Scenario Assignment

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Amani has arrived at the birth center in strong labor. Her contractions are two minutes apart and lasting 70 seconds long. How do you conduct a labor exam? Shortly after you examine her, her bag of waters ruptures and she begins spontaneously pushing.

The first thing I would do is get a quick summary of how labor has progressed and how the last 24 hours or so have gone for Amani. The questions I would ask her would be; when she started experiencing contractions and what the pattern has been up until this point (how long they are lasting and how far apart they have been), what and when she ate and drank over the last 24 hours, how much rest versus activity she has been doing, and what she has been doing to work with the contractions. I would discuss with her how much she has felt baby move, and when she had her last bowel movement/urination.

I would then conduct a labor (admission) exam. The first thing I would do is palpitate the abdomen to assess babies positioning, and then do a fetal heart rate assessment for at least a full minute, assessing through a contraction and a little bit after it subsides. I would also get the babies baseline heart rate. In an uncomplicated labor we would not see the fetal heart rate to be between 110 bpm- 160 bpm, with no late decelerations. I would then do an assessment of blood pressure, pulse, temperature, respirations and make a visual check for edema. The next thing to do would be to discuss with Amani if she would like a pelvic exam to check for dilation, effacement, and baby's station. I would explain to her that everything was moving along great (If there were no indications otherwise) and that it was not mandatory. I would explain the benefits of an exam would be to make sure baby is in an optimal position for labor and birth, and to check her cervix progression. If baby was not in an optimal position or she had a cervical lip, the information would give us some information on utilizing positions to help labor progress by

helping baby get into a better position. I would also explain the downside to doing an exam, which would be that exams can be uncomfortable, especially in labor, and that the information can be discouraging if dilation, effacement, or station are not as far along as she hopes.

If she opted for a vaginal exam, I would prepare a space on the bed by getting some sterile gloves and lube ready. When she was in between contractions I would have her lay on the bed with her hands in a fist placed under her hips. I would open the sterile gloves and carefully squeeze some lube onto the sterile portion of the paper the gloves were in. I would put the gloves on using sterile technique and wipe some lube onto my finger for the exam. I would ask her to let me know when she was ready, and then have her place her heels together and let her knees fall to the side. I would tell her that she was going to feel my touch on her tissues, and then pressure as I exam her. I would let her know that she can tell me to stop at any time and I would immediately stop. Once she was ready, I would do the exam, checking for dilation, effacement, and babies' station as well as how soft the cervix is. I would feel babies head sutures (if possible) to see if I can decipher babies' position. Once I was done with the exam, I would report the findings to her, and we would come up with a plan moving forward for laboring positions.

Once her water breaks, and she spontaneously started pushing I would help her get into a comfortable position for birth. I would make sure she had some water to sip on in between contractions as well. I would instruct my assist to prepare the space for birth, getting all supplies ready. In this scenario, I am going to assume that baby was not asynclitic and there was no cervical lip- so I would encourage Amani to listen to her body and push when she feels the urge. Our birth team would continue to encourage Amani and her partner and have her take sips of water between contractions. If pushing did not seem to be effective in the position she was in, we would encourage her to change positions, incorporating a trip to the toilet to void as well. Once

birth was imminent, I would put on sterile gloves (or elbow length gloves for a water birth) to prepare to catch baby. In a normal, uncomplicated birth, the baby would be caught by partner, Amani or midwife and go straight to Amani. We would assess babies heart rate and respirations as well as get a visualization of appearance, grimace, and activity at 1 minute and 5 minutes for the APGAR score. We would then deliver the placenta and cut the cord once it stopped pulsing. The placenta would then be examined for any retained pieces and 2 vessels/1 vein. The next step would be to get Amani into the bed, get her a snack and some hydration and support her in getting baby latched. We would do a check of Amani's blood pressure and pulse, and if everything was normal, we would leave the family alone to bond and cuddle baby, checking on them every once and while for at least the next hour to assess blood loss, afterpains (does she need or want herbs, a heating pad or allopathic remedy like Ibuprofen), and baby well-being. We would do a laceration check as well and assess if sutures or transfer (3rd degree or worse laceration) was needed, and have Amani void in order to have an empty bladder for uterine involution.

References

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