa Rouleau and Marie-Josée Trépanier

Advantages of a written birth plan:

- It enables the woman and her health care provider(s) to work toward a common goal – that of a safe and positive childbirth experience.
- It can encourage open, honest discussion that promotes informed, joint decision making and provides a focus for this discussion.
- It provides a starting point for the woman to reveal her fears, expectations, wishes, and needs.
- It builds trust by fully addressing the individual woman's concerns.
- It is a tool for education (e.g. about options available at the place of birth and the evidence/research basis for certain practices).
- It allows for efficient use of the care provider's time – as the plan is refined, providers can help women to find appropriate resources within the community.
- It offers staff in labour and birth settings an opportunity to learn about the woman, her knowledge, and her wishes.
- It is a vehicle for women to question local practices.

THE ROVING BODY CHECK

by Penny Simkin (www.pennysimkin.com)

The *Roving Body Check* is a relaxation technique that combines patterned breathing with touch, relaxation, and guided imagery. This technique may be used with either slow or light breathing.

You ask the woman to:

- release tension from only one body part at a time
- use her exhalations for tension release
- focus on the decrease in the pressure of your touch

INTRODUCTION TO THE TECHNIQUE:

- Ask her to breathe in and hold her breath for a few seconds
- Ask her to notice the feeling of tension when her lungs are full
- As she breathes out, point out the release of tension that comes with the release of air. Every "out-breath" is a relaxing breath.

THE TECHNIQUE (with slow breathing):

- Note the rhythm of her breathing. Match your breathing to hers, so that you are in synchrony
- While she is breathing IN, ask her (in a soothing tone of voice) to focus on a particular body part (e.g., the brow or the neck) and find any tension. Place your hands firmly on the part, molding them comfortably and creating pressure (it should feel good to the woman)
- While she is breathing OUT, ask her to release any tension for that part only, and simultaneously relax your hands while keeping them in place
- Repeat, focusing on a different body part with each breath or two until you have gone through her whole body. Slide your hands from one body part to another; do not remove and replace your hands.

BODY PARTS TO FOCUS ON:

- Brow and jaw
- Back of the neck
- Shoulders and arms
- One or both hands
- Back of the chest
- Small of the back
- Hips, buttocks and perineum
- One or both thighs and legs

ALTERNATIVES:

- She may prefer you to focus opn only her "tension spots", those body parts that are particularly tense (e.g., neck, shoulders and back; or buttocks, perineum and legs)
- She may want only your verbal directions, or only your touch. Adapt the technique to suit her.
- If using the *Roving Body Check* with light breathing, have her imaging releasing tension, a bit at a time, or step-by-step down the body part (i.g., from the shoulders down the back) with each light breath out. You can move your hands down in rhythm with her OUT breaths. Try to use your voice in a rhythm that reflects and reinforces the rhythm of her breathing.

HEAT AND COLD - Physiological Effects

HEAT	COLD
EFFECTS: 1. Increased local blood flow 2. Increased local skin and muscle temperature 3. Increased tissue metabolism 4. Decreased muscle spasm 5. Relaxation of tiny muscles in skin (capillaries, hair follicles) 6. Raises pain threshold 7. Reduces "fight or flight" response *NOTE:* One study found that hot water bottle applied to fundus might increase uterine activity *	***EFFECTS:*** 1. Decreased local blood flow 2. Decreased local skin and muscle temperature 3. Decreased tissue metabolism 2. Decreased muscle spasm (longer lasting than heat) 3. Slow transmission of impulses over sensory neurons, leading to decreased sensation (numbing effect) 4. Reduces swelling
WHEN TO USE: 1. Woman reports or shows pain in specific area 2. Woman reports or shows signs of anxiety or muscle tension 3. Woman reports feeling chilled 4. Increased uterine activity is desirable *(Put warm compress or hot water bottle on abdomen over fundus)* 5. In the second stage, hot compressed on perineum enhance relaxation of pelvic floor and reduce pain.	***WHEN TO USE:*** 1. Woman reports back pain in labour 2. Woman feels overheated or is sweating 3. Hemorrhoids cause excessive pain 4. After the birth, as a cold compress on woman's perineum to relieve swelling or stitch pain
WHEN NOT TO USE: 1. Woman reports feeling uncomfortably warm or has fever 2. Staff are worried about potential harm from heat	***WHEN NOT TO USE:*** 1. Woman is already feeling chilled. Use heat first in this case 2. Women from cultures in which use of cold is a threat to woman's wellbeing during labour or postpartum. Ask her if she prefers a hot pack or a cold pack or nothing. 3. Woman reports that use of cold is not helping her or is irritating.

From: Simkin, P. & Ancheta, R. (2005). The Labor Progress Toolkit: Part 2. In *The labor progress handbook* (2e ed., pp. 248-252). Oxford, UK: Blackwell Science.

* Kamis, Y., Shaala, S., Damaraawy, H., Romia, A. & Toppozada, M. (1983). Effect of heat on uterine contractions during normal labor. *International Journal of Gynecology & Obstetrics, 21*(6), 491-493.

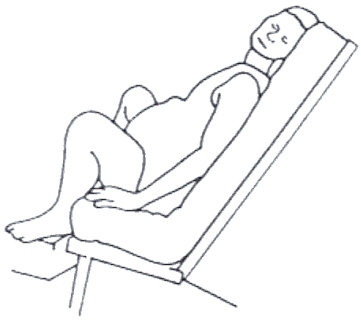
PHYSIOLOGIC POSITIONS FOR LABOUR AND BIRTH

From Simkin & Ancheta (2005) *The Labor Progress Handbook*

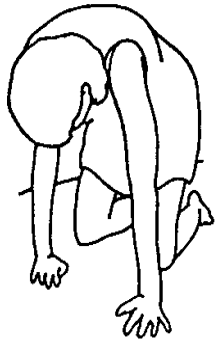
POSITIONS	UNIQUE CONTRIBUTING FEATURES
STANDING & LEANING FORWARD *Woman stands and leans on partner, on raised bed, over birth ball placed on bed, or on counter* **Use:** • Slow or arrested labour progress • When contractions space out or lose intensity • Backache • Comfortable for woman in 1st or 2nd stage	• Provides gravity advantage • Enlarges pelvic inlet (when compared with supine or sitting) • Aligns fetus with pelvic inlet • May promote flexion of fetal head • May enhance rotation from OP, especially if combined with swaying movements • Causes contractions to be less painful but more productive than in supine or sitting • Relieves backache by reducing pressure of fetal presenting part on woman's sacrum • May be easier to maintain than hands and knees position • If woman embraced and supported in upright position by her partner, the embrace increases her sense of wellbeing and may reduce catecholamine production • May increase urge to push in second stage
ASYMMETRICAL UPRIGHT (standing, kneeling, sitting) *Woman sits, stands, or kneels, with one knee and hip flexed, and foot elevated above the other.* **Use:** • Backache • Slowing of active labour progress • Rotation desired in 1st or 2nd stage • Fetus suspected to be asynclitic	• Exerts mild stretch on adductor muscles of raised thigh, causing some lateral movement of ischium, thus increasing pelvic outlet diameter • May aid rotation from OP • Reduces back pain • Provides gravity advantage • Allows woman to "lunge" in this position, thereby causing the pelvic outlet to widen even more on that side.

