

## Chapter 1 : Labor and Birth Processes

*Bloody show occurs throughout the labor process and is not an indication of an imminent birth. Rupture of membranes can occur at any time during the labor process and does not indicate an imminent birth.*

The distress levels reported by labouring women vary widely. They appear to be influenced by fear and anxiety levels, experience with prior childbirth, cultural ideas of childbirth and pain, [18] [19] mobility during labour, and the support received during labour. Women are often encouraged to refrain from screaming, but moaning and grunting may be encouraged to help lessen pain. Crowning may be experienced as an intense stretching and burning. Even women who show little reaction to labour pains, in comparison to other women, show a substantially severe reaction to crowning. Back labour is a term for specific pain occurring in the lower back, just above the tailbone, during childbirth. The act of nursing a child also causes a release of oxytocin. The symptoms normally occur for a few minutes up to few hours each day and they should lessen and disappear within two weeks after delivery. Preventive group therapy has proven effective as a prophylactic treatment for postpartum depression. Vaginal delivery Sequence of images showing the stages of ordinary childbirth. Humans are bipedal with an erect stance. The erect posture causes the weight of the abdominal contents to thrust on the pelvic floor, a complex structure which must not only support this weight but allow, in women, three channels to pass through it: Six phases of a typical vertex or cephalic head-first presentation delivery: Engagement of the fetal head in the transverse position. Descent and flexion of the fetal head. The fetal head is bowed, chin on chest, so that the back or crown of its head leads the way through the birth canal, until the back of its neck presses against the pubic bone and its chin leaves its chest, extending the neck - as if to look up, and the rest of its head passes out of the birth canal. The fetal head turns through 45 degrees to restore its normal relationship with the shoulders, which are still at an angle. The shoulders repeat the corkscrew movements of the head, which can be seen in the final movements of the fetal head. Station refers to the relationship of the fetal presenting part to the level of the ischial spines. When the presenting part is at the ischial spines the station is 0 synonymous with engagement. This change in the shape of the fetal head is called molding and is much more prominent in women having their first vaginal delivery. A scoring system called a Bishop score can be used to judge the degree of cervical ripening in order to predict the timing of labor and delivery of the infant or for women at risk for preterm labor. It is also used to judge when a woman will respond to induction of labor for a postdate pregnancy or other medical reasons. There are several methods of inducing cervical ripening which will allow the uterine contractions to effectively dilate the cervix. There are various definitions of the onset of labour, including: Regular uterine contractions at least every six minutes with evidence of change in cervical dilation or cervical effacement between consecutive digital examinations. Lightening describes the baby moving down from the rib cage with the head of the baby engaging deep in the pelvis. The pregnant woman may then find breathing easier since her lungs have more room for expansion, but pressure on her bladder may cause more frequent need to void urinate. Lightening may occur a few weeks or a few hours before labour begins, or even not until labour has begun. The mucus plug may become dislodged days before labour begins or not until the start of labour. Shortly before, at the beginning of, or during labor the sac ruptures. Women report a spurt of energy shortly before going into labour. All other births are most likely to occur between 8 a. Likewise, births from induced deliveries rose during the morning hours and peaked at 3 p. The latent phase ends with the onset of the active first stage. The World Health Organization describes the active first stage as "a period of time characterized by regular painful uterine contractions, a substantial degree of cervical effacement and more rapid cervical dilatation from 5 cm until full dilatation for first and subsequent labours. These factors form the Bishop score. The Bishop score can also be used as a means to predict the success of an induction of labour. During effacement, the cervix becomes incorporated into the lower segment of the uterus. During a contraction, uterine muscles contract causing shortening of the upper segment and drawing upwards of the lower segment, in a gradual expulsive motion. A standard duration of the latent first stage has not been established and can vary widely from one woman to another. However, the duration of active first stage from 5 cm until full cervical dilatation usually

