

Precipitous Labor/Delivery or Unplanned/Out-of-Hospital Delivery

Rapid progression of labor, lasting less than 3 hr from onset to delivery, and out-of-hospital delivery are emergency situations that place the client/fetus at increased risk for complications and/or untoward outcomes. The attending nurse may have primary responsibility for the safety of the mother and fetus.

CLIENT ASSESSMENT DATA BASE

Ego Integrity

Irritability

Food/Fluid

Nausea/vomiting

Pain/Discomfort

May have an unusually high pain threshold or not be aware of abdominal contractions
Possible absence of palpable contractions, as occurs with maternal obesity
Low back discomfort (may not be recognized as a sign of progressing labor)
Intense/prolonged uterine contractions; inadequate uterine relaxation between contractions
Involuntary urge to bear down

Safety

Accelerated cervical dilation and fetal descent
Preterm or small-for-gestational age infant (increases potential for rapid labor/delivery)
Rectal/perineal bulging
Increased vaginal show

Sexuality

History of short or rapid labor
Young maternal age; large pelvis
Multiparity or previous vaginal surgery (decreases soft-tissue resistance)

NURSING PRIORITIES

1. Promote maternal and fetal/newborn well-being.
2. Provide a physiologically and psychologically safe experience for client and newborn.
3. Prevent complications.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

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

Anxiety [specify level]

Situational crisis, threat to self/fetus, interpersonal transmission

Increased tension; scared, fearful, restless/jittery; sympathetic stimulation

Use breathing and relaxation techniques effectively.

Cooperate with necessary preparations for a rapid delivery.

Follow directions and/or actively participate in delivery process.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Maintain calm, deliberate manner. Offer clear, concise instructions and explanations.

An emergency or extremely rapid delivery occurring out of the hospital or in a hospital setting without the presence of a clinician (physician or nurse midwife) can be extremely anxiety-provoking for the client/couple, who had anticipated an orderly progression through labor and delivery. When the actual birth event is not in keeping with their expectations, reactions may include hostility, fear, and disappointment. Composure of nurse reassures client and prevents transmission of undue concern and anxiety.

Provide a quiet environment and privacy within parameters of the situation. Position client for optimal comfort.

Reduces distractions/discomfort, allowing client to focus attention. May reduce "contagious" anxiety of onlookers in out-of-hospital delivery and support modesty.

Encourage partner/support person to remain with client, provide support, and assist as needed.

Allowing full participation by a support person enhances self-esteem, furthers cohesion of family unit, reduces anxiety, and provides assistance for the professional.

Remain with client. Provide ongoing information regarding labor progress and anticipated delivery.

Reduces anxiety, fosters positive coping and cooperation, and reduces fear associated with the unknown.

Support appropriate coping/relaxation techniques.

Enhances sense of control; optimizes participation in the birth process.

Arrange for services of medical/nursing staff as soon as possible. Inform client that help has been requested.

The arrival of assistance helps the client/couple to feel less anxious and more secure.

Conduct delivery in a calm manner; provide ongoing explanations.

Helps client/couple remain calm and cooperate with instructions.

Place newborn on maternal abdomen once newborn respirations are established. Allow partner to hold infant.

Helps promote bonding and establishes a positive feeling about the experience.

Collaborative

Administer sedation as appropriate.

May help slow labor progress and allow client to regain control.

NURSING DIAGNOSIS:

Skin/Tissue Integrity, risk for impaired maternal

Risk Factors May Include:

Rapid progress of labor, lack of necessary equipment

Possibly Evidenced By:

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

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

Be free of lacerations/tears.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess level of preparedness and knowledge.
Provide information as necessary regarding the labor process and breathing/relaxation techniques.

Information helps nurse to manage the situation effectively, promotes client cooperation with necessary emergency measures, and reduces risk of injury.

Perform Leopold’s maneuvers to determine fetal position. If abnormal presentation or position is detected, arrange for immediate transfer, as appropriate.

If presentation and position are other than vertex/occiput anterior, complications could arise, so that transportation to hospital or delivery setting is imperative.

Perform vaginal examination, as appropriate and situation permits.

