LABOR AND DELIVERY NURSING:

A Guide to Evidence-Based Practice

MICHELLE L. MURRAY,
PhD, RNC-OB

and

GAYLE M. HUELSMANN,
BSN, RNC-OB, C-EFM

New York

About the Authors

Michelle L. Murray, PhD, RNC-OB, is an international educator, author, and expert in obstetric nursing. She has taught nursing students and nurses in the United States, Canada, and Bahrain. Dr. Murray has spent the majority of her career as a labor and delivery nurse and as an obstetric nursing educator. She was appointed by the provost at the University of New Mexico as a clinical associate professor.

Dr. Murray's company, Learning Resources International, Inc. produces clinical and educational products and seminars for labor and delivery nurses and midwives. Since 1986, more than 50,000 obstetric care providers, including nurses, physicians, and midwives, have participated in Dr. Murray's classes and seminars. Her work has been published in journals such as *Birth: Issues in Perinatal Care*; *The American Journal of Maternal Child Nursing (MCN)*; the *Journal of Perinatology*; the *Journal of Nursing Care Quality*; and the *Journal of Obstetric, Gynecologic, and Neonatal Nursing (JOGNN)*. Dr. Murray was also a contributor to the Association of Women's Health, Obstetric, and Neonatal Nursing (AWHONN) publication, *Nursing Management of the Second Stage of Labor*. Her best-selling books include *Antepartal and Intrapartal Fetal Monitoring* (3rd ed.) and *Essentials of Fetal Monitoring* (3rd ed.). Her books and products are available at www.fetalmonitoring.com.

Dr. Murray has been an active member and officer of the Association of Women's Health, Obstetric, and Neonatal Nursing as well as the American Nurses Association's New Mexico Nurses Association. She is an award winner in education from AWHONN (formerly the Nurses Association of the American College of Obstetricians and Gynecologists), and from the nursing honor society, Sigma Theta Tau.

Gayle M. Huelsmann, BSN, RNC-OB, C-EFM, is certified in inpatient obstetrics and holds a certificate of added qualification in electronic fetal monitoring from the National Certification Corporation in Chicago, Illinois. She has been an antepartal nurse and a labor and delivery staff nurse for 28 years. In addition, she is a maternal air transport nurse with fixed wing and rotor wing aircraft. She is also an education resource nurse at Presbyterian Hospital in Albuquerque, New Mexico. Ms. Huelsmann is the co-author of *Essentials of Fetal Monitoring* (3rd ed.) and the monograph on *Uterine Hyperstimulation: Physiologic and Pharmacologic Causes with Results from a Survey of 1000 Nurses* with Dr. Michelle Murray. Ms. Huelsmann is an award winner of the PRIDE nurse award from Presbyterian Hospital. She was nominated by her peers for her exemplary contribution to patient care.

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DISCLAIMER

This book is not intended to replace your hospital's policies, procedures, guidelines, or protocols. It is not intended to dictate a standard of care. We recommend that the reader always consult current research and specific institutional policies before performing any clinical procedure. This book is intended for use during the process of orientation of nurses in the labor and delivery setting, and to bring experienced nurses up to date with regard to current practice and research findings. It can also be used as a reference or as a study guide by nurses preparing to take a certification examination in the field of inpatient obstetrics or labor and delivery.

This book does not include directions for equipment use or specific tests. These must be learned in the hospital setting, preferably with a mastery-based skills checklist. In addition, care should be individualized to the patient.

True/false questions appear at the end of each chapter as a complement to the learning process. Each chapter contains the information necessary to answer the questions.

The content of this book was based on the best available research at the time it was written. Some studies may appear dated and may have been the only study on the subject that was readily available at the time of this publication. Every attempt was made to provide current information that is evidence-based.

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Susan Mocsny Baker, RNC
Staff Nurse
University of Massachusetts Memorial Medical Center
Worcester, Massachusetts

Darcie Beckwith, RNC, MSN
Clinical Practice Specialist
The Birthing Inn
Inova Loudoun Hospital
Leesburg, Virginia

Lynne Brengman, RN, BSN, MBA
Education Department
PeaceHealth – St. Joseph Hospital
Bellingham, Washington

Cindy Curtis, RNC, IBCLC, CCE
Staff Nurse and Director of the Lactation Center
Culpeper Regional Hospital
Family Birth Center
Culpeper, Virginia

Garla DeWall, RNC
Staff Nurse, Family Birthing Center
Presbyterian Hospital
Albuquerque, New Mexico

Becky Dunham, RNC
Staff Nurse, Labor and Delivery
Dublin Methodist Hospital
Dublin, Ohio

Donna McAfee Frye, RN, MN
Clinical Director
Women's and Children's Clinical Services
Nashville, Tennessee

Aurora Gumamit, RN, MSN, CNS
Charge Nurse, Labor and Delivery
Corona Regional Medical Center
Corona, California

Julie Holden, RN, BSN, MA
Nurse Manager
Beverly Hospital
Beverly, Massachusetts

Theresa Hyland, RNC
Yale New Haven Hospital
New Haven, Connecticut

Wanda Jeavons, RNC, MSN, PNNP
Perinatal Outreach Coordinator
Andrews Women's Hospital
Baylor All Saints Medical Center
Fort Worth, Texas

Suzanne Ketchem, MSN, RNC, CNS
Director of Women's and Children's Services
Medical Center of Aurora
Aurora, Colorado

Reta M. King, BSN, RNC
Staff Nurse, Labor and Delivery
University of New Mexico Medical Center
Albuquerque, New Mexico

Nanci Koperski, RNC, LNCC, MBA, MHSA
Legal Nurse Consultant
Omaha, Nebraska

Debra Mills, RN, BSN, MSN, CNS
Clinical Nurse Specialist, Family Birth Center
Methodist Hospital
Sacramento, California

Angela Murphy, RNC
Charge Nurse, Family Birthing Center
Presbyterian Hospital
Albuquerque, New Mexico

Nancy Powell, RNC, MSN, CNM
Clinical Educator
Shore Memorial Hospital
Somers Point, New Jersey

Michelle Rupard, MSN, RNC, FNP, LNCC
Assistant Professor, College of Nursing
The University of North Carolina at Pembroke
Laurinburg, North Carolina

Wendy Sinanan, RN
Staff Nurse, Labor and Delivery
Mt. Sinai Hospital
Toronto, Ontario, Canada

Ann Weed, RNC, MSN, CNS
Clinical Nurse Specialist
Mary Washington Hospital
Fredericksburg, Virginia

Diana Wigham, RNC, MSN
Staff Nurse, Labor and Delivery
Saint Francis Medical Center
Hartford, Connecticut

Preface

The interests of the patient are the only interests to be considered.

— William Mayo

The family is constant, but service systems and personnel within those systems fluctuate (Petersen, Cohen, & Parsons, 2004). Nurses are part of the service system that provides family-centered care. To be an effective care provider, nurses must develop confidence and competence. They need an open mind, an accepting attitude, hands-on skills, and a broad and deep understanding of the research related to pregnancy, labor, and birth. Ideally, they should work in a hospital that uses the latest research findings in patient care. That is rare, however (Scott-Findlay, 2007). The best care will be evidence-based. Therefore, the goal of this book is to provide you with the information to develop an evidence-based practice of labor and delivery nursing. Labor and delivery nursing requires critical thinking, constant caring, listening to your inner voice, anticipation of the needs of many, teamwork, communication, and collaboration (see Exhibit P.1).

Proper surveillance and care of the fetus and mother during labor and delivery depends on comprehensive data acquisition, attention to detail, adequate knowledge to properly understand and interpret the meaning of data, verbal and nonverbal cues, and teamwork. This book was created with these elements in mind. Figure P.1 illustrates the nursing process from admission to delivery. If possible, review the patient's prenatal record before she arrives.

Exhibit P.1: Some characteristics of a critical thinker.

1. States the question or concern clearly
2. Creates order in complex situations
3. Diligently seeks relevant information
4. Focuses on the concern at hand
5. Persists until results are obtained in spite of difficulties
6. Is inquisitive, well-informed, open-minded, and flexible
7. Acknowledges personal biases
8. Makes prudent judgments
9. Is willing to reconsider
10. Is clear regarding the issues

Labor and delivery nurses provide patient-centered care that is "high tech" and "high touch" in settings such as a family birthing center. "High-touch" care can be thought of as "labor support," empathy, and use of touch. Labor support may play a part in shortening a woman's labor, decreasing her use of analgesia and anesthesia, labor augmentation, possibly decreasing the need for an operative vaginal delivery or a cesarean delivery, and increasing satisfaction with the birthing experience. Labor and delivery nursing or intrapartal nursing is part of the culture of obstetrics and this culture has its own myths, taboos, artifacts, and traditions.