does not extend beyond 12 hours in first labours "primiparae" , and usually does not extend beyond 10 hours in subsequent labours "multiparae". The median duration of active first stage is 4 hours in first labours and 3 hours in second and subsequent labours. The term is used to describe a lack of progressive cervical dilatation or lack of descent of the fetus. However, more recent medical research suggests that the Friedman curve may not be currently applicable. The expulsion stage begins when the cervix is fully dilated, and ends when the baby is born. As pressure on the cervix increases, women may have the sensation of pelvic pressure and an urge to begin pushing. At the beginning of the normal second stage, the head is fully engaged in the pelvis; the widest diameter of the head has passed below the level of the pelvic inlet. The fetal head then continues descent into the pelvis, below the pubic arch and out through the vaginal introitus opening. This is assisted by the additional maternal efforts of "bearing down" or pushing. The appearance of the fetal head at the vaginal orifice is termed the "crowning". At this point, the woman will feel an intense burning or stinging sensation. When the amniotic sac has not ruptured during labour or pushing, the infant can be born with the membranes intact. This is referred to as "delivery en caul ". Complete expulsion of the baby signals the successful completion of the second stage of labour. The second stage varies from one woman to another. In first labours, birth is usually completed within 3 hours whereas in subsequent labours, birth is usually completed within 2 hours. Umbilical cord and Placental expulsion The period from just after the fetus is expelled until just after the placenta is expelled is called the third stage of labour or the involution stage. Placental expulsion begins as a physiological separation from the wall of the uterus. The average time from delivery of the baby until complete expulsion of the placenta is estimated to be 10â€”12 minutes dependent on whether active or expectant management is employed. Active management is described as the administration of a uterotonic drug within one minute of fetal delivery, controlled traction of the umbilical cord and fundal massage after delivery of the placenta, followed by performance of uterine massage every 15 minutes for two hours. However a recent review found that delayed cord cutting in healthy full-term infants resulted in early haemoglobin concentration and higher birthweight and increased iron reserves up to six months after birth with no change in the rate of postpartum bleeding.

## Chapter 2 : Labor and Birth - American Pregnancy Association

*Factors Affecting Labor At least five factors affect the process of labor and birth. These factors are easily remembered as the five Ps: passenger (fetus and placenta), passageway (birth canal), powers (contractions), position of the mother, and psychologic response.*