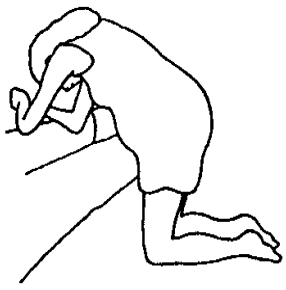
POSITIONS	UNIQUE CONTRIBUTING FEATURES
SEMI-SITTING *Woman sits with trunk at <45° angle with bed* **USE:** • If progress is good, and woman prefers it • When woman needs rest • When epidural is in place • For caregiver's convenience during 2nd stage in viewing perineum	• Provides some gravity advantage, when compared with supine • May be better than supine for: - Increasing pelvic inlet dimensions - Improving oxygenation of fetus • Is an easy position to assume • Pressure on sacrum and coccyx may impair pelvic joint movement
SITTING UPRIGHT *Woman sits straight up on bed, chair or stool* **USE:** • When woman needs to rest • Backache • Woman finds it comfortable in 1st or 2nd stage • When active labour progress has slowed; sitting up is especially beneficial if her knees are lower than her hips	• Provides gravity advantage • Allows tired woman to rest, if she is well supported • Allows for placement of hot or cold packs on shoulders, low back, lower abdomen • Enables woman to rock or sway if rocking chair or birth ball is used
SITTING, LEANING FORWARD WITH SUPPORT *Woman sits with feet firmly placed and leans forward, arms resting on thighs or on a prop in front of her; or she straddles a chair or toilet and rests her upper body on the back* **USE:** • If woman is semi-reclining and labour is not progressing, to shift the weight of fetal torso off woman's spine • Backache • When woman finds it comfortable in 1st or 2nd stage • When active labour progress has slowed	• Provides gravity advantage • Is restful if woman is well supported • Relieves backache • May enhance rotation from OP (when compared with supine, semi-sitting) • Aligns fetus with pelvis • Enlarges pelvic inlet (when compared with supine) • Allows easy access for backrub

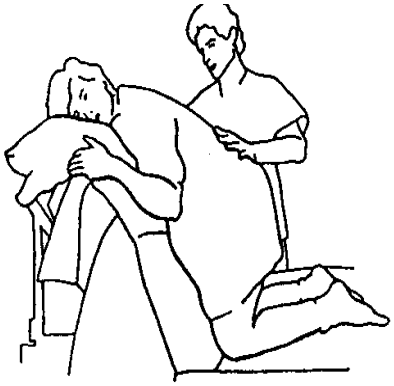


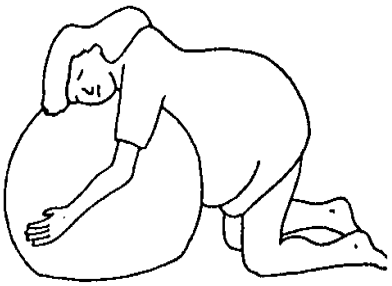



POSITIONS	UNIQUE CONTRIBUTING FEATURES
KNEELING, LEANING FORWARD WITH SUPPORT *Woman kneels on bed or floor, leaning forward onto back of bed, chair seat, birth ball, or other support* USE: • Fetus in OP • Backache • Woman in a bath or pool • When fetal compromise noted with supine or sidelying position • Fetus is at a high station • Woman finds it comfortable • To alternate with other positions for backache	• Provides some gravity advantage • Aligns fetus with pelvic inlet • Enlarges pelvic inlet more than sidelying, supine, or sitting • Allows easy access for back pressure • Relieves strain on hands and wrists when compared with hands & knees position • Allows easy movement (swaying, rocking) • May relieve cord compression • May cause soreness in knees *(to prevent this, woman can wear kneepads made for sports or gardening)*
HANDS AND KNEES *Woman kneels (preferably on padded surface), leans forward and supports herself on either the palms of her hands or her fists (the latter being more tolerable if she has carpal tunnel syndrome). Knee pads may make her more comfortable.* USE: • Backache • Fetus in OP • Woman finds it comfortable in 1st and 2nd stage • When cervical anterior lip slows progress	• Aids fetal rotation from OP • May aid in reducing anterior lip in late first stage • Reduces back pain • Allows swaying, crawling or rocking motion to promote rotation and increase comfort • Relieves hemorrhoids • May resolve FHR problems, especially if due to cord compression • Allows easy access for counterpressure or double-hip squeeze • Allows access for vaginal exams • Arms may tire; to relieve, she rests upper body and head on pile of pillows, chair seat or birth ball



