Organization of Perinatal Nurses’ Work Following Epidural Insertion

By

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Abstract

The perinatal nurse’s work is influenced by the particular needs of each labouring women as well as by institutional discourses and textually mediated work processes that guide obstetrical care in hospital. Institutional Ethnography (IE) was used to explore the work performed by perinatal nurses in relation to the pain management of women labouring with mobile labour epidural analgesia. The data collection process involved interviews with five perinatal nurses working in a tertiary care centre in British Columbia and an in-depth review of the institutional texts used by these nurses.

The perinatal nurse’s work associated with the initiation and maintenance of the epidural involves a constant re-prioritizing of the nurse’s actions and interventions in order to attend to multiple demands associated with the care of a labouring woman. The nurse’s extensive knowledge work requires an awareness of the effects of the epidural on maternal and fetal wellbeing and the labour progress. The nurse’s work of promoting effective pain relief is managed separately from the process of supporting labour and birth.

Once the epidural is inserted and the contraction pain alleviated, all manifestations of pain are perceived as problematic. Within the context of epidural management, the goal becomes taking every measure possible to alleviate the presence and re-occurrence of contraction pain. The nurse’s work of mobilizing a labouring
woman with an epidural involves an additional layer of assessment and evaluations which require additional work on the part of the nurse. The nurse must choose and prioritize the care she provides to the labouring woman. Needing to focus more intensely on the safety of the labouring woman and her fetus, alongside ensuring the required epidural work processes are completed, results in mobility falling to the lowest priority level within the nurse’s epidural management work. The textually mediated work processes embedded in the intuitional policies and forms associated with epidural management reinforce this hierarchy of priorities and directly structure the nurse’s work time away from providing care that supports women to cope with labour pain and encouraging mobility to promote labour progress. The various hospital forms, policies and guidelines coordinate and organize the nurse’s epidural work so that promoting mobility is subsumed; potentially increasing the risk of labour dystocia and caesarean birth for women labouring with a mobile labour epidural analgesia.
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Dedication

Dedicated with love to Garry, Sabrina and Matthew
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Chapter 1

Why don’t RNs mobilize more women following initiation of “Mobile Labour Epidural Analgesia”?

Over the last century dramatic change has occurred in the pain management options for labouring women (Wong, 2009; Gogarten and Aken, 2000). The progress in neuraxial techniques, the advent of low and ultra-low dose epidural, combined-spinal analgesia and patient-controlled epidural analgesia have replaced the “traditional” epidural for labour (Poole, 2003; Wong, 2009). These advancements in neuraxial analgesia are redefining what constitutes effective and safe pain relief for women in labour by preserving maternal mobility (Preston, 2010). The shift from dense-regional block anaesthesia to minimum motor blockade neuraxial analgesia is also changing the work performed by perinatal nurses when caring for labouring women. The low dose epidural blockades permits an increase in mobility and offers the possibility for nursing care to mitigate the risks of dystocia for women labouring with an epidural (Mayberry, Strange, Dunphy Suplee and Gennaro, 2003).

The perinatal nurse’s work that is associated with the care of the woman labouring with an epidural is complex. The nurse’s work is influenced by the particular needs of each labouring women as well as by institutional discourses and textually mediated work processes that guide obstetrical care in hospital. Macro-institutional policies and practices in healthcare facilities organize the perinatal nurses’ work according to dominant biomedical and medico-legal discourses rendering nurses’ work and contributions to the overall care of labouring women invisible (Quance, 2007). At the micro level, the individual practice patterns of anaesthetists, obstetricians, family
practice physicians and midwives further frame, coordinate and direct the work performed by perinatal nurses (Quance, 2007).

The work performed by perinatal nurses is therefore influenced and regulated by institutional and interprofessional relations which direct the delivery of nursing care. I used Institutional Ethnography (IE) as a means to explore the institutional and interprofessional relations that organized the pain management work performed by perinatal nurses when caring for women labouring with mobile forms of labour epidural analgesia. In this study, I sought to understand how the nurses’ everyday activities, actions, and practices in relation to the overall care of women labouring with an epidural are shaped and coordinated within the institutional order of the hospital (Smith, 2006; Quinlan 2009). The disjunction between my personal experience of providing care to labouring women and the invisibility of my nursing work in caring for women labouring with an epidural represents the problematic which guided and directed the development of my IE research project. The narrative of my personal experience therefore represents the starting point of my institutional ethnographic research study.

