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## Obstetrics Guidelines

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### **SUBJECT: CARE OF THE LOW RISK WOMAN IN LABOR**

**Overview:** A low risk patient is one who has exhibited no significant medical or pregnancy problems during prenatal care.

#### **I. Routine admission care**

Admission to UIH requires performance of a history and physical examination, no sooner than 30 days before or 24 hours after admission.

##### A. History includes:

1. Presenting complaint: including contractions, status of membranes, show, fetal activity, and general condition.
2. Current pregnancy history
3. Past obstetrical history
4. Medical-surgical history, including gynecologic history.
5. Allergy history
6. Current medications
7. Psychosocial history: use of drugs, alcohol, tobacco; living conditions, stress, social support, psychological illness history, sexual history
8. Significant family history.

##### B. Complete physical exam documentation includes:

1. Vital signs
2. Document height and weight, if not in medical record.
3. Heart and lung assessment
4. Fundal height
5. Fetal presentation and/or position (by Leopold's maneuvers)
6. Estimated Fetal Weight (EFW)
7. Pelvic exam (to include visualization of cervix for lesions if history of herpes)
  - a. Determine dilatation, station, effacement, consistency and position of cervix and status of membranes.
  - b. Defer digital exam if membranes ruptured and not in labor (may confirm vertex presentation by ultrasound)

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9. Extremities (edema, reflexes, etc.)
10. Other findings as indicated by history
11. Assessment of monitor tracing: fetal heart rate characteristics and uterine contraction pattern

### C. Routine orders:

1. Admit
2. Nutrition/Fluid Balance: Oral and/or parenteral  
Indications for intravenous access include but are not limited to:
  - a. Epidural anesthesia
  - b. Risk of postpartum hemorrhage (e.g. Large fetus, hydramnios, history of postpartum hemorrhage, parity > 4)
  - c. Administration of intrapartum oxytocin/antibiotics
  - d. Trial of labor
  - e. Abnormal fetal heart rate (FHR) tracings
  - f. Large ketones on urine dipstick
3. Maternal Assessment:
  - a. Vital signs q 4 hours (TPR, B/P)  
Temp every 2 hours after rupture of membranes
  - b. Uterine contractions should be evaluated for frequency, intensity, and duration at the same time as the fetal heart rate.
4. Fetal Assessment:
  - a. Activity/Ambulation
  - b. Bedrest on side, positioning as tolerated/indicated. If confinement to bed becomes necessary, frequent position changes, excluding the supine, increase maternal comfort and decrease the length of labor.
  - c. Bathroom privileges: contraindicated if membranes are ruptured and vertex is unengaged
  - d. Shower: contraindicated if ruptured and unengaged vertex
  - e. Tub: contraindicated with ROM and unengaged head.
5. Diagnostics
  - Hemoglobin/CBC
  - RPR: if no third trimester RPR done
  - HIV-rapid screen: if no prenatal HIV result available

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-Type and Rh only for patients who:

- \*are unregistered
- \*are undergoing a trial of labor
- \*have a positive antibody screen

6. Pain management: hydrotherapy, analgesia, anesthesia options.

7. Nurse-midwifery admissions: the CNM will notify the medical service of the admission, and any significant issues.

### II. Ongoing management in first stage of labor

- A. Provider will document maternal and fetal status on admission, and with significant change in maternal or fetal status.
- B. Vaginal examinations
- C. Amniotomy: AROM should be performed with indications. These include:
  - Inability to adequately monitor fetus or labor externally
  - Abnormal fetal heart rate
  - Avoidance of delivering fetus *en caul*
  - Protraction/arrest disorders
- D. Amnioinfusion
- E. Pharmacologic and non-pharmacologic pain relief: assess for need and patient desire

### III. Second Stage Management

- A. Notify Neonatology if indication exists for Neonatology's presence at delivery.
- B. Monitor fetal heart rate and uterine activity per guidelines.
- C. If accomplishing fetal descent and fetal status is stable, may continue to push beyond 2 hours (multipara) or 3 hours (primipara). Document progress in medical record.
- D. Episiotomy, as indicated.

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### IV. Third Stage Management

**Expectant versus active management** — The optimal approach to management of the third stage of labor is controversial. The two approaches are:

1. Expectant management — Expectant or physiologic management refers to spontaneous delivery of the placenta without the use of uterotonic agents or cord traction.
2. Active management — Active management generally consists of early cord clamping, controlled cord traction, and administration of a uterotonic agent.

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- A. If placenta remains undelivered after 30 minutes and patient is stable, notify the attending physician prior to manual removal.
- B. If placenta is undelivered and patient develops significant bleeding, notify attending physician immediately.
- C. After placental delivery determine need to send placenta for evaluation.
  1. Check fundus for contractions to decrease bleeding, give uterine massage as needed.
  2. Check placenta for completeness of cotyledons and membranes, and for any abnormalities.
  3. Document “placenta intact” and number of cord vessels
- D. Inspect vagina, perineum and cervix for lacerations and/or hematoma.
- E. Control of bleeding:
  - a. Fundal massage
  - b. Repair of episiotomy, lacerations
  - c. Postpartum hemorrhage – observation, prevention, management

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Oxytocics

The administration of oxytocin is standard postpartum management to decrease uterine bleeding. Early breast feeding enhances uterine contractions.

Med/Onset	Dose/Route	Effect	Side Effect	Contraindications
Oxytocin Rapid onset	20-40 U/L IV 10-20 U IM	Rapid muscle contraction	Uterine hyperstimulation Water intoxication	IV push may cause hypertension
Methylergonovine (Methergine) 40 sec IV 7 min IM	0.2 mg. IV or IM	Sustained Uterine contraction	Transient,severe hypertension Nausea Vomiting Headaches	Extreme caution with hypertension
Carboprost tromethamine ( Hemabate) IM 15-60 min	0.25 mg IM or intramyometrial every 15-60 min as necessary Max dose 2 mg	Inhibits adenylyl cyclase with strong uterotonic response	Severe hypertension GI upset Headaches Fever	Asthma Hypertension, Hypersensitivity
Prostin E2	20 mg PR q 2 hours	Contraction of smooth muscle	Nausea/vomiting Fever Diarrhea	Diastolic BP may decrease by 20 mmHg
Misoprostol Rectal 3-5min	400-1000mcg rectal X1	Prostaglandin E1 analog Uterotonic	Nausea/vomiting Diarrhea Abd. Pain Chills Fever	Only if others not available or failed

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**Obstetrics Guidelines**

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[signatures on file]

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