Determines cervical effacement, dilatation, fetal station, and imminence of delivery.

Stay with client continuously. Send for help in hospital setting, or enlist the aid of the most competent bystander or significant other in out-of-hospital setting.

Constant monitoring ensures nurse will be present should delivery occur.

Discontinue oxytocin, if being administered.

Reduces uterine stimulation; may enhance uterine relaxation between contractions.

Observe client for rectal distension, fecal discharge, or increased vaginal flow.

These signs indicate labor progress as descending; presenting part compresses sigmoid and rectum.

Encourage client to pant, rather than push, when crowning occurs.

Decreases urge to push and helps reduce likelihood/degree of lacerations and perineal trauma.

Gently massage perineum (“ironing”) with index finger on inside of vagina and thumb on outer portion.

Aids in stretching perineal tissue, reducing risk of tearing.

Apply gentle pressure against fetal head; support perineum with other hand. Facilitate delivery of the shoulders with gentle upward traction.

Helps prevent fetal head from delivering too rapidly, which can contribute to lacerations of the birth canal.

NURSING DIAGNOSIS:

Fluid Volume risk for deficit

Risk Factors May Include:

Presence of nausea/vomiting, lack of intake, excessive vascular loss

Possibly Evidenced By:

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

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

Maintain adequate level of hydration, as evidenced by palpable pulses, prompt capillary refill, moist mucous membranes.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Note characteristics of labor pattern and uterine tone. Monitor uterine activity manually or electronically. Assess for any abnormal vaginal bleeding or uterine rigidity.

Place newborn on client's abdomen following delivery, once respiratory pattern is well established.

Observe for signs of placental separation; avoid exerting force on umbilical cord. Save placenta for inspection by physician or nurse midwife. If out-of-hospital setting, wrap up placenta to be sent with client on transfer to hospital.

Monitor degree of uterine contractility and the color and amount of vaginal flow. Massage fundus gently; place infant to breast.

Inspect perineum for lacerations. If they are present, press clean perineal pad against perineum. Instruct client to keep thighs together.

Arrange for transportation to acute-care setting in out-of-hospital birth.

Record time/method of placental expulsion, appearance of intactness of placenta, client's condition, and any medications administered.

Abruptio placentae can be a complication of emergency childbirth.

Weight of newborn stimulates uterine contractions and aids in placental separation.

A complete inspection of the placenta can be carried out later to ensure that no tissue remains in utero.

Stimulates uterine contractility, reducing vaginal flow, and helps to prevent hemorrhage caused by uterine atony. Potential for abruptio placentae exists in the presence of rapid, severe uterine contractions without a sufficient period of relaxation between them.

Pressure limits bleeding until help is available to make needed repairs.

Examination of client by physician or nurse midwife is necessary to rule out retained placental tissue, and possibly to repair perineal or vaginal lacerations.

Accurate record aids in identification of potential for complications.

NURSING DIAGNOSIS:

Infection, risk for

Risk Factors May Include:

Broken skin/traumatized tissue, increased environmental exposure, rupture of amniotic membranes

Possibly Evidenced By:

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

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Be free of infection.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Provide as much privacy as possible in cases of unplanned out-of-hospital delivery. Prepare clean delivery surface using clean towels, clothes turned inside out, or unread newspapers placed under the client's buttocks.

Reduces possibility of contamination.

Scrub hands, don sterile gloves, place sterile towels under buttocks, and clean perineum with soap/water solution if time permits in hospital setting.

Reduces likelihood of postdelivery infection.

Remove undergarments/newspapers when soiled.

Removes media that would support growth of pathogens.

Record time of rupture of membranes. Note amount, color, and odor of drainage, and whether there is particulate present.

Rupture of membranes increases risk of ascending infection. Characteristics of drainage may indicate presence of infection.

NURSING DIAGNOSIS:

Pain [acute]

May Be Related To:

Occurrence of rapid, strong muscle contractions; psychological issues

Possibly Evidenced By:

Verbalizations of inability to use learned pain-management techniques, sympathetic stimulation, distraction behaviors (moaning, restlessness)

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Relax between contractions.