**Problematic from My Practice**

It was seven o’clock in the morning and shift change for nurses working on the Single-Room Maternity Care Unit at British Columbia Women’s Hospital. I was assigned to the care of a labouring woman. This labouring woman was primiparous and was admitted to the unit early the previous evening. At the time of her admission she was 6 cm and progressed to 8 cm before receiving an epidural at around 11 PM. The epidural was effective in managing her pain allowing her to rest on and off throughout the night. This woman’s labour never progressed past 8 cm and she was diagnosed at around five
o’clock in the morning with “first stage arrest” (i.e. labour did not progress beyond the first stage of labour) which would require a caesarean section. During the report, the night nurse informed me that all preoperative preparations were completed and we were waiting for the go ahead to transfer this woman to the operating room. Shortly after the morning hand-over report, the Charge Nurse provided me with an up-dated plan of care. The caesarean section for this woman would be delayed until 8:30 AM because of ongoing emergencies in the operating room.

Knowing that transfer to the operating room was not imminent, I proceeded with my nursing assessment (i.e. fetal heart rate, contraction patterns, vital signs, sensory & motor block, abdominal palpation, etc.) of this woman and reviewed the nursing notes written during the night. It became clear to me that this woman’s first stage arrest of her labour was caused by fetal position. My abdominal palpation assessment clearly indicated that the baby was in a direct occipito-posterior (OP) position. This labouring woman had all the clinical signs associated with posterior position. The review of the night nurse’s documentation revealed that this woman’s epidural, while providing effective pain relief also produced a heavy motor block which was preventing this woman from mobilizing and changing her position in such a way as to promote the natural physiological process of labour. This woman had spent most of the night labouring in the lateral or supine with a wedge position. Although my options to reposition this labouring woman to facilitate fetal rotation were limited due to her heavy motor block, I decided to attempt to have her assume the prone position. As I explained my plan of care to her, I emphasized that it may be possible for the baby to rotate into a more favourable position. I also explained that she may be able to avoid a caesarean
section. Within 20 minutes of repositioning her in the prone position, the woman informed me that she was now feeling pressure and was having the urge to bear down. With her consent, I did a vaginal examination. The fetal head was visible at the introitus and this woman delivered vaginally within 20 minutes.

Repositioning this woman with a significant motor block into the prone position was very difficult. It required assistance from her husband and multiple pillows to support her legs, abdomen and head. This simple nursing intervention, although very effective in promoting the natural physiological process of labour and spontaneous vaginal delivery, was complicated by the side effects of the epidural which created a less than optimal clinical context in which I could reposition this labouring woman.

This experience reaffirmed for me the importance of preserving maternal mobility following epidural insertion. I realized that morning that the nurse’s ability to mobilize labouring women with epidurals can directly influence the natural physiological process of labour and ultimately the mode of delivery.

This experience awakened my interest in improving the epidural policy at our hospital and working more closely with anaesthesia to identify an appropriate plan of care for nursing care for women labouring with an epidural which would incorporate effective pain relief and preserve maternal mobility. Through my interactions with anaesthetists and hospital administrators I came to realize that the work done by nurses when they care for women in labour following epidural insertion was not well understood. The plan of care for epidural management for woman in labour was defined within a medical paradigm of “painless labour equals good labour” (Preston, 2010, p. 104). However, consideration was not given to the importance of preserving maternal
mobility or to the role of nurses in supporting the labouring woman once the epidural was in place.