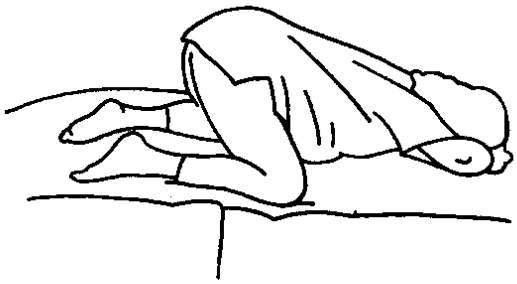






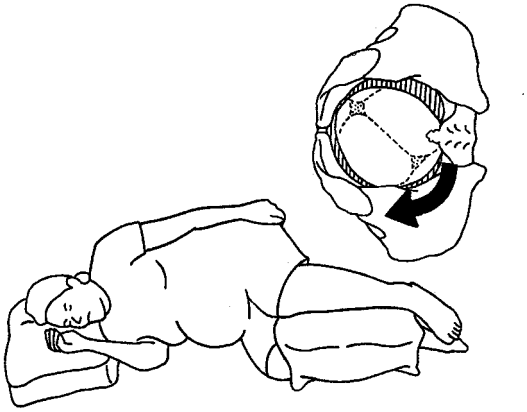
POSITIONS	UNIQUE CONTRIBUTING FEATURES
OPEN KNEE-CHEST POSITION *Woman kneels, leans forward to support weight on her hands, then lowers her chest to the floor, so that her buttocks are higher than her chest. In this OPEN knee-chest position, her hips are less flexed (>90° angle) than in the usual CLOSED knee-chest position.* USE: • Prolapsed cord • When OP suspected in pre-labour or early labour, as indicated by contractions that are short, frequent, irregular & painful, especially in low back, and not accompanied by dilation • Backache • To avoid a premature urge to push • Swollen cervix or anterior lip • If caregiver needs to perform a manual rotation of the posterior head during second stage	• Protects against fetal compromise with prolapsed cord • If used for 30-45 minutes during latent phase or any time before engagement, it allows repositioning of the fetal head. Gravity encourages the fetal head to "back out" of the pelvis and rotate or flex before re-entering • May resolve some fetal heart rate problems • Reduces back pain • Relieves hemorrhoids • It is tiring; pillows and support from partner makes the position easier.
CLOSED KNEE-CHEST POSITION *Woman kneels, and leans forward, supporting herself on her hands, then lowers her chest to the bed, with her knees and hips flexed and abducted under her abdomen* USE: • Backache • Swollen cervix or anterior lip • Prolapsed cord	• Reduces back pain • Is less strenuous than hands and knees or OPEN knee-chest position • Spreads ischia, enlarging bispinous and intertuberous diameters • Relieves hemorrhoids • May resolve some FHR problems • Is an anti-gravity position which may help reduce an anterior lip

Open knee–chest position.

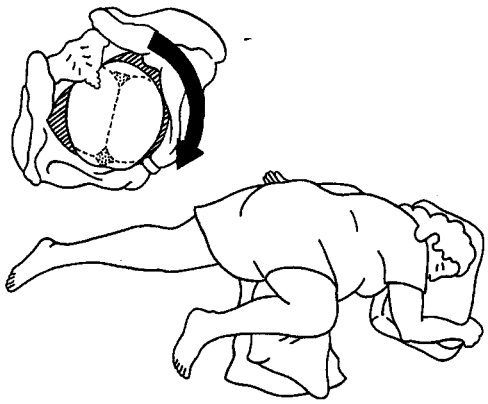


Closed knee–chest position.

POSITIONS	UNIQUE CONTRIBUTING FEATURES
SIDELYING POSITIONS USE: • As long as labour continues to progress well and woman wants it • When supine hypotension occurs • When woman has been given narcotics or epidural • Pregnancy-induced hypertension • Woman finds it comfortable in 1st or 2nd stage • When woman is tired • In second stage, if hemorrhoids are painful in dorsal positions *NOTE: Gravity effects are different when a woman is in pure sidelying or semi-prone (see below).*	• Allow tired woman to rest • Safe if pain medications have been used • Gravity neutral (can be used with very rapid 1st or 2nd stage) • May relieve hemorrhoids • May relieve FHR problems, if due to cord compression or supine hypotension • Help lower high blood pressure (especially left lateral) • May promote progress when alternated with walking • Avoid pressure on sacrum (unlike sitting and supine positions) • In second stage, because there is no pressure on sacrum (as with sitting), these positions allow posterior movement of sacrum as fetus descends • May enhance rotation of OP baby
PURE SIDELYING *Woman lies on side with both hips and knees flexed and a pillow between her legs, or with her upper leg raised and supported*	• Woman with OP fetus should lie on the *SAME* side as the fetal occiput and back (*baby's back toward bed*). This should be done 15-30 minutes to encourage rotation from OP to OT • Then ask woman to change to kneeling and leaning forward for 15-30 minutes to encourage rotation from OT to OA
EXAGGERATED SIMS OR SEMI-PRONE *Woman lies on side with lower arm behind (or in front of) her trunk, her lower leg extended, and her upper leg flexed > 90° and supported by one or two pillows. She rolls partly toward her front*	• Woman with OP fetus should lie on the side *OPPOSITE* the fetal occiput (*baby's back toward ceiling*). This should be done for at least 15-30 minutes. • In this position, her pelvis is rotated so that the front of it is pointing more toward the bed than with straight sidelying. This alters the effects of gravity so that the fetal trunk is encouraged to rotate to transverse and then to anterior.



Woman in pure sidelying on the 'correct' side, with fetal back 'toward the bed'. If fetus is ROP, woman lies on her right side. Gravity pulls fetal occiput and trunk toward ROT.



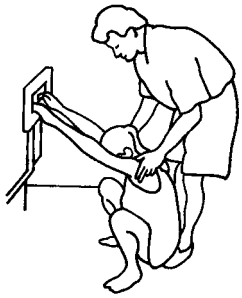
Woman semi-prone on the 'correct' side, with fetal back 'toward th ceiling'. If fetus is ROP, the semi-prone woman lies on her side. Gravity pul fetal occiput and trunk toward ROT, then ROA.

POSITIONS	UNIQUE CONTRIBUTING FEATURES
SQUATTING *Woman lowers herself from standing into a squatting position with her feet flat on floor or bed, using her partner, a squatting bar, or other support for balance, if necessary* USE: • When more space within pelvis is desired during 2nd stage, especially when fetus is OA • When descent is inadequate	• Provides gravity advantage • Enlarges pelvic outlet by increasing the intertuberous diameter • May require less bearing-down effort than horizontal positions • May enhance urge to push • May enhance fetal descent • May relieve backache • Allows freedom to shift weight for comfort • Provides mechanical advantage: upper trunk pressed on fundus more than in other positions • May impede correction of angle of head if fetus is at high station and asynclitic. However, may hasten descent if fetal head is engaged and well-aligned in OA • If used for prolonged period, compressed blood vessels and nerves behind knee joint; avoided by sitting back or standing after every contraction or two.
SUPPORTED SQUATTING POSITIONS *During contractions in the second stage, woman leans with back against partner, who places his/her forearms under her arms and holds her hands, taking all her weight. She stands between contractions* **THE "DANGLE"** *Partner sits on high bed or counter, feet supported on chair or footrest, with thighs spread. Woman stands between partner's legs with her back to her partner, and places her flexed arms over partner's thighs. During contraction, she lowers herself, and her partner grips sides of her chest with his/her thighs; her full weight is supported by her arms on his/her thighs and the grip of his/her thighs on her upper trunk. She stands between contractions. A "birth sling", suspended from ceiling, may also be used to support the woman. This is much easier fro the partner than the supported squat.* USE: • When more mobility of pelvic joints is needed • When lengthening of woman's trunk seems desirable • In 2nd stage, when fetal head is thought to be large, asynclitic, OP or OT • When descent is not taking place	• Provides gravity advantage • Elongates woman's trunk: may help resolve asynclitism by giving fetus more room to renegotiate angle of head in pelvis • Allows more mobility in pelvic joints than in other positions • Allows fetal head to "mold" the woman's pelvis as needed • Enables woman to feel safe and supported by partner, which may reduce catecholamines • *Supported squat* requires great strength in support person and is tiring. To make it easier, partner may lean back on wall for support, make sure to maintain straight back, and alternate this with other positions. • If prolonged, may cause paresthesia (numbness, tingling) in woman's hands, from pressure or partner's arms or thighs in her armpits. To prevent this, suggest that woman stand up and lean on her partner between contractions. • *The dangle* allows partner's legs or birth sling to support all of woman's weight, making it less tiring for partner than supported squat. This also leaves partner's hands free to stroke or hold woman.

