

Be sure the perinatal nursing care you deliver  
meets today's top practice standards!



# PERINATAL NURSING

EDITION

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The fully updated Third Edition of this respected resource draws upon the expertise of AWHONN nurses to guide you through today's most advanced practice standards and evidence-based care guidelines.

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## 8 CHAPTER 1 ■ Perinatal Patient Safety and Professional Liability Issues

medication-dispensing cabinet (including wasted excess dosages) (JCAHO, 2006).

- Acknowledge and support the responsibility of registered nurses to practice within the guidelines of their professional association. Expect that anesthesia providers will acknowledge this right and duty as well.

### Fundal Pressure During the Second Stage of Labor

#### Common Allegations

- Application of fundal pressure during second stage of labor that resulted in shoulder dystocia and/or other maternal-fetal injuries
- Application of fundal pressure during shoulder dystocia that further affected the shoulder and delayed the birth, resulting in maternal-fetal injuries

(See also Shoulder Dystocia.)

#### Standards, Guidelines, and Recommendations

- Fundal pressure applied during the second stage of labor is associated with risks of adverse outcomes to the mother and the baby (Simpson & Knox, 2001).
- Risks to the baby include inadvertent shoulder dystocia, which in turn places the baby at risk for brachial plexus injuries; fractures of the humerus and clavicles; hypoxemia, asphyxia, and death; an increase in fetal intracranial pressure, resulting in significant decreases in cerebral blood flow and nonreassuring FHR patterns; umbilical cord compression negatively affecting maternal-fetal exchange; functional alterations in the placental intervillous space, which increases the risk of fetal hypoxemia and asphyxia; subgaleal hemorrhage, and spinal cord injuries (ACOG, 2002; Amiel-Tison, Sureau, & Shneider, 1988; Gherman, Ouzounian, & Goodwin, 1998; Hankins, 1998).
- Risks to the mother include perineal injuries such as third- and fourth-degree lacerations, anal sphincter tears, uterine rupture and uterine inversion, pain, hypotension, respiratory distress, abdominal bruising, fractured ribs, and liver rupture (Cosner, 1996; Kline-Kaye & Miller Slade, 1990; Lee, Baggish, & Lashgari, 1978; Rommal, 1996).
- Avoid fundal pressure to shorten an otherwise normal second stage of labor (Simpson & Knox, 2001).
- Avoid fundal pressure during shoulder dystocia (ACOG, 2002b).

- Avoid clinical disagreements about fundal pressures at the bedside in front of the patient by having an agreed-upon policy.

### Shoulder Dystocia

#### Common Allegations

- Failure to accurately predict risk of shoulder dystocia
- Failure to diagnose labor abnormalities
- Failure to appropriately initiate shoulder dystocia corrective maneuvers
- Failure to perform a cesarean birth
- Application of forceps or vacuum at high station or continued application without evidence of descent resulting in shoulder dystocia
- Application of fundal pressure during shoulder dystocia further affecting the shoulder and delaying birth, thereby resulting in maternal-fetal injuries

(See also Fundal Pressure During the Second Stage of Labor.)

#### Standards, Guidelines, and Recommendations

- Most cases of shoulder dystocia cannot be predicted or prevented (ACOG, 2002b).
- There is no evidence that any one maneuver is superior in releasing an impacted shoulder; however, the McRoberts maneuver and suprapubic pressure are easily implemented without an associated increase in risk of injury to the baby.
- Excess traction and fundal pressure should be avoided because of increased risk of injury to the baby (ACOG, 2002b).

#### Suggestions for Medical Record Documentation (Simpson, 1999)

- Provide emergent nursing care to woman and newborn as a first priority.
- Provide a narrative note that summarizes a series of interventions and clinical events that have taken place, with a focus on a logical, step-by-step approach to relieving the affected shoulder and resuscitating the newborn.
- Avoid documenting a minute-by-minute account of the emergency unless it is absolutely certain that the times included are accurate.
- Attempt to closely approximate the time interval between delivery of fetal head and body.
- Review the EFM strip and talk with other providers in attendance to ensure the most accurate details of clinical circumstances are accurately recorded.

