Thompsonhealth

350 Parrish Street, Canandaigua, NY 14424

LABOR AND DELIVERY ORIENTATION

Objectives:

	Demonstrated to Orientee	Return Demonstration	Comments	Approved Date	Approved Initials	Additional Activities
I. Introduction to Labor and Birthing Area: A. Location of Supplies in room and on Unit Ex. Linen, oxygen, suction, IV solutions, and portable oxygen						
B. Location and use of: 1. Forcep cart 2. Speculum Exam tray 3. Emergency delivery tray 4. Ruptured membrane tray						
C. Operation of birthing beds (Swedish, Hill Rom and Adel): 1. Labor bar 2. Stirrups 3. Foot rest						
D. Call and phone system: 1. Intercom system 2. Emergency button 3. Nurse emergency blue button 4. Doctor's call list 5. Telephone directory 6. Supervisor number 7. Numbers for back door 8. Triage / Message book						
E. Birthing room set-up: 1. Linen pack 2. Delivery set 3. Sterile gloves 4. Birthing lights-Ceiling & Portable 5. Cluster cart 6. Stocked monitor 7. Baby warmer						

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8. Neo Puff 9. Step stool 10. Ready room checklist						
F. C-Section room set-up: 1. Check blanket warmer supplies 2. Check suctions 3. Check Oxygen 4. C-section packs in place 5. Check baby warmer 6. Obix hook-up 7. Set–up for twins						
II. Forms used in Labor and Delivery a. Birthing center charts / location b. Add-on charts for c – sections / B.T.L.'s c. NST schedule book / Rhogam book d. Out Pt. Discharge instructions / kick count sheet e. Kardex's – Ex. Post partum and Ante partum f. Transfer Packets g. Fetal loss packets h. Policies and procedures i. Anesthesia packet for epidurals			h. Review all P.P.'s			
III. Safety: a. Huges system						DVD
IV. Use of Equipment A. Fetal monitor 1. Operation: a. Turning on b. Setting clock c. Changing paper d. Marker e. Toco Pressure f. Telemetry g. Test button h. Function button						

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2. Using external monitors a. Belts b. Twins 3. Using Internal monitors a. Internal scalp lead b. IUPC 4. Reading & Interpreting fetal monitor strip a. Fetal monitoring class						
B. Use of Doppler- C/S room Doppler & waterproof Doppler						
C. Cluster cart 1. Equipment within 2. Setting up for delivery						
D. Baby warmer 1. Operation: a. Turning on b. Servo mode c. Manual mode d. Light e. Apgar timer f. Alarm g. Removing heater for X-ray 2. Application of temperature sensor 3. Location of supplies in drawers & shoe bag on warmers in O.R. and Nsy.						
E. Use of OBIX 1. Operation: a. Signing on b. Admission of patient c. Notes- labor & delivery d. Reviewing notes e. Late notes f. Deleting notes g. Printing notes & graphs h. Locking notes 2. Phone number to contact: Obix help line 3. Location of key for HAL						

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F. Jacuzzi 1. Temperature 2. Cleaning						CC.12.001.24
V. Pre – Admission testing: A. NST Procedure- Recognizing reactive pattern- Notifying MD B. Procedure changes C. Calendar notation and scheduling D. Discharge instructions and kick count E. BPP F. Stress test- Ex. OCT, Nipple stimulation G. External version procedure						CC.12.001.32
VI. Admission Procedure: A. Nursing Assessment B. Domestic violence assessment C. Admission Signatures D. Medication reconciliation form E. Physician orders – Labor pt & Ante Partum pt F. Social service referral G. Education – Discharge planning H. Admission binder in room I. Check labor room readiness – Ex. Monitor ready, O2 in ready room baby warmer ready						P.P. # 12.001.33 CC .12.001.28
VII. Labor management A. Assess labor 1. Palpate contractions: Noting interval, duration, & intensity 2. Assess F.H.R. 3. Assess Status of membranes 4. Assess vital signs 5. Perform Vaginal Exam or assist MD 6. Identify risk factors- communicate to charge nurse, Nsy nurse & MD						P.P. 12.001.11 P&P for guidelines for assessment FHR, uterine contr. &vital signs pg 306- "Perinatal nursing- Awhonn" Module 5 Module 3 Note- preterm or term pregnancies w/ SRM & no signs