Labor and delivery nurses are masters of anticipation, supporters of natural childbirth, and monitors of safety practices, because they are the first line of defense in preventing injury. They must understand maternal and fetal physiology, know the purpose and physiologic impact of their actions, and be able to evaluate their patients' responses to those actions. In addition, effective intrapartal nurses are fearless when advocating for their patients.

Modern obstetrics requires both high-touch and high-tech skills. Nurses need the knowledge and skills to properly use different types of machines and equipment. For example, the high-tech aspect of labor and delivery includes tests to confirm the rupture of membranes; the use of the electronic fetal monitor and its components (such as a spiral electrode); insertion of an intravenous catheter and administration of intravenous fluids, blood, or blood products; use of suction and oxygen equipment; and procedures such as amnioinfusion. This book is not intended to be a procedure or equipment manual, nor was it designed to replace hands-on bedside training. Instead, it is our hope that the information gained from reading this book will help labor and delivery nurses make wise decisions in their choices of interventions, in the creation of patient-centered plans of care, and in their communications with other members of the obstetrics team.

For those beginning their career as a labor and delivery nurse, Ray Spooner RN, BSN, an experienced labor and delivery nurse, has suggested, "Be yourself. Especially, do not feign

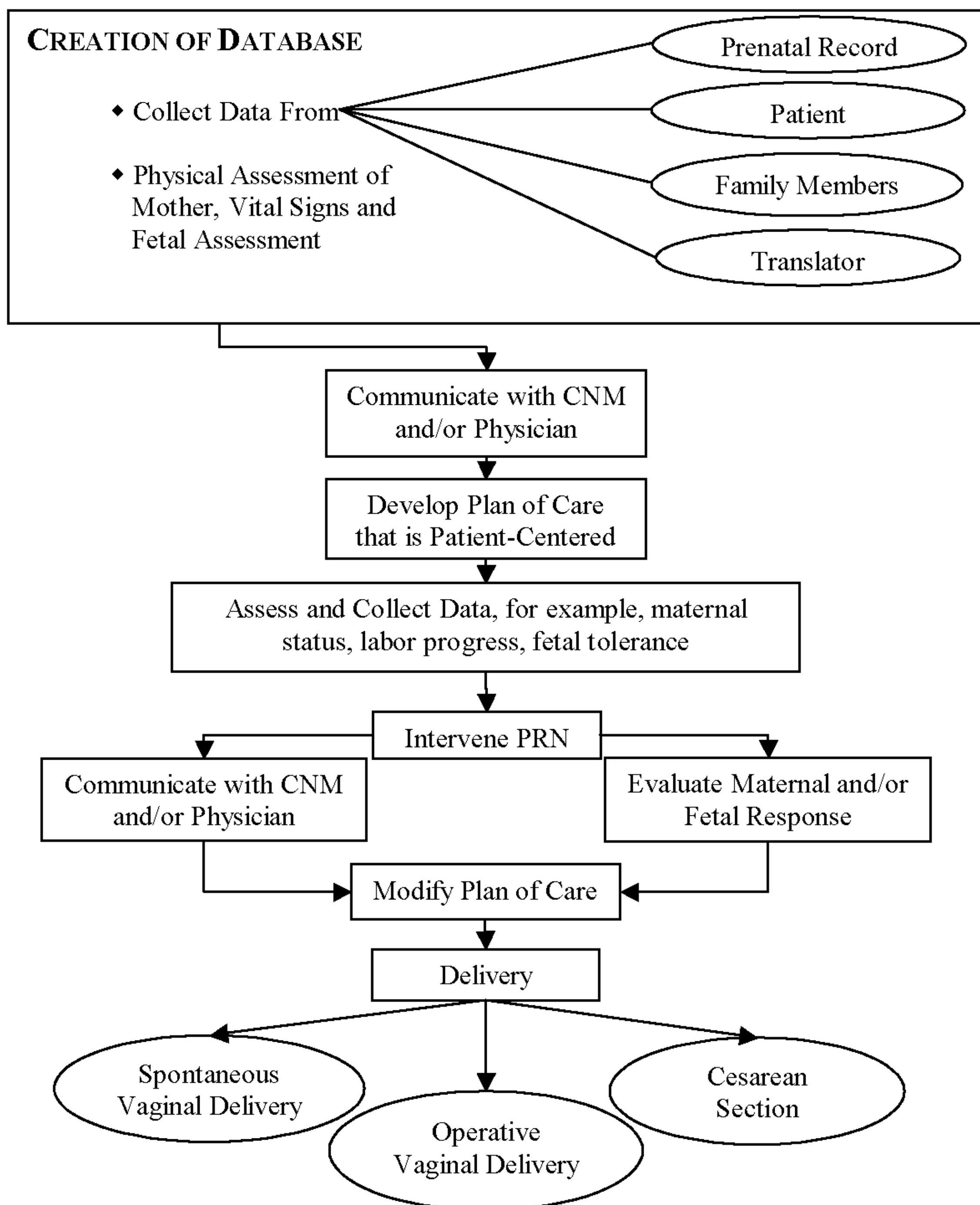

Figure P.1: The nursing process from admission until delivery. Documentation should reflect each step of this process.

knowledge. It is better to ask a stupid question than to make a stupid mistake" (Spooner, 1995).

In addition to this book, we hope nurses becoming oriented to the practice of labor and delivery nursing will read the philosophy, policies, procedures, and protocols of their facility. We encourage new nurses to ask for guidance, information, and demonstrations of procedures when they need help. We also encourage open communication with patients and other health care providers. Often the patients are the only ones who have the answers to your questions.

Benjamin Franklin once said, "The best investment is in the tools of one's own trade." Intrapartal nurses need to own equipment that aids them in their patient care (see Exhibit P.2). It is helpful to have a fetoscope in your locker, especially for those times when a patient refuses the fetal monitor or there is a power failure. As your career develops, you may find other tools that enhance your ability to meet your patient's needs.

Exhibit P.2: Some "tools" of the labor and delivery nurse.

1. Stethoscope
2. Reflex hammer
3. 2 hemostats
4. Bandage scissors
5. Pen light
6. Gestational wheel
7. Measuring tape

Our combined nursing experience totals more than 50 years. The majority of our clinical time has been spent in labor and delivery settings. We hope that our experience and education as intrapartal nurses and educators will be transmitted to you in this book and that it will provide you with the information you need to make informed decisions and provide evidence-based care.

Michelle L. Murray, PhD, RNC-OB
Gayle M. Huelsmann, BSN, RNC-OB, C-EFM

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1

Communication, Advocacy, and the Chain of Command

Words create our world. We want to create constructive discussions.

—Anna von Dielingen

ORGANIZATIONAL CULTURE

Health care organizations have a culture that includes norms, attitudes, values, assumptions, customs, and behaviors (Chervenak & McCullough, 2005; Lefton, 2007; Seren & Baykal, 2007). A healthy organization has a culture that is committed to honest business practices and is focused on the needs of patients, community, and society (Chervenak & McCollough, 2005). Great leaders create an environment that enables the best solutions and the best decisions (Henrikson, 2007). In a healthy organization, communication should occur among the patient, her partner, her friends and visitors, and all members of the health care team (Simkin & Ancheta, 2005).

Health care organizations may also be collaborative or competitive. In a collaborative organization, there is teamwork and team management to reach a desired goal. In a competitive organization, achievement, a sense of superiority, excellence, and possessing technology that is better than other organizations will be the goals. If the organization has a power culture, authority will be the center of attention, and tasks will be assigned by a manager.

Cynical organizations have leaders who are not supportive and who create a hostile work environment. Communication in that type of organization can be difficult or even intimidating. An unresponsive culture will have leaders with a dictatorial, top-down, threatening, and punishing style of behavior. This type of leadership creates communication barriers. A submissive culture will be unresponsive, will have minimal expectations and communication, and will provide minimal feedback. A submissive, but responsive, culture will have people who always agree with you, who talk a lot but do not listen, who gloss over performance issues, who only provide positive feedback, and who seek harmony (Lefton, 2007). It is important that you determine the type of organization and culture within which you work.

THE CARE MODEL IN LABOR AND DELIVERY

Within the dominant health care organization culture there are subcultures. For example, the culture in postpartum care may be different from the culture in the nursery or in labor and delivery. The norms, attitudes, values, assumptions, customs, and behaviors within the subculture of labor and delivery affect the quality and quantity of communicaton (Tucker et al., 2006). Communication is also influenced by the design of the care model. The four types of intrapartal services include the nurse-managed labor model, the academic/teaching model, the nurse-to-attending physician communication-on-site model, and the nurse-to-nurse midwife communication-on-site model (Simpson, 2005). For example, if you are the primary patient care provider and the midwife or physician

is not in the building, you work within a nurse-managed labor model. In that case you are responsible for recognizing problems, evaluating labor progress, providing hands-on care, and informing other team members when they are needed.