[ACOG, 1999, 2003, 2005; Simpson, 2002]) is essential in each institution, because clinical management strategies, policies, and protocols should include expected actions when hyperstimulation is identified.

- All perinatal healthcare providers in each institution should be aware of clinical criteria established for hyperstimulation and the expected actions.
- While hyperstimulation of uterine activity can be the result of endogenous maternal oxytocin and prostaglandins, most hyperstimulation is the result of administration of exogenous pharmacologic agents (Crane, Young, Butt, Bennett, & Hutchens, 2001).
- Treat hyperstimulation by decreasing or discontinuing oxytocin based on the individual clinical situation.
- Hyperstimulation and hyperstimulation accompanied by a nonreassuring FHR pattern are more common during cervical ripening and labor induction when compared with spontaneous labor (Crane et al., 2001).
- Be aware that some practitioners reserve the term "hyperstimulation" for excessive contractions that result in a nonreassuring FHR pattern. Contractions that are excessive without a corresponding nonreassuring FHR are often called "tachysystole" in an unsuccessful attempt to avoid the recognized liability inherent in using the term hyperstimulation. Whatever the term, however, the physiologic implications are similar. From the perspective of maternal-fetal safety, the best approach is to avoid prolonged periods of hyperstimulation (whether designated as such or not) that lead to progressive deterioration in fetal status and subsequent nonreassuring FHR patterns (ACOG & AAP, 2003). Interventions for hyperstimulation should not be delayed until there is evidence of nonreassuring fetal status (Simpson, 2002).
- Empower and encourage all members of the perinatal team to be appropriately assertive in their actions and communications with colleagues to advocate for patient safety if they feel pressured to increase oxytocin rates during uterine hyperstimulation and/or nonreassuring FHR patterns (Simpson et al., 2006).

## Pain Relief During Labor and Birth

### Common Allegations

- Failure to accurately identify and treat labor pain
- Use of "ability to pay" or insurance status as criteria for treatment of labor pain

### Standards, Guidelines, and Recommendations

- Provide adequate pain relief for all women in labor as per their request regardless of ability to pay or whether they sought prenatal care (ACOG, 2006a; JCAHO, 2006).
- Labor results in severe pain for many women. There is no other circumstance under which it is considered acceptable for a person to experience untreated severe pain, amenable to safe intervention, while under a physician's care. In the absence of a medical contraindication, maternal request is a sufficient medical indication for pain relief during labor and birth (ACOG, 2006a).
- The choice of technique, agent, and dosage should be based on patient preference, medical status, and contraindications. Decisions should be closely coordinated among the obstetrician, the anesthesia provider, the patient, and skilled support personnel (ACOG, 2006a).
- There are conflicting data about the effect of epidural analgesia/anesthesia on the risk of cesarean birth; however, based on what is known at present, if the patient desires an epidural during the early stages of labor, there is no reason to deny that request if the denial is related to potential risk of cesarean birth (ACOG, 2006a).

### Nurses' Role During Regional Anesthesia

#### Common Allegations

- Administration of bolus or change in medication rate of epidural anesthesia that resulted in subsequent maternal and/or fetal harm
- Nurses' actions beyond the scope of practice as defined by their professional association (AWHONN, 2001)

### Standards, Guidelines, and Recommendations

- Adhere to the AWHONN clinical position statement that describes the role of the nurse during epidural anesthesia. Require that only qualified, credentialed anesthesia providers adjust the dosage for labor epidurals, including boluses, and increases or decreases in rate. Require that only qualified, credentialed anesthesia providers program the epidural pumps during regional anesthesia for labor (AWHONN, 2001).
- Require that the provider who will be administering the narcotics and regional blocking agents sign-out these medications personally from the