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						of labor or bleeding should not have vaginal exam by RN pg 77 "Intrapartum management modules"
B. Positioning patient 1. Side lying 2. Use of labor bar 3. Use of labor ball						
C. Relaxation techniques: 1. Teach or review relaxation, focusing & breathing techniques 2. Whirlpool warm water bath 3. Document Response						Module 5
D. Pain management: 1. Position Changes 2. Breathing techniques 3. Analgesia 4. Epidural 5. Document Response						1&2-Module 5 pg 173-175 P.P.# CC.13.004.08
E. Care of mother at delivery: 1. Pitocin after placenta 2. Cord blood & cord gas 3. Recovery notes 4. Documentation- Obix and Kardex						
F. Care of baby at delivery: 1. Shoulder dystocia procedure 2. Resuscitation: a. Bulb and wet suction b. O2 – Anesthesia bag or Blow-by or Neo Puff c. Assisting with intubation d. Resuscitation drugs 3. Meconium stained baby procedure 4. Apgar scores 5. Baby meds- Vitamin K, Erythromycin Ointment, and Narcan 6. Identification- bands, Hugs tag, footprints 7. Kardex documentation						-Protocol and DVD - NRP Guidelines - P.P.# cc.12.001.36

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8. NSVD, "skin-to-skin"						
SPECIFIC PROCEDURES AND HIGHER RISK PROCEDUERS						
	Demonstrated to Orientee	**Return Demonstration**	**Comments**	**Approved Date**	**Approved Initials**	**Additional Activities**
XIV. Pitocin induction or augmentation A. Assessment 1. Baseline 30 Minutes - Monitor Strip 2. Informed consent						P&P# CC13.007.04 pg 314-319 Intrapartum management module 7
B. Preparation of equipment 1. Prepare the 2-bag IV Solution Setup 2. D5LR with 10 units Pitocin obtained thru piyxis 3. Initiate Infusion with M.D. on Premises 4. Increase Rate per MD Order 5. Use "Dose Mode" in IV Pump 6. Label tubing with pink label						
C. Document and take VS as per policy						
D. Continuous monitoring while Pitocin is infusing						
E. Identify need for intervention of non-reassuring strip & institute appropriate treatment. 1. Stop Pitocin 2. Pt in left or right lateral position 3. Administer O_2 4. Notify Physician 5. Reassure patient 6. Prepare for possible rapid delivery 7. Fluid bolus 8. Check BP 9. Ephedrine for hypotension per anesthesia						P%P# CC12.001.25 for non-reassuring monitor strip
XV. Cervical Ripening A. Misoprostil B. Cervidil						P&P# CC13.007.10 CC 13.007.04 Module 7

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XVI. Pregnancy Induced Hypertension Management A. Assessment 1. VS per Order 2. Deep Tendon Reflexes 3. I&O-weight daily 4. Evaluate Edema 5. Neurologic Symptoms 6. Know Relevance of Lab Results						Policy for PIH Management cc.12.001.09 Policy for $MgSO_4$ Administration Intrapartum Management Module 9
C. Nursing Interventions 1. Seizure Precautions 2. Quite, non-stimulating environment 3. Bed rest in Side Lying Position 4. VS per MD order 5. Fetal monitoring per MD order						
XVII. Pre-term Labor Management A. Assessment 1. Obtain History of Pregnancy (EDC, status of membranes, urinary infections) 2. Monitor FH and contraction						Module 8 P&P# CC12.001.22
B. Intervention 1. Position on Side 2. Hydrate 3. Contact Doctor Immediately 2. Tocolysis as ordered 3. Nifedipine protocol						P&P# Terbutaline CC13.007.08
XVIII. Speculum Vaginal Exam and Nitrazine and Fern Test for Diagnosis of Ruptured Membranes and A. Instruct Pt in procedure B. Obtain basket with sterile speculum, nitrazine paper and slides C. Assist MD D. Document						P&P 12.002.18 Module 3 & 8