The disjuncture between my personal experience of providing care for labouring women and the invisibility of my nursing work in caring for women labouring with an epidural guided and directed the development of my IE research project. The above narrative of my personal experience therefore represents the starting point (or problematic) for this institutional ethnographic research study.
Chapter Two

In this chapter, I present my analysis and critique of the research literature, which will address; the labour support discourse; work sampling studies, intervention studies; women’s expectation; evaluation and perceptions of labour support provided by nurses; the meaning of the nurse presence during childbirth; the nurse’s work associated with epidural care and nurse’s mobilization work.

Literature review

Labour support as a discourse

Labour support has been a prevalent discourse within the perinatal nursing literature to describe and understand the complexity of nursing care provided to labouring women in the hospital. Labour support is a term used by perinatal nurses and researchers alike to describe the supportive care/work provided to labouring women (Sauls, 2006). To establish a scientific base for intrapartum nursing practices, numerous research studies have attempted to define professional labour support by identifying the various elements of supportive care (i.e. physical, advocacy, emotional, informational and technical care) as well as the specific nursing behaviours associated with each element (Adam and Bianchi, 2008; Bianchi and Adams, 2009; Corbett and Callister, 2000; Miltner, 2000; Sauls, 2002; Saul, 2004; Sauls 2006; Sleutel, 2002).

Most of these research studies focus on the nurses’ perspective of professional labour support and use descriptive survey research designs. A social support framework and research-derived definitions are used to conceptualize professional labour support (Sault, 2004). Lazarus’ Cognitive Theory of Stress and Coping is the most prevalent theoretical framework used by researchers to study labour support (Corbett and Callister,
Lazarus’ theoretical framework identifies three categories of support which include emotional, tangible and informational. Sauls (2004) further theorizes the intrapartum nurse interactions with the labouring woman by adding “advocacy” as a fourth labour support category to Lazarus’ theoretical framework.

Early research conducted by Miltner (2000) used a Delphi survey research technique as the foundational base for defining professional labour support. Miltner (2000) used the research literature, the Nursing Classification system, field observations and interviews with antepartum nurses as the underlying ground work to formulate her labour support definition. The author identified 55 specific supportive care nursing actions which range from psychological support such as reassurance and encouragement, to physical comfort measures such as position change.

Adams and Bianchi (2008) and Bianchi and Adam (2009) combined a social support framework and research-derived definitions to conceptualize their 21 Nursing Labour Support Behaviours list. Bianchi and Adams (2009) conceptualized professional labour support as “behaviours to be practiced” by the intrapartum nurse which address the needs of the labouring woman.

Hence, in most of these studies, the researcher’s conceptualization of professional labour support (theoretical, research derived or both) guided and directed the development of their research design and ultimately the lens through which their findings were analysed. The conclusions drawn from these research studies may not represent the everyday reality of intrapartum nurses’ practices in the context where I work or following the insertion of an epidural.
Work Sampling

Nursing researchers have attempted to understand the delivery of supportive care by nurses in the hospital setting by using descriptive observational research designs involving two basic methodologies: work sampling and time studies. Work sampling is based on random observation of the nurse’s work and estimates the proportion of time nurses spend providing specific labour support activities using a predetermined labour support activity list (McNiven, Hodnett, and O’Brien-Pallas, 1992; Gagnon and Waghorn, 1996; Gale, Fothergill-Bourbonnais and Chamberlain, 2001). The predetermined labour support activities are separated into two general categories which are supportive and non-supportive. The supportive category is further broken down into four main categories previously identified by Hodnett and Osborn (1989). The four categories are emotional support, physical comfort measures, information/instruction and advocacy (McNiven et al., 1992; Gagnon and Waghorn, 1996; Gale, Fothergill-Bourbonnais and Chamberlain, 2001).