The four basic types of pelvis are classified as follows: Gynecoid the classic female type 2. Android resembling the male pelvis 3. Anthropoid resembling the pelvis of anthropoid apes 4. Anthropoid and android features are less common, and platypelloid pelvic features are the least common. Mixed types of pelvis are more common than pure types Cunningham et al. Examples of pelvic variations and their effects on mode of birth are given in Table 2. TABLE 2 Comparison of Pelvic Types Assessment of the bony pelvis can be performed during the first prenatal evaluation and need not be repeated if the pelvis is of adequate size and suitable shape. In the third trimester of pregnancy, the examination of the bony pelvis may be more thorough and the results more accurate because there is relaxation and increased mobility of the pelvic joints and ligaments due to hormonal influences. Widening of the joint of the symphysis pubis and the resulting instability may cause pain in any or all of the pelvic joints. Because the examiner does not have direct access to the bony structures and because the bones are covered with varying amounts of soft tissue, estimates of size and shape are approximate. Precise bony pelvis measurements can be determined by use of computed tomography, ultrasound, or x-ray films. However, x-ray examination is rarely done during pregnancy because the x-rays may damage the developing fetus. Soft tissues The soft tissues of the passageway include the distensible lower uterine segment, cervix, pelvic floor muscles, vagina, and introitus. Before labor begins, the uterus is composed of the uterine body corpus and cervix neck. After labor has begun, uterine contractions cause the uterine body to have a thick and muscular upper segment and a thin-walled, passive, muscular lower segment. A physiologic retraction ring separates the two segments Fig. The lower uterine segment gradually distends to accommodate the intrauterine contents as the wall of the upper segment thickens and its accommodating capacity is reduced. The contractions of the uterine body thus exert downward pressure on the fetus, pushing it against the cervix. The cervix effaces thins and dilates opens sufficiently to allow the first fetal portion to descend into the vagina. As the fetus descends, the cervix is actually drawn upward and over this first portion. Passive segment is derived from lower uterine segment isthmus and cervix, and physiologic retraction is derived from anatomic internal os. C, Uterus in abnormal labor in second-stage dystocia. The pelvic floor is a muscular layer that separates the pelvic cavity above from the perineal space below. This structure helps the fetus rotate anteriorly as it passes through the birth canal. As noted earlier, the soft tissues of the vagina develop throughout pregnancy until at term the vagina can dilate to accommodate the fetus and permit passage of the fetus to the external world. Involuntary uterine contractions, termed the primary powers, signal the beginning of labor. Once the cervix has dilated, voluntary bearingdown efforts by the woman, termed the secondary powers, augment the force of the involuntary contractions. Primary powers The involuntary contractions originate at certain pacemaker points in the thickened muscle layers of the upper uterine segment. From the pacemaker points, contractions move downward over the uterus in waves, separated by short rest periods. Terms used to describe these involuntary contractions include frequency the time from the beginning of one contraction to the beginning of the next , duration length of contraction , and intensity strength of contraction. The primary powers are responsible for the effacement and dilation of the cervix and descent of the fetus. Effacement of the cervix means the shortening and thinning of the cervix during the first stage of labor. The cervix, normally 2 to 3 cm long and approximately 1 cm thick, is obliterated or "taken up" by a shortening of the uterine muscle bundles during the thinning of the lower uterine segment that occurs in advancing labor. Only a thin edge of the cervix can be palpated when effacement is complete. Effacement generally is advanced in first-time term pregnancy before more than slight dilation occurs. In subsequent pregnancies, effacement and dilation of the cervix tend to progress together. Note how cervix is drawn up around presenting part internal os. Membranes are intact and head is not well applied to cervix. Head is well applied to cervix. D, Complete dilation 10 cm. There is some overlapping of cranial bones and membranes are

