Stanford HEALTH CARE

At Good Samaritan Hospital

Orders are called to the hospital after the doctor speaks with you. These orders include recommendations for walking, using the shower or Jacuzzi, diet, monitoring and pain medications or epidural. The nurses at the hospital will evaluate your labor and communicate with the doctors throughout your labor. Your baby will be monitored when you first arrive, and later in labor when you are no longer able to ambulate. Shaves, enemas, intravenous fluids, internal monitoring, and episiotomies are not performed routinely. Intervention is kept to a minimum. Our goal is to keep you and the baby healthy and to provide a positive experience.

When you are admitted to the hospital, you will be assigned a room and a nurse. Your nurse may start an IV to give you fluids and/or medication. She will monitor your blood pressure, contractions, fetal heart rate, and urine. Your cervix will be checked every so often to assess progress in dilation, effacement and fetal head positioning.

Electronic fetal monitoring uses electronic equipment to measure the fetus' heart rate and uterine contractions. These instruments are attached to your abdomen and held in place by elastic belts.

You will be positioned on your side, either sitting up or laying down. Because your gastrointestinal system is slowing down, you will be offered ice chips or clear liquids instead of food. Unless you are high-risk, you may take walks around the unit.

Pain relief options:
Natural: No narcotics or other pain medications in labor. Relaxation, breathing techniques and meditation are used.

Medications:

- Epidural - a regional anesthesia that blocks pain below the waist. With this option you may still push and take part in the delivery of your baby without feeling the pain of contractions.
- Intravenous narcotics - pain medications that are given through your IV. Demerol and Fentanyl are the most commonly used narcotics.
- Spinal – usually used for a cesarean section if an epidural is not already in place

Am I really in labor?
Labor begins with uterine contractions and the opening of the cervix. The uterus tightens and relaxes at regular intervals, causing the abdomen to feel hard, then soft. These contractions make the cervix thin out (efface) and open as wide as possible (dilate). On average, labor lasts 12-20 hours. Second and subsequent labors are much faster.

False Labor: (Braxton-Hicks)

These contractions often are irregular and do not become closer together. They may stop when you walk, rest, or change position. Often felt low in the abdomen, these contractions are usually weak and do not become stronger in intensity.

True Labor:
Regular contractions that occur closer together as time goes on and continue despite movement or rest. They increase in strength and severity with time. Contractions are usually felt in the lower back and radiate to the front of your abdomen.

Labor begins when the cervix starts to dilate and ends when the baby is born. Labor is divided into several phases. The latent phase of labor ends when the cervix is 4 centimeters dilated. Latent phase is of variable duration and can last many hours. In a low-risk pregnancy, it is best to stay at home during this phase. The active phase of labor is usually progresses rapidly at about one centimeter/hour in first labors and much more rapidly with subsequent labors.

Blood-tinged mucous (called bloody "show") is caused by cervical mucus which passes out of the vagina as the cervix dilates. It does not mean that labor will start soon, only that the cervix is beginning to soften and dilate in preparation for labor.

The second stage of labor begins when the cervix is dilated and it is time to push the baby out. Once the cervix is fully dilated, you will often feel extreme pelvic pressure. You need to push the baby out by bearing down during each contraction until the baby is born. This stage may last for 1-3 hours and ends with the birth of the baby. Rest between contractions so as not to exhaust yourself. Once your baby's head is delivered, the airways are cleared by suction and the umbilical cord placement is assessed. The body is delivered and usually placed on the mother’s abdomen. The cord is clamped and is usually cut by a family member in a low risk pregnancy. After delivery, you are inspected for vaginal tears.

The third stage of delivery is the delivery of the placenta. After the baby is born, the uterus will continue to contract and the placenta will be delivered. This stage usually lasts only a few minutes, and minimal pushing is needed. Pitocin is generally given to help the uterus contract and control bleeding.

Labor Induction:
Labor can be initiated by your physician for medical reasons or electively. Induction can be initiated with a cervical ripening agent (prostaglandins or cervidil), by breaking the amniotic sac or with pitocin. If your doctor recommends induction, the indication and the process will be discussed in detail. Generally an induction is “scheduled” on labor and delivery for a specific day and time. Orders are faxed to the hospital by your physician. You are asked to call labor and delivery (559-2327) one hour prior to the induction time. If the unit is busy at the time you are scheduled, you may be asked to come at a later time by the labor and delivery nurses.