The work sampling studies conducted in acute care settings have identified that nurses spend only 6.1% to 12.4% of their time providing supportive care to labouring women (McNiven et al., 1991; Gagnon and Waghorn, 1996; Gale et al., 2001). In these studies nurses spent on average 75% of their time outside the labouring women’s room. When in the room, a significant amount of nurse’s time was dedicated to the provision of non-supportive care activities such as assessment and technological tasks (McNiven et al., 1991; Gagnon and Waghorn, 1996). Experienced nurses also tended to spend less time providing labour support than new nurses (Gagnon and Waghorn, 1996).
In addition to work sampling studies, Gale et al. (2001) conducted semi-structured interviews to identify the factors influencing the provision of labour support by nurses. The authors noted that nurses focused “on obtaining epidural analgesia for the labouring woman as being a key component of nursing support” (p.268). The authors identified that despite a unit policy of one-on-one nurse-to-patient ratio during labour, insufficient staffing was an important factor that prevented nurses from engaging in labour support activities. Additional barriers identified by Gale et al. (2001) were rigid adherence to institutional policies, the nurse’s desire to maintain control over the birth process, and technologies that contributed to the perceived lack of time for labour support activities.

McNiven et al. (1991), Gagnon and Waghorn (1996), and Gale et al. (2001)’s work sampling research studies are methodologically sound and have conducted more observations than required (Quance, 2007). However, the authors have studied complex nursing behaviours which may not be effectively measured using a work sample methodology. The methodology used by each study allowed the researchers to collect data on only one nursing activity at the time which may explain the low percentage of nurses time spend in supportive activities as found in these work sampling studies. In addition, all three studies utilized Hodnett and Osborn’s (1989) four labour support categories and support activities list. These labour support categories were initially developed to study the effects of labour support provided by labour coaches or doulas on obstetrical outcomes and therefore may not fully represent the complexity of nurses’ work, which includes labour support along with keeping women and babies safe during labour and birth and during medical interventions (MacKinnon, 2011).
The low percentage of labour support activities performed by nurses in both the McNiven et al. (1991) and Gagnon and Waghorn (1996) studies may also have been influenced by the overall hospital epidural rate of 80% and 68.5% respectively. The work performed by nurses while caring for labouring women changes once the mother receives an epidural (Quance, 2007). Quance (2007) reported that once the labouring woman receives an epidural “the nurse seldom touches the mother” (p.292). The nurse’s work is changed by the need to focus on maternal/fetal assessment following epidural insertion such as collecting and documenting data from the various monitors required. The nurses continued to provide information and instruction while the labouring woman rested; however the advocacy aspect of her care was greatly diminished once the epidural was in place (Quance, 2007).

Miltner (2002) on the other hand, recognized the multidimensional features of intrapartum nursing care provided in hospital and stated that:

“Close observation and monitoring of labor status, maternal health status and fetal status are necessary to ensure safe outcomes. Moreover, pain management is an important aspect of the intrapartum nursing role and requires a wide range of both supportive and technical interventions based on patient preferences and labor status” (p.754).

Miltner (2002) integrated the technical and supportive aspects of intrapartum nursing care within her conceptual framework, the Intrapartum Care Management Model. The Intrapartum Care Management Model is based on Donebedian’s quality assessment model (i.e. structure, process, outcomes) which examined “the relationship between nursing staffing levels, patient medical acuity, and intrapartum nursing care to explore
whether the lack of available time predicted the amount of supportive care provided” (p.754).

Miltner’s (2002) research differed from previous work sampling studies by considering the complexity of the intrapartum nurse’s care provided in hospital. Miltner’s (2002) Intrapartum Care Management Model informed the development of the Intrapartum Nursing Observation Tool. The Intrapartum Nursing Observation Tool incorporated the technical and interpersonal aspects of intrapartum nursing care by identifying activities that are specific to the nursing profession. In addition, the complexity of nursing work is also taken into account within Miltner’s (2002) methodological approach. Miltner’s (2002) methodology allowed the researcher to simultaneously collect data on more than one nursing activity. Miltner (2002) found that nurses engaged in supportive care activities much more frequently than previously identified by work sampling studies. Her (2002) research findings indicated that nurses provided at least one supportive care intervention during 31.5% of the observation time as opposed to 9.9% (McNiven et al., 1991), 6.0% (Gagnon & Waghorn, 1996) and 12.6% (Gale et al.2001).