still intact. Dilation of the cervix is the enlargement or widening of the cervical opening and the cervical canal that occurs once labor has begun. The diameter of the cervix increases from less than 1 cm to full dilation approximately 10 cm to allow birth of a term fetus. When the cervix is fully dilated and completely retracted, it can no longer be palpated Fig. Full cervical dilation marks the end of the first stage of labor. Dilation of the cervix occurs by the drawing upward of the musculofibrous components of the cervix that is caused by strong uterine contractions. Pressure exerted by the amniotic fluid while the membranes are intact or by the force applied by the presenting part also can promote cervical dilation. Scarring of the cervix as a result of prior infection or surgery may slow cervical dilation. In the first and second stages of labor, increased intrauterine pressure caused by contractions exerts pressure on the descending fetus and the cervix. When the presenting part of the fetus reaches the perineal floor, mechanical stretching of the cervix occurs. Stretch receptors in the posterior vagina cause release of endogenous oxytocin that triggers the maternal urge to bear down, or the Ferguson reflex. Uterine contractions are usually independent from external forces. For example, laboring women who are paraplegic will have normal but painless uterine contractions Cunningham et al. Uterine contractions may decrease temporarily in frequency and intensity if narcotic analgesic medication or epidural analgesia is given early in labor Alexander et al. The exact relationship between prolonged labor and epidural analgesia continues to be investigated Thompson et al. Secondary powers As soon as the presenting part reaches the pelvic floor the contractions change in character and become expulsive. The laboring woman experiences an involuntary urge to push. She uses secondary powers bearing-down efforts to aid in expulsion of the fetus as she contracts her diaphragm and abdominal muscles and pushes. These bearing-down efforts result in increased intraabdominal pressure that compresses the uterus on all sides and adds to the power of the expulsive forces. The secondary powers have no effect on cervical dilation, but they are of considerable importance in the expulsion of the infant from the uterus and vagina after the cervix is fully dilated. When and how a woman pushes in second stage is a much-debated topic. Although no significant differences have been found in the duration of second-stage labor, adverse consequences have been reported. Fetal hypoxia and subsequent acidosis have been associated with prolonged breath holding and forceful pushing efforts Mayberry et al. Perineal tears have been associated with directed pushing. A, Positions for labor. B, Positions for giving birth. Frequent changes in position relieve fatigue, increase comfort, and improve circulation. Therefore a laboring woman should be encouraged to find positions that are most comfortable to her Fig. In societies where squatting is customary for rest and defecation, squatting for second-stage labor is far more common. Researchers have claimed several advantages of upright position during delivery: Upright positions include sitting using obstetric chair or stool, semirecumbent, kneeling, squatting unaided or using squatting bars, or squatting using birth cushion. A meta-analysis of 18 randomized and quasi-randomized trials compared labor outcomes of various positions used during second-stage labor. When compared with supine positions, upright position reduced second-stage labor by a mean of 5. This was greatly influenced by the rather large reduction The birth cushion trials also influenced the reduction in assisted deliveries with upright position, compared with supine positions. Women also had a decreased episiotomy rate when they delivered upright. Researchers speculated that the increased blood loss noted in upright labor may have been influenced by the fact that the birth chair has a receptacle for lost blood, so blood loss is measured. The researchers conclude that bearing down in the second stage of labor is more efficient in the upright position. They caution that poor overall study qualities preclude definite conclusions. Labor nurses should be familiar with different positions for second-stage labor so that they can help women find a position that feels right to them and also causes labor to progress. The Cochrane Library, Issue 2. An upright position walking, sitting, kneeling, or squatting offers a number of advantages. Gravity can promote the descent of the fetus. The increased cardiac output improves blood flow to the uteroplacental unit and the maternal kidneys. Cardiac output is compromised if the descending aorta and ascending vena cava are compressed during labor. Compression of these major vessels may result in supine hypotension that decreases placental perfusion. With the woman in an upright position, pressure on the maternal vessels is reduced and compression is prevented. If the woman wishes to lie down, a lateral position is suggested Cunningham et al. Positioning for second-stage labor Fig. The predominant position in the United States in physician-attended births is the lithotomy position.

Alternative positions and position changes are more commonly practiced by nurse-midwives Hanson, A woman who pushes in a semirecumbent position needs adequate body support to push effectively because her weight will be on her sacrum, moving the coccyx forward and causing a reduction in the pelvic outlet. In a sitting or squatting position, abdominal muscles work in greater synchronicity with uterine contractions during bearing-down efforts. The lateral position can be used by the woman to help rotate a fetus that is in a posterior position. There is no evidence that any of these positions suggested for second-stage labor increase the need for use of operative techniques e. There is also no evidence that use of any of these positions adversely affects the newborn Mayberry et al. Labor itself can be discussed in terms of the mechanisms involved in the process and the stages the woman moves through. This settling is called lightening, or "dropping," and usually happens gradually.

**Chapter 3 : PREGNANCY - THE BIRTHING PROCESS**

*When you're in the second stage of labor --delivery -- you are mere minutes to a couple hours away from meeting your baby. If you're having a natural birth, you'll push hard during your.*

