

LABOR Stage I—Transition Phase (Deceleration)

The transition phase is typically the most intense of the three phases of stage I labor. It is also the shortest phase, lasting an average of 2–3 hr in nulliparas and 1 hr in multiparas. The cervix dilates 8–10 cm as the fetus descends approximately 1 cm/hr in nulliparas and 2 cm/hr in multiparas.

CLIENT ASSESSMENT DATA BASE

Circulation

BP elevated 5–10 mm Hg above client's normal level
Pulse elevated

Ego Integrity

Irritable behavior, difficulty communicating/answering queries
May have difficulty maintaining control, requiring reminders about breathing/comfort techniques
May state, "I can't stand it anymore," or may desire to "leave the hospital and come back later"
May be amnesic

Elimination

Urge to void or defecate throughout phase (may indicate fetus in posterior position)

Food/Fluid

Nausea or vomiting may occur
Belching/hiccuping

Pain/Discomfort

Strong uterine contractions occurring every 2–3 min and lasting 60+ sec (unmedicated state).
Intense level of discomfort in abdominal/sacral area.
May become very restless, thrash with pain, or be fearful.
May report being "too hot"; tingling sensation of fingertips, toes, and face.
Leg tremors may occur.

Safety

Diaphoretic
FHTs heard just above symphysis pubis.
FHR may display variable decelerations (cord compression), late decelerations (uteroplacental insufficiency), or early decelerations (head compression).

Sexuality

Cervix dilates 8–10 cm.
Fetus descends 12–14 cm.
Copious amounts of bloody show.

NURSING PRIORITIES

1. Promote fetal and maternal well-being.
2. Provide physical and emotional support.

NURSING DIAGNOSIS:**May Be Related To:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION****CRITERIA—CLIENT WILL:****Pain [acute]**

Mechanical pressure of presenting part; tissue dilation/stretching and hypoxia; stimulation of parasympathetic and sympathetic nerves; emotional and muscular tension

Verbalizations, distraction behavior (e.g., restlessness), facial mask of pain, narrowed focus, autonomic responses

Verbalize perceived or actual reduction of pain.

Use appropriate techniques to enhance comfort and maintain control of labor process.

Rest between contractions.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Assess degree of discomfort through verbal and nonverbal cues. Assess personal and cultural implications of pain.

Assess client's need for physical touch during contractions.

Monitor frequency, duration, and intensity of uterine contractions.

Inform client of onset of contractions, as appropriate.

Assist client and partner with changing to more rapid breathing; (i.e., pant-blow).

Provide for a quiet environment that is adequately ventilated, dimly lit, and free of unnecessary personnel. Carry out nursing procedures between contractions whenever possible.

Assist client with comfort measures, including sacral/back rubs, positioning, mouth care, perineal care, change of pads/linens, hot/cold compresses, sponge baths to face and neck, or bath/whirlpool.

Monitor cervical dilation. Note perineal bulging or vaginal show.

Encourage client to void.

Attitudes toward pain and reactions to pain are individual and based on past experiences, cultural background, and self-concept.

Touch may serve as a distraction, provide supportive reassurance, and encouragement, and may aid in maintaining control/reducing pain. Note: Desire for touch may change from one contraction to the next.

Detects progress and screens for abnormal uterine response.

Client may "sleep" and/or encounter partial amnesia between contractions. This can be a problem for some clients, impairing her ability to recognize contractions as they begin and thus have a negative impact on her sense of control. For others, the brief rest may "energize" them for the next contraction.

Redirects and focuses attention; helps reduce perception of pain within the cerebral cortex.

Nondistracting environment provides optimal opportunity for rest and relaxation between contractions.

Such measures promote hygiene, relaxation, and physical comfort. Note: Individual needs/preference can change quickly during transition; i.e., client may request sacral rub, then the next moment demand everyone move away from her.

Discomfort levels increase as cervix dilates, fetus descends, and small blood vessels rupture.

May enhance labor progress and reduce risk of trauma to bladder.

Offer encouragement, provide information about labor progress, and provide positive reinforcement for client's/couple's efforts.

Provide break for partner as appropriate.

Evaluate client for tingling of lips, face, hands, or feet. If present, have client breathe into cupped hands or paper bag.

Monitor maternal vital signs and FHR variability after drug administration. Note drug's effectiveness and the physiological response.