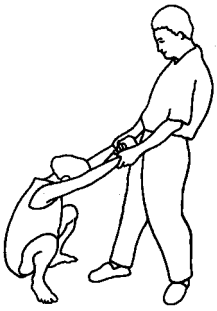
POSITIONS	UNIQUE CONTRIBUTING FEATURES
LAP SQUATTING *Partner sits on armless straight chair; woman sits on partner's lap facing partner and straddling partner's thighs. Partner spreads thighs during contractions, allowing woman's buttocks to sag between, while she keeps from sagging too far by bending her knees over partner's thighs. Between contractions, partner brings legs together so woman is sitting up on them. Another person can assist in supporting woman while she sits on partner's lap.* USE: • When 2nd stage progress has arrested • When woman has joint problems that make squatting impossible • When woman is too tired to squat or dangle • When all other positions have been tried	• Provides gravity advantage • Allows woman to rest between contractions, if she is held • Passively enlarges pelvic outlet • Requires less bearing-down effort than many other positions • Relaxes pelvic floor • May enhance descent if fetus is OA • Mechanical advantage: upper trunk pressed on fundus more than in other positions • May enhance woman's sense of security, as she is held closely • May be awkward for caregiver (who must get on floor to view progress) • May be tiring for support person who bears woman's weight. If another person is there to help support the woman, the partner does not become as tired. • May be less effective if fetus is asynclitic or OP

Supported Squats

Squat with bar.

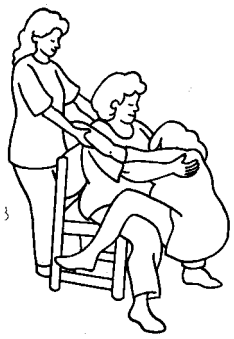


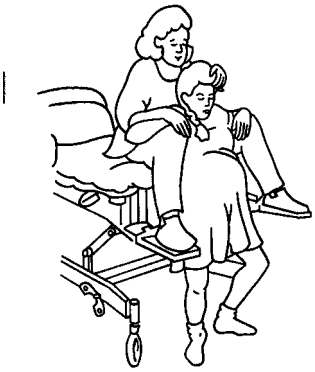
Squat with bed rail.

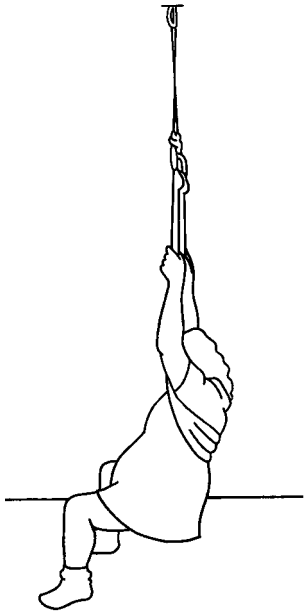


Partner squat.

Lap squat, two people.







Second Stage of Labour Clinical Practice Guidelines

Consider 2nd Stage being finished within 4 hours!

SECOND STAGE OF LABOUR – LOW-RISK PRIMIGRAVIDAS WITH EPIDURALS

Use ONLY when maternal and fetal status is REASSURING

Notify HCP or OBS resident if position is unknown or NO progress in any 1-hour time period.

1st Hour – BEGINS WHEN WOMAN IS FULLY DILATED

Time fully dilated: _____ **Position** _____ **Station** _____ **Position Confirmed?** ☐ YES

START Pushing – ONLY IF meets *Pushing Criteria*
- ☐ Head visible
  OR
- ☐ Urge to push is present
  AND
- ☐ Station is +2 or below, *AND*
- ☐ Position is OA, LOA, ROA

Started pushing @ _____

DELAY Pushing – ONLY IF (check all that apply)
- ☐ The FHR is reassuring
- ☐ No urge to push (unless head visible)
  OR
- ☐ Urge to push present, *BUT*:
  - ☐ Station is above +2, *OR*
  - ☐ Position is OP or OT

- ☐ Continue or ☐ Start ***oxytocin*** *prn*
- ☐ Urge to push remains - ***Give top-up***
- ☐ Empty bladder ☐ Reposition to facilitate rotation

2nd Hour Begins @ _____ ASSESS PROGRESS

Position _____ **Station** _____
Pushing criteria met? ☐ YES

Progress? ☐ YES ☐ NO - NOTIFY HCP or resident ☐ NO

☐ **CONTINUE or ☐ START PUSHING**

Must meet *Pushing Criteria* - *see box above*

Started pushing @ _____

☐ **WAIT* for 1 more hour**
Reassess:
- ☐ Maternal positioning
- ☐ Oxytocin augmentation
- ☐ Epidural analgesia, prn
- ☐ Assess bladder

**Can wait up to 2 hours*

3rd Hour Begins @ _____ HCP+ RESIDENT – NOTIFIED TO ASSESS ALL SHOULD BE PUSHING (unless otherwise ordered by the HCP)

Position _____ **Station** _____ **Progress?** ☐ YES ☐ NO

FP and midwife consult OB (unless delivery imminent): ☐ YES ☐ NO

Reassess: ☐ Positioning ☐ Augmentation ☐ Bladder

- ☐ Pushing for **1 hour** – **CONTINUE**
- ☐ Pushing for **2 hours** – Consider assisted delivery unless birth **IMMINENT**
- ☐ Women who have not pushed – **START** pushing **Started pushing @** _____

4th Hour Begins @ _____ HCP NOTIFIED TO ASSESS - ALL SHOULD BE PUSHING

Position _____ **Station** _____
- ☐ Pushing for **1 hour** – **CONTINUE**
- ☐ Pushing for **2 hours** – Consider assisted delivery unless birth imminent

AT END OF HOUR 4

☐ **Adequate Progress**
SVD imminent - CONTINUE pushing

or

☐ **Inadequate Progress**
SVD unlikely - NOTIFY HCP, *if not present*
- CONSIDER Assisted Birth / C-Birth

Plan for delivery communicated & documented on chart? ☐ YES ☐ NO

SECOND STAGE SHOULD ONLY CONTINUE BEYOND 4 HOURS IF VAGINAL BIRTH IMMINENT

Outcome: Birth @ _____ ☐ SVD ☐ Forceps ☐ Vacuum ☐ Both ☐ C-Birth ☐ Apgar ___ / ___
pH _____ BE _____
Comments:

*Place form in designated file

Consider 2nd Stage being finished within 3 hours!