B Molding also permits adaptation to various diameters of the maternal pelvis. Lightening is the mother's sensation of decreased abdominal distention, which usually occurs the week before labor. The Ferguson reflex is the contraction urge of the uterus after stimulation of the cervix. The Valsalva maneuver describes conscious pushing during the second stage of labor. Which presentation is described accurately in terms of both presenting part and frequency of occurrence? Regarding how the fetus moves through the birth canal, nurses should be aware that: The fetal attitude describes the angle at which the fetus exits the uterus b. Of the two primary fetal lies, the horizontal lie is that in which the long axis of the fetus is parallel to the long axis of the mother c. The normal attitude of the fetus is called general flexion d. The transverse lie is preferred for vaginal birth ANS: C The normal attitude of the fetus is general flexion. The fetal attitude is the relation of fetal body parts to each other. The normal attitude is called general flexion. The horizontal lie is perpendicular to the mother; in the longitudinal or vertical lie, the long axes of the fetus and the mother are parallel. Vaginal birth cannot occur if the fetus stays in a transverse lie. A woman's position is very important in the progress of labor. While discussing optimal positioning, maternity nurses should be able to tell the client that: The supine position commonly used in the United States increases blood flow b. The all fours position, on her hands and knees, is hard on her back c. Frequent changes in position help relieve her fatigue and increase her comfort d. In a sitting or squatting position her abdominal muscles will have to work harder ANS: C Frequent position changes relieve fatigue, increase comfort, and improve circulation. Blood flow can be compromised in the supine position; any upright position benefits cardiac output. The all fours position is used to relieve backache in certain situations. In a sitting or squatting position, the abdominal muscles work in greater harmony with uterine contractions. Certain changes stimulate chemoreceptors in the aorta and carotid bodies to prepare the fetus for initiating respirations immediately after birth. These changes occur naturally during labor and include all except: Fetal lung fluid is cleared from the air passages during labor and vaginal birth b. Fetal oxygen pressure decreases PO<sub>2</sub> c. Fetal arterial carbon dioxide increases PCO<sub>2</sub> d. Fetal respiratory movements increase during labor ANS: D Fetal respiratory movements actually decrease during labor. Fetal lung fluid is cleared from the air passages during labor and vaginal birth. Fetal oxygen pressure decreases PO<sub>2</sub>. Fetal arterial carbon dioxide increases PCO<sub>2</sub>. Which description of the four stages of labor is correct for both definition and duration? A Full dilation may occur in less than 1 hour, but in first-time pregnancies it can take up to 20 hours. The second stage extends from full dilation to birth and takes an average of 20 to 50 minutes, although 2 hours is still considered normal. The third stage extends from birth to expulsion of the placenta and usually takes a few minutes. The fourth stage begins after expulsion of the placenta and lasts until homeostasis is reestablished about 2 hours. With regard to the turns and other adjustments of the fetus during the birth process, known as the mechanism of labor, nurses should be aware that: The seven critical movements must progress in a more or less orderly sequence b. Asynclitism sometimes is achieved by means of the Leopold maneuver c. The effects of the forces determining descent are modified by the shape of the woman's pelvis and the size of the fetal head d. At birth the baby is said to achieve restitution; that is, a return to the C-shape of the womb ANS: C The size of the maternal pelvis and the ability of the fetal head to mold also affect the process. The seven identifiable movements of the mechanism of labor occur in combinations simultaneously, not in precise sequences. Asynclitism is the deflection of the baby's head; the Leopold maneuver is a means of judging descent by palpating the mother's abdomen. Restitution is the rotation of the baby's head after the infant is born. Signs that precede labor include choose all that apply:

**Chapter 4 : Labor and Birth Processes | Nurse Key**

*The Process of Labor and Birth The chart on the following pages provides an overview of the process of labor and vaginal birth. Your body will.*