Collaborative

Administer analgesic as ordered. Assist anesthesiologist if epidural or caudal anesthetic is to be used.

Provides emotional support, which can reduce fear, lower anxiety levels, and help minimize pain.

Support person may be reluctant to leave, but does need a break for renewal of energy and relaxation, which can enhance ability to help partner.

Discomfort caused by respiratory alkalosis can be relieved by increasing carbon dioxide levels through the rebreathing process.

Narcotics can have a depressant effect on the fetus, particularly when administered 2–3 hr before delivery. Therefore, use may be limited/restricted, or naloxone hydrochloride (Narcan) may be administered to reverse adverse drug effects.

Judicious use of a pharmacologic agent assists the client in coping with contractions and may facilitate labor.

NURSING DIAGNOSIS:

Risk Factors May Include:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Cardiac Output, risk for decreased

Decreased venous return, hypovolemia, changes in systemic vascular resistance

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Maintain vital signs appropriate for stage of labor, free of pathological edema and excessive albuminuria.

Display FHR within normal limits.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess BP and pulse between contractions, as indicated. Note abnormal readings.

During contractions, blood pressure usually increases 5–10 mm Hg, except during transition phase, when the blood pressure remains elevated. Increased resistance to cardiac output can occur if intrapartal hypertension develops, further elevating blood pressure. Finally, cardiac output/blood pressure may be negatively affected by uterine pressure on the inferior vena cava, reducing venous return, or by a decrease in circulating blood volume caused by dehydration or occasionally hemorrhage.

Note presence and extent of edema. Monitor FHR during and between contractions.

Accurately record parenteral/oral intake, and output. Measure specific gravity if kidney function is decreased.

Test urine for albumin. Report levels above 12.

Monitor BP and pulse per protocol or continually if hypotension is severe after administration of analgesia.

Note any hypertensive responses to oxytocin administration. (Refer to CPs: Labor: Induced/Augmented; Intrapartal Hypertension.)

Excess fluid retention places the client at risk for circulatory changes, with possible uteroplacental insufficiency manifested as late decelerations.

Bedrest promotes increases in cardiac and urine output with a corresponding decrease in urine specific gravity. An elevation of specific gravity and/or reduction in urine output suggests dehydration or possibly developing hypertension.

Indicates glomerular spasms, which reduce the reabsorption of albumin. Levels greater than 12 indicate kidney involvement; levels 11 or lower may be due to muscle catabolism occurring with activity (contraction) or to increased metabolism in the intrapartal period.

Analgesics relax smooth muscles within the blood vessels, reducing resistance to cardiac output and lowering BP and pulse.

Oxytocin increases cardiac circulating volume (sodium/water absorption) and cardiac output, and may also increase BP and pulse.

NURSING DIAGNOSIS:**Risk Factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:**

Fluid Volume, risk for deficit/excess

Excess fluid loss/hemorrhage, reduced intake, excess fluid retention, rapid parenteral fluid administration

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Maintain vital signs and urine output/concentration WNL.

Be free of thirst.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Monitor BP and pulse every 15 min and more frequently during oxytocin infusion.

Assess client's anxiety level.

Take temperature every 4 hr, as indicated (every 2 hr after membranes rupture). Assess skin and mouth for dryness.

Increased BP and pulse may indicate fluid retention; decreased BP and increased pulse may be late signs of fluid volume loss or dehydration.

Anxiety may alter BP and pulse, affecting assessment findings.

Dehydration can result in elevated body temperature, dry skin, and reduced production of saliva.

Record intake and output. Note concentration of urine. Measure urine specific gravity, as indicated.

Measure amount and character of emesis.

Remove excess clothing, keep environment cool, and wipe client's face/body with cool washcloth.

Assess amount and location of edema, Hct level, changes in behavior, and reflex irritability. (Refer to CP: Intrapartal Hypertension.)

Assess amount of vaginal bloody show; observe for excess blood loss.

Position client on side, as appropriate.

Collaborative

Administer and monitor IV fluid infusion, as indicated.

Bedrest results in decreased adrenal cortex activity, increased glomerular filtration rate, and increased urine output. When fluid volume is decreased, aldosterone acts to reabsorb water and sodium from the kidney tubules, reducing urine output.