In the nurse-to-nurse midwife or physician communication-on-site model, it should be easy to communicate with the provider. However, even if the provider is in the hospital, he or she may be distracted by the needs of other patients. Since the labor nurse, midwife, and physician are part of one collaborative team, be sure to keep them up to date so that they do not miss an opportunity to make clinical decisions that promote patient safety. If you need them to come to the bedside, ask them to do so.

Documentation example: Spontaneous rupture of membranes, fluid clear, nonfoul, saturated 1/3 of linen protector. Variable decelerations noted. Certified Nurse Midwife (CNM) called on postpartum unit and informed of spontaneous rupture of membranes, clear fluid, variable decelerations. Requested CNM come to bedside immediately to evaluate patient. CNM stated she was on her way.

Perhaps you work with residents in an academic/teaching model setting. In this setting, the residents will assess the cervix and fetal station and insert internal monitors such as the spiral electrode or intrauterine pressure catheter. Nurse-to-resident communication may be hindered by the resident's need to control the decision-making process. However, that does not mean you should withhold your findings or concerns. If you feel the plan of care needs to change, you must speak up.

Communication clinical example: You observe late decelerations and no accelerations, and the resident orders you to administer oxytocin. You change your patient's position to her right side, place a tight-fitting face mask with oxygen at 10 liters/minute on her face, adjust the ultrasound transducer and tocotransducer, and note the continuation of late decelerations. You also note her blood pressure is normal. You say, "I'd like to wait at least 15 minutes to see if the baby's heart rate improves." The resident dons a sterile glove, rubs the fetal scalp, evokes an acceleration, and insists you administer the oxytocin immediately. You then say, "There have been no spontaneous accelerations for the last hour, variability is absent or minimal, and the late decelerations continue to persist in spite of the intrauterine resuscitation actions." You then call your team leader or charge nurse to the room using the patient call light. At that point, if the resident continues to insist on the administration of oxytocin, the charge nurse and the resident should leave the room to continue the discussion about the plan of care.

PROVIDER ROLES AND EXPECTATIONS

In order to know whom to call or with whom to share information, you need to know the roles and responsibilities of the other health care providers. Your hospital should have policies and procedures that define the maternal/child services for family practitioners, residents, obstetricians, and the anesthesia providers. For example, family practitioners may be credentialed to evaluate the condition of the mother and infant, order medications, deliver the infant when there is a cephalic presentation (or by using low forceps or a vacuum extractor), and resuscitate the infant. They may be credentialed to repair the episiotomy, but must consult with the obstetrician for certain conditions. An obstetrical consult may be required for some procedures. An obstetrician may need to be consulted for abnormal bleeding, a retained placenta, preeclampsia, prolonged labor, multiple gestation, induction of labor, polyhydramnios, before any obstetrical operation or breech delivery, for medical or surgical complications, for preterm labor and tocolysis, or for a trial of labor after a cesarean section.

Obstetricians perform duties similar to family physicians, but they also usually have privileges for midforceps and cesarean sections. Anesthesia providers evaluate the condition of the mother prior to the administration of an anesthetic agent, place and remove indwelling epidural catheters, inject medication into the epidural catheter, initiate continuous infusions administered through the epidural catheter, and remain immediately available during the induction of epidural anesthesia. They rarely know how to interpret the fetal heart rate pattern or uterine activity pattern, and you should not expect them to do so. Therefore, it is your responsibility to be sure the maternal and fetal conditions are stable prior to the administration of an anesthetic. If the mother or fetus is unstable, speak to the obstetric care provider prior to the administration of analgesia or anesthesia.

Physicians and/or certified nurse midwives may create the initial plan of care with informed consent of the patient. The nurse is responsible for coordinating care, suggesting changes in the plan of care, and knowing who else is on the team taking care of the patient. An error can be committed if the wrong plan is followed or there is a failure to complete a planned action (Institute of Medicine, 1999). Therefore, you must know the plan of care and communicate with other health care team members often during your shift to accomplish that plan of care or to change the plan of care. As the patient's condition changes, the plan of care must also change.

CHARACTERISTICS OF COMMUNICATORS

Within the subculture of labor and delivery are the people with whom you may need to communicate. They may be difficult to communicate with if they are know-it-alls, passives, dictators, "yes" people, "no" people, or gripers (see Exhibit 1.1).

NURSE–PATIENT COMMUNICATION

Patients may also take the role of know-it-all, passive, dictator, griper, or someone who always agrees with you or quickly disagrees with you. On the other hand, they may be open,

Exhibit 1.1: Types of communicators.

Personality Type	Characteristics and Suggestions for Communication
Know-it-alls	Arrogant, usually have a strong opinion on every issue. When they're wrong, they get defensive. Validate their ideas. Tell them you see their point of view (if you can), then ask for their help in solving a problem.
Passives	Never offer ideas and never let you know where they stand. For example, they may perform a vaginal examination and then walk out of the room and not tell you their findings. Follow them out of the room. Establish eye contact. Ask them to tell you their findings.
Dictators	Bully and intimidate. They're constantly demanding and brutally critical. Don't try to be their friend. Just be specific in what you would like them to do and ask them if they can help you. If they refuse, ask your charge nurse or nursing supervisor to intervene or help you.
"Yes" People	Agree to cover your patient while you are on lunch break and then never see your patient. When you return from your break and see they have not charted their observations, ask them to do so. If they do not comply, notify your charge nurse or supervisor of their failure to see your patient. Document in the record the time you expected them to see your patient and their name.
"No" People	Quickly point out why something won't work and are inflexible. Avoid these people unless you have to interact with them. Keep your communications brief and clear.
Gripers	All they do is complain. See above.

honest, and genuinely interested in what you have to say. An assessment of their interaction with other family members will help you recognize their communication style and characteristics. Communication with patients, family members, and other health care providers is essential to help you prevent adverse events (JCAHO, 2000, 2004). Communication also creates relationships. Therefore, you will need to find a way to relate to your patient and her family and friends to maximize the effectiveness of your communications. By developing your emotional intelligence, you should be able to recognize your feelings and the feelings of others, and then regulate your personal feelings and expressions in response to clinical situations (Stichler, 2006).

Your first nurse–patient interaction is critical in establishing a trusting relationship with your patient and her family and friends. Introduce yourself by stating your name and licensure, and state that you will be her nurse for the next specified number of hours. When your patient speaks to you, face her, listen closely, and paraphrase what you hear. Make eye contact when it is culturally accepted, do not interrupt her, and do not multitask. It is extremely rude to look at a chart or a computer screen instead of your patient.

> **Communication example**: "Hi, Ms. Jones. I'm Michelle and I'll be your nurse today. I'm here for the next 12 hours. I understand from Gayle, your night nurse, that you are 4-cm dilated, that your plan is to have intravenous medication later in the labor, and that your husband wants to cut the cord after the birth. Is that correct? Good. It looks like you are contracting every 3 minutes and they feel strong to me. Your baby looks good. I see there are accelerations in the heart rate. Is there anything you need right now?"

Create an environment that is conducive to open communication and low stress to enhance a feeling of trust. You can enhance the environment by limiting the number of visitors, and other noise and distractions (Stichler, 2007a). Sit at eye level with your patient when you communicate. Pick your words wisely, as words might upset patients and families. For example, "failure to progress" or "noncompliant cervix" are demeaning and disparaging (Katz, 2005).

You should use open-ended questions to assess your patient's knowledge of the labor and delivery process. For example, you might say, "What questions do you have about what is going to happen today?" Some patients believe they have no questions because they have been watching birthing programs on television. They will tell you they know everything they need to know about their "epidermal." In spite of their misconceptions, it is important for you to discover their knowledge deficits and provide information during teachable moments. For example, prior to rupture of the membranes, you might want to mention that the sac around the baby has no nerves. One patient was terrified because she heard the nurse say, "The doctor will be rupturing your brains." Another patient reported she had condominiums "down there." She really had condylomata (warts). Try not to laugh. Discover the source of your patient's anxiety and fear. Perhaps her sister, cousin, or mother had a traumatic birth experience and she fears the same thing will happen to her. You will need to reassure her that you are there for her support and safety and will be in frequently during her labor. Use humor sparingly and appropriately. Listen carefully to her complaints and concerns because you may be the first person she tells or the first person who recognizes there is a problem.

To facilitate open communication, acknowledge the partner and/or labor coach and any family members present in the room. Ask them their names and recognize their supporting roles. Be sure the primary coach and the father of the baby eat and rest if there is a long labor ahead. The father-to-be may wish to play an active role during the labor process or no role at all. Assess their needs and desires as well as your patient's needs and desires. Satisfaction with the support of their partner results in less patient stress, less depression, and less anxiety for as long as three months after delivery (McVeigh, 1997).