B Molding also permits adaptation to various diameters of the maternal pelvis. Lightening is the mother's sensation of decreased abdominal distention, which usually occurs the week before labor. The Ferguson reflex is the contraction urge of the uterus after the stimulation of the cervix. The Valsalva maneuver describes conscious pushing during the second stage of labor. Health Promotion and Maintenance Which presentation is accurately described in terms of both the presenting part and the frequency of occurrence? A labor and delivery nurse should be cognizant of which information regarding how the fetus moves through the birth canal? Fetal attitude describes the angle at which the fetus exits the uterus. Of the two primary fetal lies, the horizontal lie is that in which the long axis of the fetus is parallel to the long axis of the mother. Normal attitude of the fetus is called general flexion. Transverse lie is preferred for vaginal birth. C The normal attitude of the fetus is called general flexion. The fetal attitude is the relationship of the fetal body parts to each one another. The horizontal lie is perpendicular to the mother; in the longitudinal or vertical lie, the long axes of the fetus and the mother are parallel. Vaginal birth cannot occur if the fetus stays in a transverse lie. A woman's position is an important component of the labor progress. Which guidance is important for the nurse to provide to the laboring client? The supine position, which is commonly used in the United States, increases blood flow. The laboring client positioned on her hands and knees all fours position is hard on the woman's back. Frequent changes in position help relieve fatigue and increase the comfort of the laboring client. In a sitting or squatting position, abdominal muscles of the laboring client will have to work harder. C Frequent position changes relieve fatigue, increase comfort, and improve circulation. Blood flow can be compromised in the supine position; any upright position benefits cardiac output. The all fours position is used to relieve backache in certain situations. In a sitting or squatting position, the abdominal muscles work in greater harmony with uterine contractions. Certain changes stimulate chemoreceptors in the aorta and carotid bodies to prepare the fetus for initiating respirations immediately after birth. Which change in fetal physiologic activity is not part of this process? Fetal lung fluid is cleared from the air passages during labor and vaginal birth. Fetal partial pressure of oxygen  $PO_2$  decreases. Fetal partial pressure of carbon dioxide in arterial blood  $PaCO_2$  increases. Fetal respiratory movements increase during labor. D Fetal respiratory movements actually decrease during labor. Which description of the four stages of labor is correct for both the definition and the duration? A Full dilation may occur in less than 1 hour, but in first-time pregnancies full dilation can take up to 20 hours. The second stage of labor extends from full dilation to birth and takes an average of 20 to 50 minutes, although 2 hours is still considered normal. The third stage of labor extends from birth to the expulsion of the placenta and usually takes a few minutes. The fourth stage begins after the expulsion of the placenta and lasts until homeostasis is reestablished approximately 2 hours. Nurses should be cognizant of what regarding the mechanism of labor? Seven critical movements must progress in a more or less orderly sequence. Asynclitism is sometimes achieved by means of the Leopold's maneuver. Effects of the forces determining descent are modified by the shape of the woman's pelvis and the size of the fetal head. At birth, the baby is said to achieve restitution; that is, a return to the C-shape of the womb. C The size of the maternal pelvis and the ability of the fetal head to mold also affect the process. The seven identifiable movements of the mechanism of labor simultaneously occur in combinations, not in precise sequences. Asynclitism is the deflection of the baby's head; the Leopold's maneuver is a means of judging descent by palpating the mother's abdomen. Restitution is the rotation of the baby's head after the infant is born. Which statement related to fetal positioning during labor is correct and important for the nurse to understand? Position is a measure of the degree of descent of the presenting part of the fetus through the birth canal. The largest transverse diameter of the presenting part is the suboccipitobregmatic diameter. Engagement is the term used to describe the beginning of labor. B The station of the presenting part should be noted at the beginning of labor to determine the rate of descent. Position is the relationship of the presenting part of the fetus to the four quadrants of the mother's pelvis; station is the