MULTIGRAVIDA WITH EPIDURAL

Use ONLY when maternal and fetal status is REASSURING

Notify HCP or OBS resident if position is unknown or NO progress in any 1-hour time period.

1st Hour – BEGINS WHEN WOMAN IS FULLY DILATED

Time fully dilated: _____ **Position** _____ **Station** _____ **Position confirmed?** ☐ **YES**

START Pushing – ONLY IF meets *Pushing Criteria

- ☐ Head visible
  OR
- ☐ Urge to push is present
  OR
- ☐ Station is +2 or below, ***AND***
- ☐ Position is OA, LOA, ROA

Started pushing @ _____

DELAY Pushing – ONLY IF (check all that apply)

- ☐ The FHR is reassuring
- ☐ No urge to push
  AND
- ☐ Station is above +2
- ☐ Position is OP or OT

- ☐ Continue or ☐ Start ***oxytocin*** *prn*
- ☐ Urge to push remains - ***Give top-up***
- ☐ Empty bladder ☐ Reposition to facilitate rotation

2nd Hour Begins @ _____ ASSESS PROGRESS

Position _____ **Station** _____ **Progress?** ☐ **YES** ☐ **NO -**
NOTIFY HCP or resident
Pushing criteria met? ☐ **YES** ☐ **NO**

☐ **CONTINUE or** ☐ **START PUSHING**

Must meet *Pushing Criteria - see box above*

Started pushing @ _____

☐ **WAIT* for 1 more hour**
Reassess:

- ☐ Maternal positioning
- ☐ Oxytocin augmentation
- ☐ Epidural analgesia, prn
- ☐ Assess bladder

**Can wait up to 2 hours*

3rd Hour Begins @ _____ SHOULD BE PUSHING

HCP+ RESIDENT – NOTIFIED TO ASSESS ALL

(unless otherwise ordered by the HCP)

Position _____ **Station** _____

FP and midwife consult OB (unless delivery imminent): ☐ **YES** ☐ **NO**

- ☐ Pushing for **1 hour** – **CONTINUE**
- ☐ Pushing for **2 hours** – Consider assisted delivery unless birth **IMMINENT**
- ☐ Women who have not pushed – **START** pushing **Started pushing @** _____

Reassess: ☐ Positioning ☐ Augmentation ☐ Bladder

AT END OF HOUR 3

☐ **Adequate Progress**
SVD Imminent - CONTINUE pushing

or

☐ **Inadequate Progress**
SVD unlikely - CONSIDER Assisted Birth / C-Birth

Plan for delivery communicated & documented on chart? ☐ **YES** ☐ **NO**

SECOND STAGE SHOULD ONLY CONTINUE BEYOND 3 HOURS IF VAGINAL BIRTH IMMINENT

Outcome: **Birth @** _____ ☐ SVD ☐ Forceps ☐ Vacuum ☐ Both ☐ C-Birth ☐ Apgar ___/___ *Place form in
Comments: **pH** _____ **BE** _____ **designated** file

Consider 2nd Stage being finished within 3 hours!

PRIMIGRAVIDA - NATURAL CHILDBIRTH

Use ONLY when maternal and fetal status is REASSURING

Notify HCP or OBS resident if position is unknown or NO progress in any 1-hour time period.

1st Hour – BEGINS WHEN WOMAN IS FULLY DILATED

Time fully dilated: _____ **Position** _____ **Station** _____ **Position confirmed?** ☐ **YES**

START Pushing – IF

☐ Urge to push is present

Started pushing @ _____

DELAY Pushing – ONLY IF (check all that apply)

☐ The FHR is reassuring
☐ No urge to push
☐ The woman can tolerate waiting

☐ Continue or ☐ Start ***oxytocin*** *prn*
☐ Assess bladder ☐ Reposition to facilitate rotation

2nd Hour Begins @ _____ ASSESS PROGRESS

Position _____ **Station** _____ **Progress?** ☐ **YES** ☐ **NO - NOTIFY HCP or resident**

Urge to push present? ☐ **YES** ☐ **NO**

☐ **CONTINUE or** ☐ **START PUSHING**

Started pushing @ _____

☐ **WAIT*** for 1 more hour
Reassess:
☐ Maternal positioning
☐ Oxytocin augmentation
☐ Epidural analgesia, prn
☐ Assess bladder **Can wait up to 2 hrs*

3rd Hour Begins @ _____ HCP+ RESIDENT – NOTIFIED TO ASSESS

ALL SHOULD BE PUSHING
(unless otherwise ordered by the HCP)

Position _____ **Station** _____

FP and midwife consult OB (unless delivery imminent): ☐ **YES** ☐ **NO**

Reassess: ☐ Positioning ☐ Augmentation ☐ Bladder

☐ Pushing for **1 hour** – **CONTINUE**
☐ Pushing for **2 hours** – Consider assisted delivery unless birth **IMMINENT**
☐ Women who have not pushed – **START** pushing **Started pushing @** _____

End of 3rd Hour @ _____ REASSESS

Position _____ **Station** _____

☐ **Adequate Progress**
SVD Imminent - CONTINUE pushing

or

☐ **Inadequate Progress**
SVD unlikely - Notify HCP, *if not present*
- CONSIDER Assisted Birth / C-Birth

Plan for delivery communicated & documented on chart? ☐ **YES** ☐ **NO**

If epidural is started during 2nd Stage switch to 'Primigravida With Epidural' guideline starting at the elapsed time.

SECOND STAGE SHOULD ONLY CONTINUE BEYOND 3 HOURS IF VAGINAL BIRTH IMMINENT

Outcome: **Birth @** _____ ☐ SVD ☐ Forceps ☐ Vacuum ☐ Both ☐ C-Birth ☐ Apgar ___/___ *Place audit in designated file
Comments: pH _____ BE _____

Consider 2nd Stage being finished within 2 hours!

SECOND STAGE OF LABOUR – MULTIGRAVIDA - NATURAL CHILDBIRTH

Use ONLY when maternal and fetal status is REASSURING

Notify HCP or OBS resident if position is unknown or NO progress in any 1-hour time period.