Support family-centered care, if that is desired, by keeping the baby in the birthing room after delivery. Support skin-to-skin contact between the mother and her baby. If she chooses to breastfeed, you should support breastfeeding within the first hour of the baby's life (Phillips, 2003). Communicate with the patient to learn her expectations for labor and birth.

If there is a written birth plan, read it and acknowledge its contents. Sometimes desires or plans are more like wishes which you may not be able to fulfill. You will need courage to do the right thing for your patient's safety and health, even when it seems undesired or unpopular or goes against her birth plan or wishes.

Clinical example: A nulliparous woman in labor was four feet six inches tall. At about 5-centimeters dilation, her membranes spontaneously ruptured. There was dark green, particulate meconium in the amniotic fluid. Variable decelerations appeared on the tracing. The midwife found there was a face presentation. The physician was called into the room and decided that a cesarean section was necessary. When the patient was informed, she was sad because she had planned for a vaginal delivery. The nurse said, "I'm sorry but the baby didn't read the plan." The patient said, "Neither did my sister's baby." The nurse asked for clarification. The patient told her that her sister was also petite like her and had a baby with a face presentation. In this case, there was a good outcome for both the mother and her baby.

Nurses who communicate to discover and respond to patient needs prevent injuries (Kendig, 2006). To protect patients and prevent injury, communication should be purposeful and goal oriented. For example, there may be people in the room who are watching television and talking among themselves yet the nurse perceives the laboring woman needs a quiet room because she is preeclamptic, hyperreflexive, and hypertensive. In this case, the nurse would explain the patient's needs and ask the visitors to leave or limit their conversation. The hospital's visitor policy should provide the framework for information shared with the people in the room.

The American College of Obstetricians and Gynecologists (ACOG) believes that actively involving patients in their care will increase diagnostic accuracy, patient satisfaction, and adherence to therapy, thus resulting in improved health. They recommend that health care providers (a) speak slowly and use plain, nonmedical language; (b) limit the amount of information provided; (c) repeat information; (d) use teach-back or show-me techniques; (e) create an atmosphere in which patients can ask questions; and (f) provide written materials to reinforce oral explanations (ACOG, 2005). Naturally, if the patient does not speak English, a translator should be located. Record the name of the translator or translation service in the medical record.

ADVOCACY REQUIRES COMMUNICATION

Nurses, as well as other health care providers, are patient advocates who understand patient needs and expectations. Patient advocacy requires acceptance of other people as they are; support of their choices; the ability to help them explore their feelings, options, and possible consequences of their decisions; and the ability to speak and act on their behalf. To be an effective advocate, nurses must always err on the side of patient safety. Examples of nurse advocacy would be communication with the charge nurse when there are concerns about the current plan of care, discussing the possibility of a cesarean section with a physician, and calling the pediatrician to attend a delivery for which neonatal intubation is probable.

An effective advocate is vocal. An effective advocate does not remain silent when there is a risk of patient harm. For example, if there were two pop-offs of the vacuum extractor, the nurse may say, "Doctor, the operating room is ready. Would you like me to move the patient now?" Have confidence that your communication will make a difference in the care and outcomes for your patients. You may need to confront others when you are concerned, especially when decisions are made that are clearly wrong or when another health care provider is absent or incapacitated. For example, if the physician wishes to reapply the vacuum, thus exceeding the manufacturer's recommendations, you may say, "Doctor, please stop. The operating room is ready."

Advocacy requires empathy. There will be times when the patient or family members interfere with decisions that are in the best interest of the patient. For example, a husband may refuse to let his wife have a cesarean section because he is concerned it will mutilate her body. Empathy will be your secret weapon to defuse disruptive behavior. Try to understand these concerns and inform the physician. Disruptive behavior is personal conduct, whether verbal or physical, that affects or potentially may affect patient care negatively (Lazoritz & Carlson, 2008). You must be able to acknowledge the disrupter's point of view in such a way that you validate him or her, yet do the right thing for your patient.

Advocacy requires vigilance, and vigilance is the essence of caring. For example, if you note that the fetal heart rate pattern has evolved from a normal pattern to one with decelerations and a decrease in baseline variability with no accelerations, potentially hazardous acidemia can develop in as little as one hour (Parker & Ikeda, 2007). Your vigilance to note the

change over the last 60 minutes should trigger your actions to increase fetal oxygenation and notify the physician or midwife of the changes in the fetal heart rate pattern. If the fetus needs oxygen and you do not act, the pattern may change into one with deeper decelerations or even bradycardia. Therefore, do not think, "Oh that's just a little deceleration" or "I'm reassured because I still have some variability." You should be thinking, "Wow, the fetus needs oxygen. I need to act now."

Advocacy requires the ability to make decisions that are patient centered. Decisions about patient care should be based on your knowledge of your patient's risk factors, current assessments, changes in the maternal or fetal condition following interventions, and input from the patient and her family and friends. You must be able to face problems head on and not delay decisions until it is too late. Do you know the current plan of care? If not, ask the midwife or physician, for example, "What is the plan of care for Mrs. Iminlabor?" Once you know the plan, decide if you accept the plan. Is it in the best interest of your patient and her unborn baby? If there is no clear plan of care, or if you cannot accept it, discuss your concerns with the charge nurse and midwife or physician. The plan of care must be patient centered and must prevent harm. If you believe a decision is needed to deliver by cesarean section or to expedite delivery with forceps or a vacuum extractor (an operative vaginal delivery), share your belief with the charge nurse or your supervisor first. If you do not have a charge nurse or supervisor, speak directly with the physician or midwife. It is far better to be proactive and to help the midwife or physician make a patient-centered decision now than to wait for him or her to arrive at the bedside later and make a decision at the last moment when the fetus is decompensating.

> **Staff nurse to charge nurse communication example**: "I called you into the room because I have been seeing variable decelerations that are getting deeper and longer but the baby is still at 0 station with caput and molding. We have been pushing for 2 hours. She gained 50 pounds during this pregnancy and she is 5 feet tall. I'm concerned the baby is just not going to fit. Can you discuss the plan with the physician? He wants me to start an oxytocin infusion and I don't think that will help. I think she needs a cesarean section."

Advocacy requires support of a reasonable plan of care, anticipation of potential problems, and knowledge of what is normal and abnormal. You should know what the fetal heart rate was on admission. Is the current fetal heart rate baseline rising or falling? A rising baseline may be a fetal catecholamine (stress) response to hypoxia. Falling baselines are usually a fetal decompensation response. Both are abnormal. A generic nursing plan of care may include nursing diagnoses. Examples of nursing diagnoses are: anxiety; altered body temperature; ineffective breathing pattern; decreased cardiac output; ineffective coping; fatigue; fear; fluid volume deficit or excess; hyperstimulation; hyperthermia; high risk for infection; high risk for injury; knowledge deficit; impaired mobility; nonreassuring fetal heart rate pattern; altered nutrition; pain; post-trauma response; powerlessness; self-care deficit; impaired social interaction; urinary elimination, altered patterns; and, altered tissue integrity. Your hospital may have a list of nursing diagnoses. Nursing diagnoses have also been called the problem or potential problems (see Exhibit 1.2).

Advocacy requires a nurse to recognize, verbalize, and mobilize. In some cases, you have to mobilize the operating room crew to expedite delivery before fetal decompensation, neurologic injury, or death. However, this is a rare event. Examples of acute events where the fetus quickly decompensates, include a ruptured vasa previa when an amniotomy is performed, a uterine rupture, or an amniotic fluid embolism. In those cases, it will be crystal clear that delivery needs to be expedited. Good communication occurs when you inform the charge nurse of your actions. When cesarean sections are not performed on your labor and delivery unit, you will need to inform the operating room crew through your house supervisor that you need help to mobilize the operating room crew if the pattern continues or worsens. Ask the physician to come

Exhibit 1.2: Elements of a generic nursing plan of care.

1.	Problem:	Alteration in self-perception related to anxiety.
	Outcome:	Patient will understand procedures and processes and adapt without undue additional anxiety.
2.	Problem:	Alteration in comfort related to progress in labor and delivery.
	Outcome:	Patient will become comfortable.
3.	Problem:	Potential for infection related to rupture of membranes.
	Outcome:	Patient will be free of infection.
4.	Problem:	Alteration in maternal and/or fetal perfusion and oxygen delivery related to contractions and labor process.
	Outcome:	Patient will progress through labor and delivery without complications.
5.	Problem:	Alteration in self-perception related to expanded role.
	Outcome:	Patient will experience time to bond with her infant after delivery.
6.	Problem:	Potential for hemorrhage following delivery related to altered hemodynamics.
	Outcome:	Patient will recover without unusual blood loss.

to the bedside. If there is fetal tachycardia, especially with decelerations or minimal or absent variability and no accelerations, the fetus is in jeopardy. Initiate intrauterine resuscitation measures. Communicate to mobilize resources. If you have no charge nurse, ask another nurse to prepare the operating room and mobilize the crew while you call the physician to come to the bedside. Call the anesthesia provider and the neonatal team so that they are on their way to the hospital. You will need to be proactive and request the presence of the obstetrician at the bedside any time you see tachycardia, bradycardia, or decelerations that last more than 30 seconds, especially if they are becoming deeper and longer.