Nausea and vomiting contribute to fluid losses. With reduced gastric motility, food may remain in the stomach for up to 12 hr after ingestion and pose a risk for aspiration.

Limits diaphoreses; provides comfort.

Intrapartal hypertension can develop, causing fluid shifts from the intravascular spaces and increasing Hct levels. Cerebral edema/vasospasms/hypoxia can cause increased reflex irritability and/or behavior changes.

Bloody show increases as the presenting part moves down in the birth canal; excess bleeding may indicate placental separation.

Increases venous return by taking pressure of the gravid uterus off the inferior vena cava and descending aorta.

Maintains hydration by replacing fluid losses. Rate may be adjusted to meet individual needs, but too rapid administration can lead to fluid overload, especially in a compromised client.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

**DESIRED OUTCOMES/EVALUATION
CRITERIA—CLIENT/COUPLE WILL:**

Fatigue

Discomfort/pain, overwhelming psychological emotional demands, increased energy requirements, changes in energy production, decreased caloric intake (restricted/nothing by mouth [NPO] status)

Verbalizations, impaired ability to concentrate, emotional lability or irritability, lethargy, altered coping ability

Use techniques to conserve energy between contractions.

Report sense of control.

Appear moderately relaxed.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess degree of fatigue.

Provide dimly lit, nondistracting environment.

Keep client informed of progress of labor.
Provide encouragement for efforts client makes.

Provide comfort measures. (Refer to ND: Pain [acute].)

Plan care to limit interruptions.

Encourage client to close eyes, extend legs, and relax between contractions.

Monitor urine for ketones.

Monitor energy level of partner. Assume supportive responsibilities as needed.

Collaborative

Administer an analgesic as ordered.

Provide calorie-rich fluids, e.g., fruit juices, broths.

Fatigue may interfere with the client's physical and psychological abilities to maximally participate in labor process and to master and carry out self-care and infant care after delivery.

Reducing stressors helps promote rest.

Provides reinforcement for desired behaviors.
Realizing that labor is progressing toward goal may help client maintain maximal effort.

Promotes relaxation, enhances sense of control, and may strengthen coping.

Maximizes opportunities for rest.

A comfortable position facilitates muscle relaxation.

Urinary ketones indicate metabolic acidosis resulting from a deficiency in glucose metabolism, which may reduce uterine activity and cause myometrial fatigue, which can prolong labor.

Allows partner to have a brief break and refresh self, enhancing ability to maintain focus and support client.

May help the client cope with contractions and facilitate relaxation between contractions. Use with caution, because analgesics may cause fetal depression.

Calories are necessary to maintain energy level to help with work of labor.

NURSING DIAGNOSIS:**Risk Factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION****CRITERIA—CLIENT/COUPLE WILL:**

Coping, Individual/Couple, risk for ineffective

Sense of "work overload," personal vulnerability, inadequate/exhausted support system

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Identify effective coping behaviors.

Engage in activities to maintain/enhance control.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Reinforce information that labor is progressing; encourage client to cope with one contraction at a time.

Inform client/partner of initiation of each contraction.

Ensure that client, under direction of partner, initiates breathing patterns. Breathe with client if necessary.

Acknowledge reality of both client's and partner's irritable feelings.

Encourage client and partner to verbalize doubts about ability to continue and fear of being left alone (even if this fear is unfounded).

Provide support to partner.

(Refer to CP: Labor Stage I—Active Phase; NDs: Coping, Individual/Couple, risk for ineffective; Infection, risk for maternal; Gas Exchange, risk for impaired fetal.)

Provides reassurance that baby will soon be born. A natural response in the transition phase is for the client to feel that she has had enough and wants to “quit and go home.”

Allows client to rest/relax and still maintain control of breathing pattern as contraction begins.

A more complex breathing pattern initiated at the beginning of a contraction is necessary as a distraction and helps reduce pain perception within the cerebral cortex. Client may have difficulty understanding directions because of inward focus.

The increase in intensity and frequency of contractions and the premature urge to push may add to sense of loss of control. The client's hostility may be manifested as anger at the nurse or support person(s). In addition, general fatigue of both client and partner further impair their ability to cope.

When these thoughts are expressed, they can be acknowledged and the client/partner can realize that they are coping to the best of their ability in the situation and can move forward with support.

May feel helpless and require more support as the partner becomes less able to relieve client's pain.