Coping with Labor Algorithm v2

Observe for cues on admission and throughout labor.
Assessment per protocol:
- Ask: “How are you coping with your labor?”
- Every shift
- PRN
- At signs of change.

Coping

Cues you might see if woman is coping:
- States she is coping
- Rhythmic activity during contraction (Rocking, swaying)
- Focused inward
- Rhythmic breathing
- Able to relax between contractions
- Vocalization (moaning, counting, chanting)

Not Coping

Cues you might see if woman is NOT coping
(May be seen in transition)
- States she is not coping
- Crying (May see with self-hypnosis)
- Sweaty
- Tremulous voice
- Thrashing, wincing, writhing
- Inability to focus or concentrate
- Clawing, biting
- Panicked activity during contractions
- Tense

Physiologic. Natural process of labor

- Patient desires pharmacological intervention
  - IV pain med [L]
  - Epidural [S]
  - Nitrous Oxide [I]

- Patient desires non-pharmacological intervention
  - Interventions as to what would give best relief and is indicated (what does the patient desire):
    - Tub/bath/shower [S]
    - Hot pack/cold pack [*]
    - Water injections [S]
    - Massage/pressure [*]
    - Movement/ambulation/position changes [S]
    - Birth ball [*]
    - Focus points [*]
    - Breathing techniques [*]
    - Acupuncture [S]
    - Self-Hypnosis [S]
    - TENS [*]

Follow:
- Unit
- Service line
- Hospital

Guidelines/standards for pharmacologic intervention

Physical Environment

- Appropriate changes to environment PRN [S]
  - Mood [*]
  - Lighting [*]
  - Music [*]
  - Fragrance [*]
  - TV/Movie [*]
  - Temperature [*]
  - Whispering voices [*]

Emotional/ Psychosocial

- One-on-One Support [S]
- Doula [S]
- Midwifery Care being "With Woman" [S]

The nurse should consider:
- Patient’s life
- Sexual abuse
- Fear
- Stress
- Interpersonal dynamics

Offer social work consult

Reassessment

Coping

Not Coping

Legend
[S] = Sufficient Evidence
[L] = Limited Evidence
[I] = Insufficient Evidence
[*] = No Evidence & No Harm