NURSE-TO-NURSE REPORT

When you receive the report, you must know if the amniotic fluid was clear and now has meconium in it. You must know the time of the last acceleration. It should have occurred within the last 90 minutes, even if narcotics were administered. You must know how to interpret the tracing, and over time you will become more comfortable with its physiologic meaning.

You are the conduit through which information flows to the midwife and/or physician. It has been said that the nurse is the "eyes and ears" of the midwife and physician. You are the one who keeps the charge nurse informed of changes. You have the power to make a difference. Therefore, it is your duty to advocate for the physician's presence at the bedside when the parents have requested it. You have a duty to update him or her at reasonable intervals so that they stay abreast of the maternal and fetal condition throughout the labor process. The change of shift report should be comprehensive (see Exhibit 1.3). By the end of the report you should know events that happened during the last shift, changes in the mother's or baby's status, and the interdisciplinary plan of care. You will need to decide if the current plan of care is safe and reasonable for your patient. If not, request a change in the plan of care after you report your findings and share your concerns.

> **Communication example requesting a change in the plan of care**: "Dr. Imallears, may I speak with you a moment about the current plan of care. I just learned in report that your patient, Jane Doe, now has a fever. Her temperature is 100.8 degrees. In addition, her pulse is 116 beats per minute. She's been dilated 5 centimeters for the last 3 hours. There's caput at 0 station. There are variable decelerations that are getting deeper. I just discontinued the Pitocin infusion that was at 30 mU/minute. Would you please come and evaluate her and let me know if you'd like to make any changes in the current plan of care.

If a medication is due at the time of change of shift, for example 7 p.m. or 1900, the departing nurse should administer that drug and inform the arriving nurse that the medication was given. It is also important to report the patient's intake and output, and her dietary restrictions.

Exhibit 1.3: Elements of a complete nurse-to-nurse report.

1. Patient's name and name of her partner or guardian, patient's age, gravida, parity, due date or weeks of gestation, number of fetuses, and reason for admission or diagnoses, height and current weight.
2. Provider's name, location, and telephone number.
3. Allergies, including allergy to latex, and Group B streptococcus status.
4. History of transfusion reactions or prenatal laboratory results that might affect care during labor or birth.
5. Current medications and past medications if they affect or potentially affect her current condition or care, for example, antidepressants after her last delivery.
6. Maternal habits, for example, alcohol, tobacco, or street drug use.
7. Prenatal/obstetric and medical history.
8. Last vital signs and any abnormal findings.
9. Physical assessment of abnormal findings.
10. Fetal normal baseline rate (based on past nonstress tests and/or the admission report).
11. Current fetal baseline rate and other features of the fetal heart rate pattern.
12. Current uterine activity.
13. Last cervical examination, fetal station, status of membranes, including color, amount, and odor of amniotic fluid.
14. A review of progress, for example, abnormally slow dilatation or arrest of descent.
15. Last dose of medications, including prostaglandins, oxytocin, antibiotics, narcotics, insulin, antihypertensives, etc.
16. Current pain level and ability to cope with the labor, and patient desires for pain management.

NURSE–PROVIDER COMMUNICATION

Physical or psychological needs that promote patient well-being should be communicated to midwives and physicians (Henrikson, 2006). Nurses should also communicate to clarify orders, discuss therapeutic plans, report changes in the patient's condition, share questions the patient or her family members have, and report abnormal or significant findings.

Strong nurse-physician relationships affect both nurse and patient satisfaction. If nurses and physicians have equal power

Exhibit 1.4: Certified nurse midwife management without a requirement for a physician consultation.

1. Gestational diabetes (diet controlled).
2. Fetus that is 36 or more weeks of gestation.
3. Internal and external fetal monitoring, including insertion of a fetal spiral electrode and intrauterine pressure catheter.
4. Meconium with reassuring fetal heart rate pattern.
5. Group B streptococcus prophylaxis according to protocol.
6. Urinary tract infection diagnosis and treatment.
7. Initiation of anesthesia request when a normal spontaneous vaginal delivery is expected.
8. Amnioinfusion.
9. Episiotomy.
10. First- and second-degree laceration repair.

Exhibit 1.5: Example of certified nurse midwife intrapartal management that may require a physician consultation (consult your hospital's requirements).

1. Multiparous woman (with more than 5 pregnancies).
2. Severe anemia (hemoglobin less than 9 mg/dL).
3. Estimated fetal weight greater than 4,500 grams.
4. Postterm pregnancy (gestation of 42 weeks or more).
5. Pregnancy less than 36 weeks gestation.
6. Induction of labor.
7. Oxytocin-induced augmentation of labor.
8. Maternal fever.
9. Preeclampsia.
10. Thick and/or particulate meconium-stained amniotic fluid.
11. Regional anesthesia in the presence of dystocia.
12. Arrest of labor.
13. Second stage greater than 2 hours (without an epidural) or greater than 3 hours (with an epidural).
14. Nonreassuring fetal heart rate pattern.
15. Suspected chorioamnionitis.

within their respective practice areas and they collaborate to provide patient care, staff nurses will continue to work at that hospital. In fact, increased communication between nurses and physicians reduces bad outcomes (McClure & Hinshaw, 2002). Communication and relating to others requires a sense of social competency (Stichler, 2007b). Social competence includes the ability to assess the emotions of others and relate to them in a manner that diffuses anger and conflict, provides encouragement, or inspires them. Social management is part of emotional intelligence or being intelligent in our relationships (Goleman, 2002).

If you work with certified nurse midwives, you should work to develop a positive relationship with them. It will help if you know that they probably are limited in what they can do without the consultation of the back-up obstetrician (see Exhibits 1.4, 1.5, and 1.6).

Nurses must notify the midwife or physician when an order should not be followed. The American Medical Association (AMA) supports communication between a nurse and a physician when the nurse finds an order to be in error or contrary to customary medical or nursing practice. The AMA has opined that "the physician has an ethical obligation to hear the nurse's concern and explain those orders to the nurse involved. The ethical physician should neither expect nor insist that nurses follow orders contrary to standards of good medical and nursing practice" (AMA, 1997).

If you encounter a clinical situation in which you believe a physician's opinion, attention, or care is needed, discuss this with the midwife. If the midwife refuses to communicate with her consulting physician and you still feel a physician's care is needed for your patient, share your concern with the midwife in the presence of the charge nurse or supervisor. The charge nurse or supervisor possess the authority and responsibility to act in the best interests of the patient. If the charge nurse also finds that a physician is needed, it is his or her responsibility to discuss the need for a physician evaluation with the midwife. After that conversation, if the midwife fails to call the physician to the bedside, the charge nurse or supervisor has the responsibility to make that call.

To improve your communication abilities, develop your emotional intelligence. Do not let others push your buttons. In the event you work with a "know-it-all" who hangs up on you after you make a reasonable request for your patient, do not chart "Provider hung up on me." Instead, notify your charge nurse of the situation and your patient's needs. Ask the charge nurse to make the next call. This action is invoking the chain of command or chain of communication. That is the right thing to do. Alternatively, if you do not have a charge nurse, ask another nurse to listen on another line (if possible) and call the "know-it-all" again. In the second call, let him or

Exhibit 1.6: Example of midwife and physician intrapartal collaborative management (consult your hospital's requirements).

1. Insulin-dependent diabetic or not well-controlled gestational diabetic without suspected fetal macrosomia.
2. Known intrauterine growth restriction (IUGR).
3. Nonreassuring fetal heart rate (FHR) patterns not resolving with in utero resuscitation. Interventions such as:
   A. position change
   B. correction of hypotension (e.g., administration of Ephedrine slow IV push)
   C. discontinuation of oxytocin
   D. hyperoxia (using a tight-fitting face mask at 10 liters/minute)
   E. stop pushing or push with every other contraction
   F. tocolysis (e.g., IV bolus or Brethine (terbutaline) 0.25 mg SQ or slow IV push)
4. Preeclampsia with "mild" laboratory abnormalities.
5. Excessive bleeding during labor.
6. Fetal malpresentation.
7. Greater than 30-minute, third stage (delivery to placenta time).
8. Less than 1-cm change in station during pushing in the second stage.
9. Vaginal birth after cesarean section (VBAC).
10. Excessive uterine tenderness or rigidity.
11. Suppression of preterm contractions.
12. Sickle-cell anemia or disease.

her know that your colleague is listening in. Your colleague should say, "hello." Then ask the provider again for what your patient needs. If he or she hangs up or refuses to come in, activate the chain of command and record who you notified in the chain.