measure of degree of descent. The largest diameter is usually the biparietal diameter. The suboccipitobregmatic diameter is the smallest, although one of the most critical. Engagement often occurs in the weeks just before labor in nulliparous women and before or during labor in multiparous women. Which basic type of pelvis includes the correct description and percentage of occurrence in women? What is the nurses understanding of the appropriate role of primary and secondary powers? Primary powers are responsible for the effacement and dilation of the cervix. Effacement is generally well ahead of dilation in women giving birth for the first time; they are closer together in subsequent pregnancies. Scarring of the cervix caused by a previous infection or surgery may make the delivery a bit more painful, but it should not slow or inhibit dilation. Pushing in the second stage of labor is more effective if the woman can breathe deeply and control some of her involuntary needs to push, as the nurse directs. A The primary powers are responsible for dilation and effacement; secondary powers are concerned with expulsion of the fetus. Effacement is generally well ahead of dilation in first-time pregnancies; they are closer together in subsequent pregnancies. Scarring of the cervix may slow dilation. Pushing is more effective and less fatiguing when the woman begins to push only after she has the urge to do so. Which statement regarding the care of a client in labor is correct and important to the nurse as he or she formulates the plan of care? The womans blood pressure will increase during contractions and fall back to prelabor normal levels between contractions. The use of the Valsalva maneuver is encouraged during the second stage of labor to relieve fetal hypoxia. Having the woman point her toes will reduce leg cramps. Endogenous endorphins released during labor will raise the womans pain threshold and produce sedation. D The endogenous endorphins released during labor will raise the womans pain threshold and produce sedation. In addition, physiologic anesthesia of the perineal tissues, caused by the pressure of the presenting part, decreases the mothers perception of pain. Blood pressure levels increase during contractions but remain somewhat elevated between them. The use of the Valsalva maneuver is discouraged during the second stage labor because of a number of unhealthy outcomes, including fetal hypoxia. Pointing the toes can cause leg cramps, as can the process of labor itself. Which adaptation of the maternal-fetal exchange of oxygen occurs in response to uterine contraction? The maternal-fetal exchange of oxygen and waste products continues except when placental functions are reduced. This maternal-fetal exchange increases as the blood pressure decreases. It diminishes as the spiral arteries are compressed. This exchange of oxygen and waste products is not significantly affected by contractions. C Uterine contractions during labor tend to decrease circulation through the spiral electrodes and subsequent perfusion through the intervillous space. The maternal blood supply to the placenta gradually stops with contractions. The exchange of oxygen and waste products decreases. The exchange of oxygen and waste products is affected by contractions. Which statement is the best rationale for assessing the maternal vital signs between uterine contractions? During a contraction, assessing the fetal heart rate is the priority. Maternal circulating blood volume temporarily increases during contractions. Maternal blood flow to the heart is reduced during contractions. Vital signs taken during contractions are not accurate. B During uterine contractions, blood flow to the placenta temporarily stops, causing a relative increase in the mothers blood volume, which, in turn, temporarily increases blood pressure and slows the pulse. Monitoring fetal responses to the contractions is important; however, this question concerns the maternal vital signs. Maternal blood flow is increased during a contraction. Vital signs are altered by contractions but are considered accurate for that period. What is the primary difference between the labor of a nullipara and that of a multipara?

### Chapter 5 : About Your Privacy on this Site

*The third stage of labor lasts from the birth of the fetus until the placenta is delivered. This stage may be as short as 3 minutes or as long as 1 hour. The fourth stage of labor, recovery, lasts about 2 hours after delivery of the placenta.*

### Chapter 6 : Childbirth - Wikipedia

*Labor and Birth Processes Chapter DEITRA LEONARD LOWDERMILK 11 â€¢ Explain the five factors that affect the*

## DOWNLOAD PDF LABOR AND BIRTH PROCESSES

*labor process. Describe the anatomic structure of the bony.*

### Chapter 7 : Labor and Birth Processes | midwife reference | Pinterest | Midwifery, Ob nursing and Birth

*What are the stages of labor and birth? The process of labor and birth is divided into three stages: The first stage begins when you start having contractions that cause progressive changes in your cervix and ends when your cervix is fully dilated.*

### Chapter 8 : Stages of Labor: Early Labor, Active Labor & Transition Stage

*Placenta rarely impedes the process of labor in a normal vaginal birth, except in the case of sutures and fontanelles Allow flexibility of the skull in order to accommodate the infant's brain during birth.*

### Chapter 9 : Chapter 13 Labor And Birth Process Flashcards by Jasmin Lacy | Brainscape

*Labor is the process of moving the fetus, placenta, and membranes out of the uterus and through the birth canal. Various changes take place in the woman's reproductive system in the days and weeks before labor begins.*