Reasons for induction include: Post-dates (usually one week past your due date), a history of complications in labor, premature rupture of membrane (water breaking early), high-risk

pregnancy (diabetes, hypertension, and twins), macrosomia (big baby) or elective (usually after 39 weeks).

Vaginal Delivery:
Most deliveries are spontaneous without intervention. If your doctor finds it necessary to intervene, the indication and the method will be explained to you. Most interventions are used to prevent a worse outcome. Forceps and the vacuum are used to prevent a cesarean section; an episiotomy is used to prevent lacerations. The following are brief explanations:

- Episiotomy: A small incision on the perineum used to open the vagina and allow delivery of the head. It is used to prevent lacerations and tears into the rectum, clitoris and vagina. Most physicians will only cut an episiotomy if necessary. Mineral oil and massage are often used during the second stage of labor to stretch the vagina and allow a small tear or episiotomy. Local or epidural anesthesia is given prior to the episiotomy so it is not felt.
- Forceps: These instruments look like large spoons. They are inserted in the vagina and gently placed on baby's head to facilitate delivery.
- Vacuum: A soft plastic cup that is placed on the baby's head. Suction is used to hold the cup in place so that the infant can be delivered during a contraction with the mother pushing. It is frequently used when the baby's head is not in the correct position for a vaginal delivery. It would not be used unless it was considered both safe and necessary.

Cesarean Delivery:
Reasons for a cesarean section include an abnormal position of the fetus (breech), a medical complication of the pregnancy (pre-eclampsia, active herpes, heart disease), a previous cesarean section, a large baby, a fetal heart rate abnormality signaling distress or a baby that is "stuck" (Cephalo-pelvic disproportion or CPD). Cesarean sections are either scheduled (planned or elective) or unplanned (emergency or after laboring). If a C-Section is required, the reason will be discussed with you in detail. Your partner may stay with you throughout the procedure.

If you have been laboring and have an epidural already, this will be used for your delivery. If you do not have an epidural, a spinal is the usual anesthetic. This will be discussed with you by your anesthesiologist. Once you are comfortable with your anesthetic, your lower abdomen is shaved, a urinary catheter is placed in your bladder and your abdomen is washed with sterile soap. Drapes are placed to maintain a sterile environment. Your physician will start the procedure after you are ready and comfortable.

After delivery, the baby will be examined by the pediatric nurse and a neonatolgist in a room next to the operating room. Amniotic fluid is suctioned from the baby's mouth and nose and the baby will be returned to you in the operating room. Your partner can stay with the baby during the brief time that the baby is out of the operating room. You will be in the recovery room with the baby and your spouse until your anesthesia wears off. This is usually about two hours. Your baby is usually weighed in the recovery room after your surgery. The baby remains with you during the entire hospitalization unless you ask the nurses to watch him/her in the nursery.

You will have an IV in your arm and catheter in your bladder for the first 12 – 24 hours. Once you are tolerating liquids, the IV can be discontinued. The nurses will ask you to stand during the first day and then start walking soon after. You may eat regular food as soon as you are hungry. The hospital has a "room service" menu that you may order from 7 am to 7 pm. We encourage you to start oral pain medication as early as possible. Ibuprofen is also given to increase the effectiveness of the narcotic (Vicodin or Darvocet) and also to decrease the uterine cramping after deliver

If you are scheduled for a planned cesarean section, you should arrive at the hospital two hours prior to your surgery time. You may bypass the admitting desk and go directly to Labor & Delivery. If you arrive at the hospital before 6 am, you must enter through the emergency room. It is not necessary to stop in the ER. If you have not pre-registered, please do so at least one day prior to your surgery. You may obtain a pre-registration form in admitting, from your physician or on the Good Samaritan Hospital website:www.goodsamsj.org/reginfo.asp.

For a scheduled C/S, do NOT have anything to eat or drink after midnight the night before surgery or 8 hours prior to surgery (including water). You will meet the anesthesiologist the morning of surgery. A spinal is normally given for a scheduled cesarean section. If you have questions regarding insurance billing by the anesthesiologist, please contact Group Anesthesia Services at 354-2114 or visit their website at www.groupanesthesia.com.