DISRUPTIVE BEHAVIOR IS INAPPROPRIATE BEHAVIOR

Disruptive behavior includes intimidation, violence, inappropriate language or comments, sexual harassment, and/or inappropriate responses to patient needs or staff requests. Hanging up midsentence or refusing to come in are examples of disruptive behavior. If someone verbally threatens you, that is disruptive behavior. Throwing things such as instruments or lap sponges in your direction is disruptive behavior. No person with whom you work should ever hurt you. Abuse and battery must not be tolerated — and must always be reported. If you feel you are the victim of disruptive behavior in the workplace, speak with your nurse manager and discuss the incident. Disruptive behavior cannot and must not be tolerated and silence on your part is not an option. Speak to the "disrupter" privately with your supervisor present. In the meeting, state the disruptive behavior by explaining what you found to be disruptive. Keep your statement brief, factual, and descriptive. Also share how you felt when the disruptive behavior occurred. When confronted, the disrupter may argue or yell or dispute what you say. If this happens politely thank the disrupter for his or her time and leave. Write an occurrence or problem/resolution report and include his or her response. Continue to act professionally, even if the disrupter is rude to you. If the behavior continues, follow the same plan: meet, discuss, report. The report provides an opportunity for the disrupter to change his or her behavior (Lazoritz & Carlson, 2008).

Communication is necessary to gather and to share information and to mobilize help. Use a translator service if you feel you are not communicating effectively with your patient. Communicate and collaborate with the primary health care provider to ensure there is an appropriate plan of care and evaluation of the patient's condition prior to beginning a procedure such as cervical ripening or induction. For example, you might say to the midwife or obstetrician, "I'm really worried about the baby. Can you please come in and evaluate the tracing for me?" If you do not get the response you desire, it may be because you did not communicate your degree of concern. Try again and say, "I guess I didn't communicate well. I'm very concerned about the baby and I'd like you to come to the bedside now to evaluate the tracing." If you still do not get the response you desire, use your chain of command process.

Obstetricians are used to four basic types of telephone calls (see Exhibit 1.7).

If you are trying to decide whether to call the physician or midwife, just make the call. The time of day should not stop you from sharing important patient information. Call when the patient needs a medication, is not tolerant of labor, or is

Exhibit 1.7: Telephone calls from a nurse to a physican or midwife.

1. Patient has arrived.
2. Status update and request for new orders.
3. New, significant findings and a need to come to the unit to assess the patient.
4. There is an emergency and we're taking the patient to the operating room for a cesarean section.

ready to push, or any time there is concern for the fetus. Call for orders, to clarify orders, or to change orders.

When there are new and/or significant findings, it is especially important that you report information in a timely manner (meaning within a few minutes of knowing the information) to the midwife or physician. For example, if your patient complains of constant pain in the suprapubic area and her bladder is empty, think about the fit of the fetal head in the pelvis. Is it pressing down above her pubic bone? Ask the midwife or physician to come to the bedside and evaluate this unusual pain. If you are given an order, be sure you accept that it is safe to follow that order. If you are concerned about a risk of harm, discuss it with the person who wrote the order. It is your responsibility to question orders that may harm the patient and you must not follow harmful orders.

SBARR

The letters S, B, A, R, and R represent the words *situation*, *background*, *assessment*, *recommendation*, and *response*. The situation is the patient's current condition and your major concern. The background includes the pertinent facts from the patient's history. The assessment is what you think the problem is. The recommendation is what you recommend the provider do. The response is what he or she said or did when you made your recommendation (Cherouny, Federico, Haraden, Leavitt Gullo, & Resar, 2005; Guise & Lowe, 2006; Nunes & McFerran, 2005).

To help midwives and physicians make good decisions, they need you to provide them with relevant facts, abnormal findings or laboratory results, and any other information that paints a complete picture in their minds. For example, if there is fetal tachycardia, you will also want to inform them of the maternal pulse and temperature. Both are elevated when there is chorioamnionitis. If there is vaginal bleeding, they will need to know about contractions and details related to pain, such as the location of the pain, whether it is constant or intermittent, sharp or dull, how the patient is responding to the pain, and the fetal status. If you need a physician or midwife at the bedside, you might say "I need you to come to the hospital now" or "The patient (fetus or mother) needs you to come to the bedside now." When the midwife and/or physician respond to your request without delay, they promote a safe, reliable organization that is patient-centered.

> **Documentation example**: Jane Doe, CNM, called at 2330. Informed her of patient's BP 156/92, facial and hand edema, and hyperreflexia with unrelenting headache and abdominal pain, but no vaginal bleeding, with contractions every 1 to 2 minutes. Patient reported no history of preeclampsia. Recommended CNM come to bedside immediately. CNM informed this nurse she was on her way.

COMMUNICATION DURING EMERGENCIES

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN, 2004), supports nursing action that may be contrary to a physician's order when fetal well-being is in question and the external fetal monitor tracing is not reassuring or is unreadable. They have taken the position that a registered nurse may apply a fetal spiral electrode (FSE) through intact membranes for the purpose of obtaining additional assessment data and treatment provided the nurse has had appropriate education and has met competence requirements in accordance with institutional policy and state or provincial nurse practice legislation. Throughout your career in nursing, you may be confronted with a decision to not follow a standing order because it may harm the patient.

Nurses communicate when they believe the plan of care needs to change. Nurses also identify care issues that need ethical, legal, or risk intervention. In either case, communication with the supervisor is required to advocate for a change in the plan of care. If communication with a provider intimidates you, talk to your charge nurse or a more experienced nurse and ask for help. Once you have communicated the patient's information and needs, you should document in the medical record the time you communicated, whom you spoke to, what you said, what the person said, and any actions taken by you, your supervisor, or the provider.

> **Documentation example**: Subtle late decelerations, fetal heart rate pattern sinusoidal-like. Dr. Seinwave called at home. Informed of baseline 130 to 140 bpm, recurrent subtle late decelerations, contractions every 2 minutes lasting 50 seconds, moderate to palpation. Telephone order for Pitocin received and read back to physician. This nurse refused order and requested physician come to bedside now to evaluate patient and tracing.

> **Documentation example**: Repetitive variable decelerations with baseline 140 bpm, minimal variability. Dr. Listo called to bedside. This nurse reviewed tracing with physician. Cesarean section ordered.

Nurses recognize, verbalize, and mobilize. "In emergencies, when prompt action is necessary and the physician is not immediately available, a nurse may be justified in acting contrary to the physician's standing orders for the safety of the patient" (AMA, 1997). Staffing should be based on the acuity of patients and standardized protocols should be followed for emergencies (Fariello & Paul, 2005). Therefore, if you recognize a problem, notify other nurses, and tell them what you want them to do. A pilot once said, "In a storm, just keep the wings level. Tough it out. Fall apart after you land."

CHAIN OF COMMAND

Each hospital should have a chain of command policy, procedure, or protocol. You may need to activate your chain of command to resolve conflicts over patient management plans (Mahley & Beerman, 1998). The chain of command is a process that is used when the nurse feels that ethical or practice standards are not being maintained or there are unresolved con-

flicts or clinical issues that affect patient well-being. Prior to invoking the chain of command, every effort should be made to clearly and fully communicate with the midwife, resident, or physician directly involved in the patient's care. If the communication fails, the chain of command policy must be followed.

Unresolved conflicts often involve a disagreement in patient care, such as the need to apply oxygen or a spiral electrode. The chain of command or chain of communication is invoked as the patient's safety net. Your role as a patient advocate creates an ethical duty to prevent harm, and requires courage to acknowledge the disagreement and seek its resolution. You might say to the midwife or physician (away from the patient's bedside), "We have an unresolved disagreement here. I've asked the charge nurse to help us resolve this issue." You can also say, "I'm activating our chain of command policy." The charge nurse may decide to assume care of your patient or assign another nurse to care for your patient. The charge nurse can be asked to speak with the midwife and may need to speak with the next highest level in the chain, that is, the midwife's back-up physician or the attending physician. If the provider is the Chief of Obstetrics, involve your nursing chain of command, for example, the charge nurse and nurse manager. If the Chief of Obstetrics is also the Chief of the Medical Staff, involve your charge nurse or supervisor, who may need to involve the Vice Chief of the Medical Staff to resolve the conflict.

Documentation of the chain of command should include the observations and events that created a need to use the chain of command, specific facts, and the time of events and communications.