Report discomfort/pain is reduced.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Note character and location of pain. Evaluate strength and intensity of contractions and duration of relaxation period.

Contractions may be of unexpected severity. Excess myometrial hypoxia may result from a tumultuous labor, intensifying discomfort.

Initiate breathing and relaxation techniques. Have partner/support person provide effleurage and sacral back rub. Encourage client to assume position of comfort, preferably left lateral or semiupright.

In accordance with gate control theory, cutaneous stimulation and counter-pressure helps reduce discomfort. Positioning can increase circulation to myometrium.

Remove excess or constrictive clothing. Provide cool/comfortable environment, if possible. Change underpad/linens, as needed.

Promotes relaxation and comfort; enhances sense of well-being. Reduces discomfort.

Use physical restraint cautiously, using verbal commands, or have significant other(s) hold gently, if necessary.

Monitor bladder distension; encourage voiding.

Provides safety in an “uncontrolled” setting.

Urine retention and consequent bladder distension may increase discomfort, impede labor, and result in bladder trauma.

NURSING DIAGNOSIS:**Risk Factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION CRITERIA—NEWBORN WILL:****Injury, risk for fetal**

Rapid descent/pressure changes, compromised circulation, environmental exposure

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

Display Apgar score of 7 or better at 1 min and at 5 min.

Be free of injury.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Assess fundal height and uterine size. If possible, obtain information from client interview or chart regarding prior testing to determine or confirm gestational age. Ascertain expected birth date.

Monitor FHR electronically or with fetoscope in hospital setting. In any setting, assess fetal activity level.

Remain with client. In hospital setting, send for emergency delivery kit. Have staff person notify attending physician or nurse midwife of imminent delivery.

Place client in left or right lateral position. hypotensive syndrome.

Encourage client to pant rather than push as crowning occurs.

Assess for nuchal cord. If present, loop cord over newborn’s head before delivery of body. In hospital setting, if cord is too tight, place two clamps on cord and cut cord before delivery of body. In out-of-hospital setting, clean shoelaces or cloth strips can be used.

Rupture membranes if they are intact following delivery of head; suction (if available) mouth, throat, and then nasal passages.

Helps predict size and potential needs of infant at birth.

Provides data regarding condition of fetus.

Kit contains equipment necessary for management of newborn in precipitate labor and delivery.

Helps promote adequate placental perfusion; prevents supine

Helps prevent dural or subdural tears during rapid descent and delivery.

Nuchal/short cord may cause hypoxia/anoxia to newborn during delivery process.

Prevents aspiration of amniotic fluid. Removes secretions and facilitates initial respiration efforts.

Support newborn during delivery of body. difficult to grasp.

Hold newborn at the level of, or slightly lower than, the uterus.

Suction or clear oropharynx again. Place infant on client's abdomen, with infant's head slightly lower than body if respirations adequate.

Dry newborn immediately (especially head); wrap infant in blanket, coat, or unused plastic food wrap; and give to client to hold next to her own body or place at client's breast. Without unwrapping infant, reassess temperature by feeling infant's stomach with back of fingers.

Determine infant's condition at birth, noting Apgar score at 1 min and at 5 min. Keep accurate record of time of delivery, position of fetus at birth, presence of nuchal cord, sex, and condition of newborn (including Apgar scores), any medications given to mother/newborn, and resuscitative measures used.

Prepare for transfer to hospital setting. Placenta can be left attached to newborn during the transfer (wrapped in newspaper or towel).

(Refer to CP: The First Hour of Life.)

Vernix and amniotic fluid covering the body may make newborn

While controversial, it is believed to facilitate blood flow through the umbilical cord, thereby providing an additional amount of blood to the newborn. Note: Holding the newborn above the uterus causes blood to flow from the cord by force of gravity.

Helps clear airway; facilitates drainage of mucus.

Reduces likelihood of cold stress. Mother's body warmth helps warm the newborn. Early feedings, help prevent hypoglycemia.

Provides information that is needed by medical personnel for later evaluation of the newborn.

Client and newborn need to be evaluated by medical personnel.