1st Hour – BEGINS WHEN WOMAN IS FULLY DILATED

Time fully dilated: _____ **Position** _____ **Station** _____ **Position confirmed?** ☐ **YES**

START Pushing – ONLY IF
- ☐ Urge to push is present

DELAY Pushing – ONLY IF (check all that apply)
- ☐ No urge to push (can push at anytime if urge occurs)
- ☐ The FHR is reassuring
- ☐ The woman can tolerate waiting

- ☐ Continue or ☐ Start ***oxytocin*** *prn*
- ☐ Reposition to facilitate rotation

2nd Hour Begins @ _____ ASSESS PROGRESS - ALL SHOULD BE PUSHING

(unless otherwise ordered by the HCP)

Position _____ **Station** _____ **Progress?** ☐ **YES** ☐ **NO**

Reassess: ☐ Positioning ☐ Augmentation ☐ Bladder

- ☐ Pushing for **1 hour** – Consider assisted delivery unless birth **IMMINENT**
- ☐ Women who have not pushed – **START** pushing **Started pushing @** _____

End of 2nd Hour - **HCP+ RESIDENT – NOTIFIED TO ASSESS**

HCP refers to Obstetrician on-call or family practice physician

FP and midwife consult OB (unless delivery imminent): ☐ **YES** ☐ **NO**

☐ **Adequate Progress**
SVD Imminent - CONTINUE pushing

or

☐ **Inadequate Progress**
SVD unlikely - CONSIDER Assisted Birth / C-Birth

If epidural is started during 2nd Stage switch to 'Multigravida With Epidural' guideline starting at the elapsed time.

SECOND STAGE SHOULD ONLY CONTINUE BEYOND 2 HOURS IF VAGINAL BIRTH IMMINENT

Outcome: **Birth @** _____ ☐ SVD ☐ Forceps ☐ Vacuum ☐ Both ☐ C-Birth ☐ Apgar ___/___ *Place audit in designated file

Comments: pH _____ BE _____

PROLONGED SECOND STAGE

Adapted from ***Penny Simkin***

DEFINITION

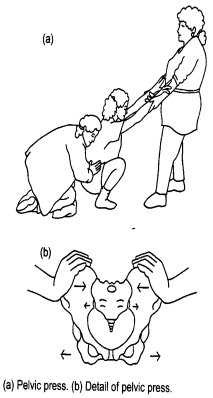
- *Latent phase of the second stage* – Often perceived as abnormal uterine inertia. Physiological phenomenon relating to the retraction of the cervix around the head and the descent of the fetal head into the vaginal canal. Contractions may be weak or unnoticeable, and the woman may doze off. Contractions then resume and woman experiences an increasingly powerful urge to push, with a spurt in oxytocin release.
- *Active phase of the second stage* – Involuntary urge to push and descent of fetus.

CAUSES OF PROLONGED SECOND STAGE

- Pushing which is diffuse, unfocused, and results in little progress. Often occurs when woman has eyes tightly closed, or vocalizing continuously, and no/little progress after 20-30 minutes.
- Epidural analgesia:
  - Leads to reduced tone of pelvic floor muscle, which tends to inhibit rotation of fetal head
  - Woman lacks feelings to help her discover how to push effectively
  - Restricted to few positions without full sensation or use of her legs
  - May interfere with spurt of endogenous oxytocin
  - With reduced urge to push, pushing requires greater voluntary effort
- Malpresentations (persistent OP or OT, or asynclitism)
- Cephalo-pelvic disproportion (CPD) or macrosomia
- Emotional dystocia

HOW TO HELP

- Wait for urge to push before checking woman's cervix (less likely to consider it prolonged)
- Change woman's position to sitting upright, squatting or walking; acupressure; nipple stimulation
- Encourage woman's spontaneous bearing-down efforts and praise her efforts
- With diffuse pushing, instruct woman to open her eyes and look at her vagina and think about pressing the baby out.
- With epidural, some problems may be partly solved by:
  - Using lower concentrations of anesthetic, combined with low-dose narcotics, to allow more motor control
  - Discontinuing or decreasing dose of epidural at end of first stage of labour to allow return of sensation and urge to push
  - Delaying pushing for up to 2 hours, or until fetal head is OA or becomes visible at vaginal outlet
  - Removing time limit for second stage, as long as fetus and woman are tolerating it well
  - Using EFM as biofeedback to encourage her bearing-down efforts
  - Being more directive, telling the woman when to breathe and when to bear down
- For malpositions, encourage woman to assume different positions to encourage the baby to turn:
  - leaning forward while kneeling, standing, or sitting
  - squatting positions
  - asymmetrical positions
  - lateral positions
  - supported squat or dangle
  - **PELVIC PRESS** → → → → → → → → → →



(a) Pelvic press. (b) Detail of pelvic press.

ONE-MINUTE COMFORT MEASURES FOR THE "BUSY BUT CARING" NURSE

The following techniques require very little of your time, but they express your kindness and concern, and make the mother more comfortable. Women often remember kind gestures, encouraging words or wonderful backrubs with great appreciation, even years later.

PHYSICAL COMFORT MEASURES	***EMOTIONAL SUPPORT***	***INSTRUCTION / INFORMATION***
❑ Apply cool cloths, warm compresses ❑ Assist with shower, bathing ❑ Change linen / underpad ❑ Offer fluids, ice chips ❑ Help woman determine *"Pain Management Preference Scale"* ❑ Help woman follow her original preferences regarding pain-relief measures ❑ Help position comfortably ❑ Encourage use of other positions/movements *(standing, leaning, slow-dancing, walking, lunge, kneeling, sitting up, birth ball, sidelying, squatting, supported squat)* ❑ Massage back, hand, foot or other body parts ❑ Perform effleurage, stroking, acupressure ❑ Assist with specific backache relief measures *(double-hip squeeze, counterpressure, pelvic rocking, knee press, hands & knees, lunge, hot/cold pack, rolling pressure, shower to back, bathtub)* ❑ Reduce tension *(Roving Body Check)* ❑ Assist with ambulation ❑ Ensure voiding every one to two hours	❑ Assess woman's preferences regarding birth ❑ Support woman's decisions / wishes ❑ Reassure, encourage, praise *(focus on what woman does well)* ❑ Acknowledge and validate woman's pain ❑ Stay with woman, keep her company, provide undivided attention ❑ Use "labour voice" *(murmuring, soothing, calming, encouraging)* ❑ Assist with/support woman's ritual during contractions ❑ Use specific distraction techniques during contractions *(count breaths, attention-focusing, focal point, visualization, eye contact, guided imagery, music)* ❑ Give reassuring touch *(holding, patting hand, stroking cheek)* ❑ Directly address discouragement, when expressed ❑ Assist partner in providing support ❑ Support woman's partner in help offered ❑ Share woman's wishes with other team members ❑ Accept woman's behaviour without judgement, even when behaviour is unusual or upsetting	❑ Assist with breathing / relaxation ❑ Encourage use of specific techniques to promote relaxation, comfort & improve physical condition ❑ Watch woman/couple through a contraction & give feedback/suggestions ❑ Explain what is happening, provide information about progress, fetal wellbeing, what to expect ❑ Ask for feedback between contractions *("What's going through your mind?")* ❑ Reframe distress-related responses to coping-related responses ❑ Use the *Take Charge Routine* if panicky ❑ Encourage spontaneous, self-directed pushing ❑ Help with diffuse, holding-back pushing ❑ Interpret caregiver's findings