> **Documentation example**: Dr. Noetaul ordered oxytocin. Physician was informed at nurses' station at 1205 that patient was contracting every 2 minutes x 50 to 70 seconds, and was moderate to palpation. Order to administer oxytocin was questioned. Charge nurse Sally Smith was informed of communication with physician. Nurse Smith spoke with physician who insisted on oxytocin administration. Chief of OB was called by charge nurse at 1210.

The nurse's responsibility is to advocate for the patient's safety. It is imperative that the nurse continue to communicate with the charge nurse or supervisor until the conflict is resolved. The nurse must act to prevent injury.

Patients really want a nurse who cares for them as if they were a family member. They want a nurse who is responsive to their needs, including their physical, emotional, and spiritual needs. They want a nurse who is willing to do extra things and who follows through on promises (Trossman, 2007). Sometimes our communications are ineffective in moving toward a patient-centered goal. For example, what would you do if the physician asked you to do something in front of the patient that you felt was not best for the patient or her baby?

If you receive a verbal order at the bedside, but are concerned that following the order may harm the patient, do not follow the order. When the provider leaves the room, repeat the order. For example, an order you should question is "Begin oxytocin per protocol on this patient" but you know the patient has a baby in a transverse lie. When the provider leaves the room, follow him or her. In the hallway ask if he or she wanted oxytocin to be administered to this patient who has a transverse lie. If the answer is yes, do not follow the order. Instead, speak to your charge nurse or supervisor and inform him or her of the order, the provider's response, and your concerns. The charge nurse or supervisor has the responsibility and authority to speak with the provider so that the order is changed. Your responsibility is to continue to care for your patient.

In your career, there will be times when you need to initiate the chain of command and involve your charge nurse or house supervisor — or even the Chief of Obstetrics. If you have a clinical nurse specialist, he or she often works with the Patient Care Manager as a dyad and may also be able to help you obtain the care you need for your patient. In some cases, the Director of Maternity Services or Maternal Child Services, the Assistant Vice President for Women and Children's Services, or the Executive Vice President for Patient Care Services will be called. When the chief nursing officer is called, the entire nursing chain of command will be involved.

You can develop your own list of names and phone numbers of people in your chain of command. It is a good idea for the hospital to give you a copy of the chain of command policy. It is your responsibility to find it if you do not receive it. From time to time you may want to return to the policy for guidance or to refresh your memory. In general, there are two "chains" of command that compose the overall "chain of command," the nursing chain of command and the medical chain of command (see Figures 1.1 and 1.2).

Activate the chain of command or chain of communication whenever there are unresolved issues related to patient care or if you have concerns related to a provider. If resolution of the conflict or issue is not achieved at any step up the chain of command, continue up the chain until a mutual resolution is met. Perhaps once in your entire career, you may follow the chain all the way to the top (Chief Nursing Officer and Hospital Medical Director).

If discussions with the midwife or physician do not result in appropriate care, the nurse is responsible to ensure timely and appropriate actions (Simpson & Chez, 2001). Advocacy for the patient may require you to invoke your hospital's chain of command.

A retrospective review of 90 risk manager files from 1995 to 2001 revealed that adverse outcomes are directly related to procedures and people (White, Pichert, Bledsoe, Irwin, & Entman, 2005). Half of those files were related to labor and delivery, the rest were related to gynecologic surgery (38%) and ambulatory care (12%). Communication failures were associated with 31% of the adverse events. For example, there

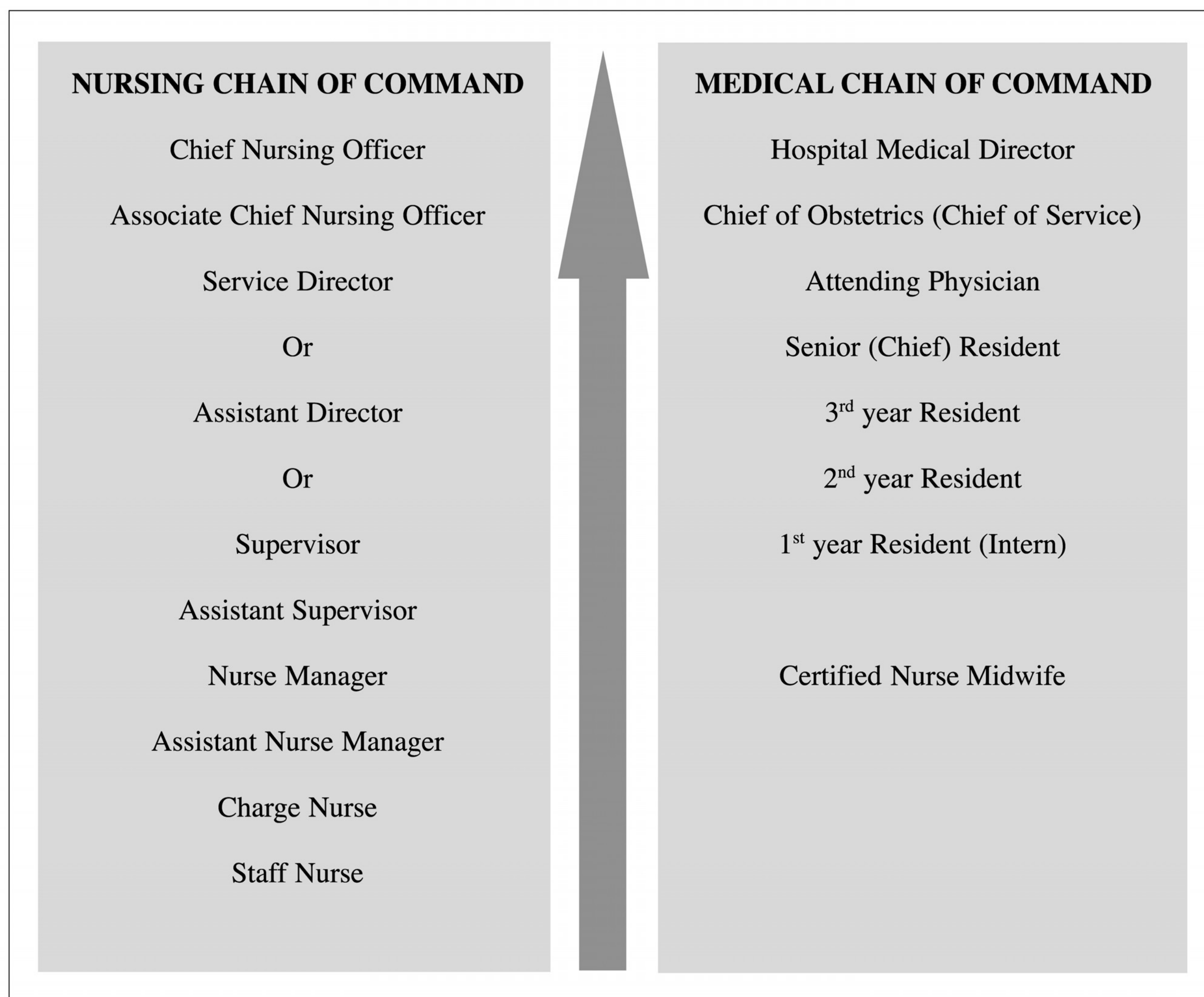
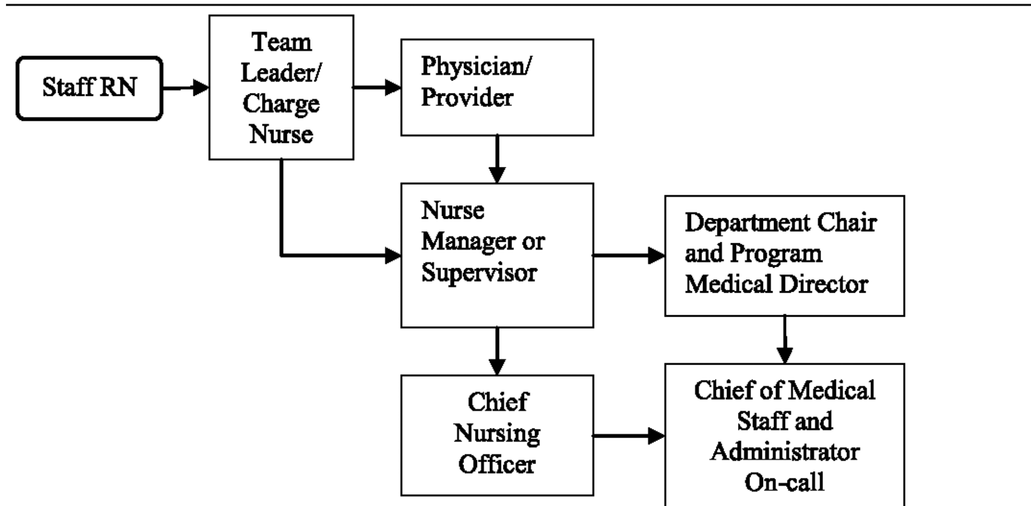


Figure 1.1: Sample chain of command with the staff nurse as the first link in the chain.

were disruptions in the flow of critical information from one caregiver to another, or there were communications that upset the patient or her family.