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XIX. Amnioinfusion A. Assist with IUPC insertion B. Set up NaCl or LR per MD order C. Instill fluid as ordered D. Document fluid return and Pt's tolerance F. Document results of procedure RE FHR and decelerations						P&P CC 12.001.15 pg 153-154 Amnioinfusion
XX. Code Green: A. Notify charge nurse B. Charge nurse notifies supervisor, Nsy, ped's, and switchboard C. Perform pre-op procedures as time permits D. O2 E. Lateral or trendelenburg as indicated F. Support and reassurance Pt and family G. Go with Pt to O.R. and assist with placing BP cuff, heart monitors, O2, Bovie, and leg straps. H. Prepare baby warmer I. Circulating until OR nurse arrives						cc12.003.01
XXI. Non-Emergent / Elective C / Section A. Preparation of mother 1. 30 min. monitor strip 2. Full assessment on Obix 3. IV 4. Foley and clip prep 5. Pre & post-op teaching 6. Sage skin prep B. Charting 1. Consent signed in chart 2. O.R. check list 3. Lab work in chart 4. Physical and History in chart						P&P# CC12.001.02
XXII. Prolapsed Cord A. Assessment 1. Vaginal Exam for ROM with breech presentation or any fetal Bradycardia						P&P# CC12.001.20 pg57-59, 77

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2. Examine for Protrusion of Cord from Vagina 3. Notify MD						
B. Interventions 1. Place Patient in Knee/Chest Position to reduce compression of cord. 2. O2 3. Do not handle cord 4. Vaginal Exam- Apply pressure (on either side of cord) to presenting part vaginally to relieve pressure 5. Prepare for emergent delivery (C-section) 6. As always -Document						
XXIII. Placenta Previa A. Assessment 1. Painless bleeding during 2nd and 3rd trimester B. Management 1. Continuous fetal monitoring 2. Lateral position 3. No vaginal exams. 4. Assessment of bleeding 5. Assessment of VS						
XXIV. Abruptio Placenta A. Assessment 1. Board-like Rigidity of Abdomen 2. Port wine colored amniotic fluid 3. Sudden onset, intense localized pain 4. Signs of shock						P&P CC12.001.23 pg 71
B. Interventions 1. Treatment depends on maternal fetal status 2. Continuous Fetal Monitoring 3. Aggressive fluid replacement 4. Prepare for emergent delivery (C-section)						

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XXV. Postpartum Hemorrhage A. Assessment 1. Heavy vaginal flow 2. Boggy Uterus 3. Constant Trickle of Blood 5. Increased Pulse, Decreased Blood Pressure *Traditional signs of hypovolemic shock are not evident until 15% to 20% of total blood volume lost						P&P# CC12.001.08 pg 556-559 module 14
B. Interventions 1. Massage Fundus 2. Check VS q15” 3. IV Fluids 4. Administer oxytocins as ordered 5. I & O 6. Trendelenburg 7. Provide emotional support and explanations for pt. And family						
XXVI. Precipitous Vaginal Delivery A. Assessment 1. Vaginal exam to determine dilatation or crowning 2. Monitor FHR 3. VS						Module 14
B. Intervention 1. Do not leave patient 2. Call for help 3. Have someone call Doctor and open emergency tray. Call Emergency Room Doctor if Delivery Imminent 4. Deliver Baby if necessary – no one available						

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XXVII. Pregnant Woman with Diabetes A. Assessment: 1. Type: Pre-gestation, gestational, with or without insulin control 2. Evaluation of Bg's, signs of hyper/hypoglycemia 3. Evaluation of risk factors: sign of pre-eclampsia; polyhydramnios; bacterial infections B. Management: 1. NST' s begin weekly @ 32 wks – earlier if poor glycemic control. Twice wkly @ 36 wks (per MD order) 2. Labor: maintain glucose @ 80-120 3. Monitor Bg's every 2hrs (per MD order) 4. Continuous fetal monitoring						Module 13
XXVIII. Stillbirth A. Care of Mother 1. Grieving Packet 2. Perinatal Loss Checklist 4. Death Certificate - Attachment A						P&P CC12.008.02
B. Care of Baby 1. Footprints, Bands, Crib Card 2. Weight 6. First Photo Pictures 7. Special Gowns 8. Release of Body Form 9. Call Steve Chesler for photos if appropriate 8. Digital photos						Policy & Procedure for Care of Grieving Family
XXIX. Specific Procedures 1. Leopold maneuvers 2. Vaginal exams 3. Testing for ruptured membranes 4. Use of IUPC 5. Use of scalp lead						1. Intrapart management modules pg 113 2. pg 57, 90-96

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**** References:** **1. Awhonn Perinatal Nursing- 2nd edition, Lippincott, simpson/Creehan 2001** **2. Intrapartum Management Module- A Perinatal Education Program, Lippincott, Martin 2003**						