RECOGNIZE AND USE YOUR POWER CONSTRUCTIVELY. You can have an enormous positive impact on both the obstetrical outcome and the woman's

CMNRP's Regional Documentation Tool

Patient: Chart no.:

MATERNAL/FETAL ASSESSMENTS

		Date / Time															
FETAL ASSESSMENT	Mode																
	FHR																
	Rhythm/Variability																
	Acceleration																
	Deceleration																
	Stimulation (scalp) / pH																
	Classification (N, AT, AB)																
UTERINE ACTIVITY	Mode																
	Frequency																
	Duration																
	Intensity																
	Resting tone																
IV MED.	**Oxytocin OXY** mu/min																
MATERNAL ASSESSMENT	**Blood Pressure** 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 — Systolic v — Diastolic ^ — **Pulse** •																
	Temperature																
	Respiration																
	O_2 sat.																
	Breath sounds																
	Arterial line (✓, F, Z)																
	Reflexes																
	Pain scale																
	Vaginal exam (✓)																
SUPPORTIVE CARE	Emotional status																
	Emotional support																
	Teaching																
	Comfort measures																
	Activity/Position																
	Analgesia																
INTERVENTIONS	Position : change																
	Fluid BOLUS (mL)																
	O_2 (8-10 L/min)																
	Physician notified																
	Fall risk (✓/+)																
	Interventions (U, I)																
	Hourly rounding ✓																
	Init.																

OBS 93 C 2-12

Patient: Chart no.:

PARTOGRAM

Draw alert / action lines in active labour

DATE (yyyy/mm/dd):

Exam Time

2nd stage hour indicator **Hours**

CERVICAL DILATATION (cm) ●

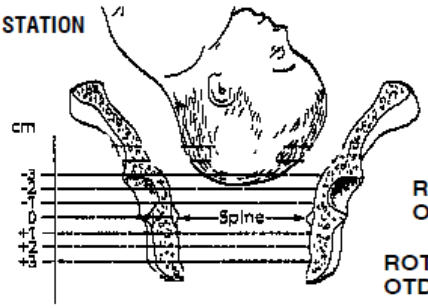
10 9 8 7 6 5 4 3 2 1 0

STATION -3 -2 -1 0 X +1 +2 +3

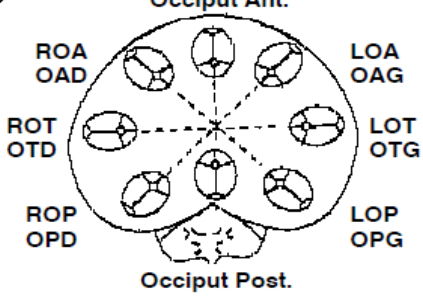
Prior to induction
Bishop's Score _____

Cervix	effacement (cm/%)
	consistency
	position
Moulding	Caput
Fetal position	
Membranes	
Quantity of amniotic fluid	
Colour	
Show (✔ if present)	
Bleeding	
Pushing status	
Cervical ripening/Dose **C** Cervidil **M** Misoprostil **P** Prostin **F** Foley **L** Laminaria	
Examiner(s) or INIT.	

STATION



POSITION



MEMBRANES
- **I** Intact
- **S** Spontaneous rupture
- **A** Amniotomy

AMNIOTIC FLUID
- **Ø** None
- **M** Moderate
- **CI** Clear
- **B** Bloody
- **SC** Scant
- **L** Large
- **BT** Blood Tinged
- **M** Meconium

PUSHING STATUS
- **P** Pushing
- **NP** Not pushing
- **UP** Urge to push
- **NUP** No urge to push
- **IP** Involuntary pushing

CONSISTENCY
- **S** Soft
- **F** Firm
- **M** Medium

CERVICAL POSITION
- **A** Anterior
- **M** Mid position
- **P** Posterior

BLEEDING
- **SC** Scant
- **M** Moderate
- **L** Large

OBS 93 C 10-12

Patient: Chart no.:

ACTIVE SECOND STAGE

Time	FHS					CONT.		Pushing	Mat. Position	OXY mu/min	Comments	Init.
	Mode	FHR	Var. Rhythm	Accel.	Decel.	Freq.	Dur.					

NOTIFICATION	Time called	Time arrived
Obstetrician/GP/Midwife		
Resident		
Intern/Medical student		
Pediatrician/Neonatologist		
Neonatal resuscitation Team		

COUNT	FIRST	ADDED	FINAL	INIT.
Instruments				
Needles				
Sponges				
Other				

Indication

PUSHING EFFICACY: **E** = Effective **NE** = Non effective **NP** = Not pushing

OBS 93 C 11-12

Patient: Chart no.:

LEGEND

FETAL ASSESSMENT

Mode: **A** Auscultation **NST** Non stress test
EFM: **Ext** external **Int** Internal

Baseline FHR (AUSC/EFM): ___ bpm

Rhythm (AUSC) : **R** Regular **I** Irregular

Variability (EFM):
↓ Minimal (less than or equal to 5 bpm) + Moderate (6-25 bpm)
↑ Marked (greater than 25 bpm) **Ø** Absent

Accelerations (AUSC/EFM):
√ Present/Spontaneous **Ø** Absent/Not heard **SS** Scalp stimulation

Decelerations (AUSC/EFM):
√ Present/Heard **Ø** Absent/Not heard
E Early **L** Late *
P Prolonged *
UV Uncomplicated variables *
CV Complicated variables *
___* ↓ ___bpm x___sec/min ___

CLASSIFICATION
Auscultation : **N** Normal **AB** Abnormal

Electronic Fetal Monitoring:
N Normal **AT** Atypical **AB** Abnormal

Non Stress Test:
N Normal **AT** Atypical **AB** Abnormal

UTERINE ACTIVITY

Mode: **P** Palpation **T** Toco **I** IUPC
Intensity: **MI** Mild **MO** Moderate **ST** Strong ___ mmHg (IUPC)
Resting Tone:
SO Soft **F** Firm ___ mmHg (IUPC)

MATERNAL ASSESSMENT

Arterial line: ✓ Within normal limit
* includes site, patency, wave form, pressure bag
F Flush **Z** Zero
Breath sounds: ✓ Clear, good air entry
AB * ↓ air entry, crackles and wheezes