Example of the need for the chain of command: Dina was 29 years old, a gravida 4, having her second baby at 40 weeks of gestation. She arrived in labor and delivery with bloody show and a thick, closed cervix with a high, vertex fetal station. The unit was a nurse-managed labor unit and there was no charge nurse on duty. Dina was contracting and dilated to 5 centimeters within 6 hours of admission. However, she remained at 5 centimeters for the next 3 hours. The fetal heart rate pattern demonstrated a loss of accelerations and baseline variability decreased. Oxygen was applied at 10 liters per minute using a nonrebreather mask. The attending family physician wanted oxytocin to be administered. The nurse started the oxytocin infusion. Within 30 minutes there were late decelerations. The nurse showed the tracing to the family practice physician who asked that she continue the oxytocin infusion. The nurse continued the infusion but informed the physician she would be calling the obstetrician for a second opinion. The obstetrician arrived and the oxytocin was discontinued. Both physicians remained on the unit. Within another 3 hours, Dina had progressed to an anterior lip but the fetal heart rate fell to a bradycardic level below 90 beats per minute. There were also late decelerations and prolonged decel-



Reasons to Activate the Chain of Command or Chain of Communication

1. **Issues requiring communication.**
2. **Issues surrounding patient care.**
3. **Concerns related to physican/provider.**

Figure 1.2: Another example of the chain of command or chain of communication with the staff nurse as the first link in the chain.

erations. The nurse never called the house supervisor or her unit supervisor. One hour later and after use of the vacuum extractor, the baby's head was delivered. There was a shoulder dystocia. The Zavanelli maneuver and a cesarean section were performed. The Apgar scores were 0 at 1 minute and 3 at 5 and 10 minutes. The newborn weighed 4,345 grams and suffered from severe perinatal asphyxia.

Dystocia is derived from the Greek word for "abnormal" or "difficult" and the Greek word *tokos* for "labor" or "delivery." A difficult delivery of the shoulders was encountered. In fact, all maneuvers failed to deliver the baby. The nursing chain of command should have been activated when Dina's baby was bradycardic but remote from delivery. The plan of care needed to change to a cesarean section, however, the nurse remained silent. Failure of the nurse to discuss a change in the plan of care, including a cesarean section, and to activate the nursing chain of command were considered by the plaintiff's nurse expert to be substandard nursing care. The case settled prior to the trial.

This example illustrates the nurse's need to advocate for the patient and use the chain of command when the midwife or physician is unresponsive to reasonable concerns about the patient's condition or is making inappropriate patient care decisions. Any order or plan that is not consistent with standard medical practice should be questioned by the nurse.

The plan of care should be more than "monitor" or "expect vaginal delivery." It should provide a road map toward a safe outcome. Sometimes the plan of care is in conflict with the patient's needs. To resolve clinical issues related to patient care conflicts, your hospital should have a "Resolution of Clinical Issues" or "Resolution of Conflict" procedure. This procedure should define the channels of communication and decision making that you should follow when there are questions or concerns regarding medical or nursing care. Knowing your patient should be the basis for clinical decisions and judgments and individualized care.

When orders deviate from the plan of care or customary or safe practices, discuss the situation and your concerns with the midwife and/or physician(s) responsible for the patient. If the issue needing clarification is not resolved, the chain

of command should be initiated and your charge nurse or immediate supervisor must be notified. The charge nurse or supervisor will discuss the concern with the midwife or physician. If the issue remains unresolved, other individuals in the "chain of command" will become involved so that the conflict can be resolved. Avoid documentation that reflects a disagreement between yourself and others. Instead, document your assessments, plans, actions, evaluations, and communications.

Example of documentation that reflects disagreement between a nurse and a physician: "Dr. Disreguarde aware of FHR throughout second stage of labor. Dr. desires no interventions at this time. Nurse manager in room. Dr. orders pushing to continue. Dr. informed of meconium and nonreassuring FHR pattern. Dr. still refuses to order any interventions at this time. Dr. asked if NICU should be called. Dr. said they are not needed. Dr. reminded of particulate meconium. Dr. said there is no meconium."

Example of appropriate documentation: Frequent discussions with Dr. Disreguarde during second stage about FHR pattern, including meconium and nonreassuring pattern at this time. No new orders. Nurse manager in the room at this time. NICU called by nurse manager to attend delivery.

The first narrative note demonstrates the lack of collaboration and teamwork. The second note demonstrates how well the chain of command worked to secure personnel for delivery.

FATIGUE AND FAULTY COMMUNICATION

Successful decision makers and communicators are well rested, not driven by pressures, and aware of their biases. To eliminate bias, you must recognize and acknowledge what the bias is and be willing to change (Cudé & Winfrey, 2007). Being well rested may be a difficult goal, but it is an important goal that prevents errors and patient injuries. Research shows that error rates increase when nurses work more than 12 hours a day, or more than 40 hours a week (Rogers, Hwang, Scott, Aiken, & Dinges, 2004). Unfortunately, nurses often work more than 40 hours per week. Some nurses work more than six days in a row and many rotate shifts (Trinkoff, Geiger-Brown, Brady, Lipscomb, & Muntaner, 2006). If you do the same, you increase your risk of becoming overtired, chronically stressed, or injured — and you therefore increase the risk of injuring a patient. For example, sleep-deprived military gunners hit their targets but shot at the wrong target (Kushida, 2005). An error-prone environment is one that has inadequate staff to get the job done, rude coworkers or supervisors, insufficient resources, ever-changing technology, too little training, excessive paperwork, and communication failures (Welker-Hood, 2006). If you work in an error-prone environment, share your concerns with nursing management.

Clinical reasoning, good problem solving, sound judgment, and effective clinical decision making require clear thinking, knowledge, and experience (Croskerry, 2003, 2005, 2006). Experience will help you develop your clinical reasoning. Good clinical reasoning means inductive, fast, and intuitive recognition of a problem. Some people call this "having a gut feeling." However, it is based on knowledge and experience, not just a feeling. For example, when a pregnant woman presents with decreased fetal movement, frequent mild contractions, a nonreassuring fetal heart rate pattern, a closed cervix, and blood in her shoes (known by skilled nurses as "the positive shoe sign"), an experienced nurse will think there is a placental abruption. The obstetrician will be called and the patient will be prepared for surgery.

Other decisions are a result of a slower, rational, deductive, rule-based, analytical process. This process takes more time, but is valuable because it results in fewer errors (Croskerry, 2006). Errors in our decisions increase when we are uncertain, hurried, pressured, or have biases (Croskerry, 2003). Therefore, if you are new to the practice of labor and delivery nursing and/or you feel something is amiss, or you feel hurried but lack the confidence, knowledge, or motivation to make a decision or to call the midwife or physician, it is best to admit you need help and confer with a more experienced nurse or your charge nurse. By constantly expanding your experiences and knowledge base, you should become a better decision maker and communicator, and you will increase your ability to see the broad range of possibilities in any given clinical situation.

CONCLUSIONS

Communication is necessary to provide the best care for patients and to prevent errors and injury (Cherouny, Federico, Haraden, Leavitt Gullo & Resar, 2005). However, mistakes do occur, especially when there is poor communication, poor documentation, a lack of planning, a lack of action, and a lack of appropriate decisions. Ideally you will work in a healthy culture where communication is open and collaborative, and health care providers know their role and work to provide patient-centered care. But if concerns exist or issues related to care arise, you should consult members of your chain of command. You are a vital part of the health care team, the patient's advocate, and the person responsible for patient well-being.

REVIEW QUESTIONS

True/False: Decide if the following statements are true or false.

1. It is best to avoid words like "noncompliant" or "failure" when communicating with patients or their families, because these words can be hurtful or demeaning.
2. A cynical health care organization is not supportive or is hostile, which impedes communication.

3. Experience is not an important factor that influences decisions.
4. Family-centered care requires care providers to make choices for the mother about the labor and birth process.
5. A reason to communicate with a midwife or physician is when the patient has a physical or psychological need.
6. Patients can provide valuable information to increase the ability of physicians to diagnose their condition.
7. A collaborative culture promotes communication with and among the patient, her significant other or family, and members of the health care team.
8. A nonreassuring fetal heart rate pattern that does not resolve after in utero resuscitation interventions should be reported to the midwife or physician.
9. The last R in SBARR stands for the patient's response to your interventions.
10. Patients want a nurse who follows the physician's orders even when they have the potential to harm the patient.

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