Reflexes: **Ø** Absent
1+ Weak 2+ Normal
3+ Increased 4+ Brisk with clonus

Pain scale:
0-10 None to excruciating

MATERNAL ASSESSMENT

Emotional Status:
C Calm **A** Anxious **P** Panicky **D** Difficulty coping
E Exhausted **S** Sleeping

Membranes : **I** Intact
SRM Spontaneous rupture of membranes
ARM Artificial rupture of membranes

Amniotic fluid: **Ø** None **SC** Scant
M Moderate **L** Large **Cl** Clear
BT Blood Tinged **B** Bloody **M** Meconium

Show/Vaginal Bleeding:
SC Scant **M** Moderate **L** Large

Woman abuse (WA)
D Disclosure **ND** Non disclosure **NA** Not able to ask

SUPPORTIVE CARE

Emotional support
A Undivided attention **F** Feedback
SP Support to partner **P** Presence: Continuous
R Reassurance/praise **D** Distraction techniques

Teaching
I/A Induction / Augmentation **CB** Cesarean Birth
LP Labour Progress **PC** Peri Care
RT Relaxation Techniques **SS** Second Stage
PR Pain Relief Options **BT** Breathing Techniques
PB Preterm Birth **H** Hypertension
GC Grief Counselling

Comfort measures
CC Cool compresses **M** Massage
WC Warm compresses **BB** Birth ball
IP Ice pack **CP** Counterpressure
F Fluids **S** Shower
PC Pericare **WP** Whirlpool
B Bath

Position/Activity:
A Ambulating **C** Chair
HK Hands & knees **KC** Knee-chest
RL Rt lateral **Li** Lithotomy
LL Lt lateral **S** Squatting
WL Wedge left **SF** Semi-Fowler's
WR Wedge right **T** Trendelenberg

FALL SAFETY

Assessment:
✓ Ambulates independently, is alert & oriented, no visual or hearing deficits or is utilizing corrective devices
+ Patient has factor(s) that may increase fall risk

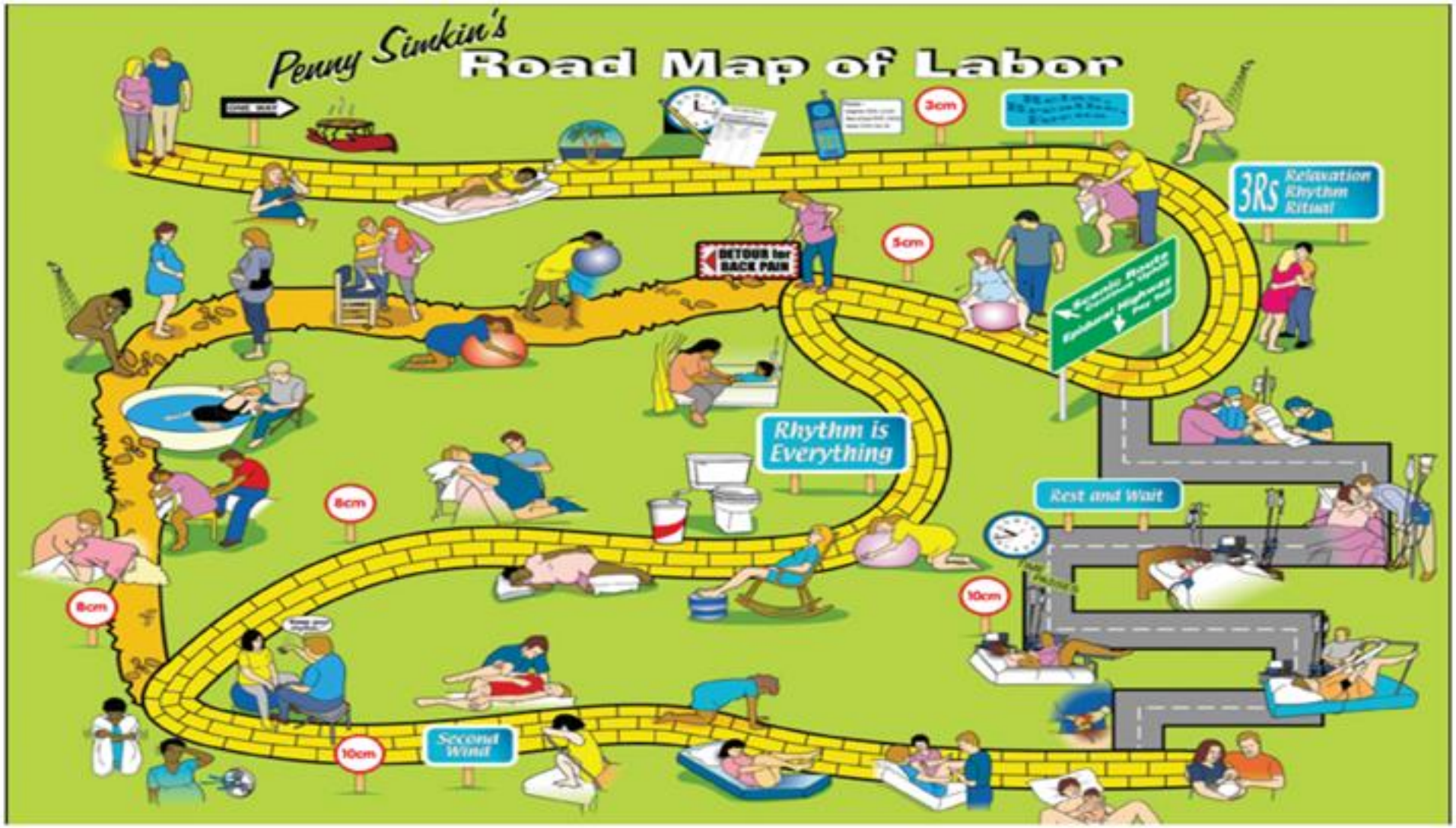
Intervention (as per policies):
U Universal interventions for all patients
I Individualized interventions for patients at higher risk

Factors that may increase fall risk:
Related Diagnoses:
Cognitive impairment (eg.: delirium, street drugs, ETOH), vertigo, symptomatic hypotension
Pre-existing conditions (diabetes, arrhythmias, pre-eclampsia, seizures)
Hemorrhage

Mobility:
Requires assistance (eg.: PCEA, early PP)
Unable to ambulate or transfer
Medications:
Sedatives, opioids, antihypertensives, anti-convulsants

Use * if details noted in Integrated Progess Notes

OBS 93 C 12-12


Penny Simkin's
Road Map of Labor
3cm
3Rs Relaxation Rhythm Ritual
DETOUR for BACK PAIN
5cm
Rhythm is Everything
Rest and Wait
8cm
8cm
10cm
10cm
Second Wind

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