Barnett’s (2008) observational, descriptive time study used a computerized program to simultaneously measure time and the supportive care activities provided by nurses to a labouring woman. Barnett (2008) also used the four labour support categories and 23 supportive care nursing activities originally identified by Hodnett and Osborn (1989). An additional category was defined by the author which is “other professional activities”. This category included assessing the woman or her fetus, performing or assisting with medical procedures, documenting, notifying a healthcare provider, and
teaching people other than the support persons or patient (such as nursing or medical students). Rather than following the nurse from room to room, the observer remained in a single patient’s room to observe and recorded the nurse’s time and supportive care activities.

Barnett’s (2008) findings indicated that nurses spend 40% of their time providing supportive activities (emotional support 15%, physical support 8%, informational support 16% and advocacy 1%) to the labouring woman. In addition, 63% of nurses’ time in the patient room was occupied in “other professional activities” such as: teaching students, documenting, notifying, assessing, applying electronic monitoring, maintaining equipment, procuring supplies, and assisting other professionals (Barnett, 2008). Barnett’s (2008) research simultaneously measured various supportive activities but was limited to observations performed in the labouring woman’s room.

The study was also conducted in a hospital centre where nurses were routinely assigned more than one woman. Eighty percent of the nurses cared for two to four women and their fetus during the observation period. Barnett also reported that when taking into account the duration of the active phase of labour, a labouring woman receives nursing support for only 13% of that phase. Miller (2002) concluded that nurses spend much less time in supportive care activities when assigned to more than one patient. These researchers also noted that multi-tasking occurred 22% of the time that nurses were in the room with their patients which may better reflect the complexity of the intrapartum nurse’s work. The epidural rate of 97% may also have influenced the percentage of supportive care activities provided by nurses (Quance, 2007).
**Intervention Studies**

In an attempt to promote one-on-one nursing care for labouring women, various studies have explored the benefits of supportive care provided by nurses on labour processes and outcomes. Hodnett, Gates, Hofmeyr and Sakala (2007) conducted a systematic review of sixteen randomized control trials involving 13,391 women to assess the effects of continuous labour support by professionals (e.g. nurses, midwives) and non-professionals (e.g. doulas) on maternal and neonatal outcomes. The results of the review indicate that women who receive continuous intrapartum support were more likely to have shorter labour and spontaneous vaginal delivery as well as less likely to have intrapartum analgesia or to report dissatisfaction with their childbirth experience (Hodnett et al., 2007). In addition, the continuous intrapartum support had greater benefits when the provider was not a member of the hospital staff, began early in labour, and occurred in settings where epidural analgesia was not routinely available (Hodnett et al., 2007). These findings may reflect contextual differences that affect the competing demands on the nurse’s time which make continuous labour support difficult to provide.

These randomized controlled research trials focused on the effects of different forms of supportive care on labour outcomes and included both professional and “lay” (non-professional) support. Although the trials included in the systematic review (Hodnett et al., 2007) had similar components and research designs, the setting in which the trials occurred varied greatly from crowded public wards in Guatemala to a quiet birthing unit in Canada (Gale et al., 2001). Each participating institution in these various randomized controlled trials had their specific policies/procedures and culture which influenced the delivery of care to labouring women (Hodnett et al., 2002). These
researchers concluded that the organizational culture and birthing environment also powerfully influenced how labour support was provided (Hodnett et al., 2002; Gagnon, Waghorn & Covell, 1997).

**Women’s expectations, evaluation and perceptions of labour support provided by nurses**

Women bring to childbirth their personal expectations of the nurse’s role and ideas about the type of supportive care they would like to receive from the labour and delivery nurse during their birth experience (Mackey and Lock, 1989; Tumblin and Simkin, 2001). Pregnant women expect their nurse to provide physical, emotional, and informational support which is demonstrated by promoting comfort, providing calm reassurance and assisting with breathing/relaxation techniques (McKay and Smith, 1993; Tumblin and Simkin, 2001; Bowers, 2002). Pregnant women also expect the nurse to keep them informed about their progress, focus on their individual needs, and help them achieve a positive birth experience (Tumblin and Simkin, 2001).

Research addressing the labouring women’s evaluation of nursing care provided during the birthing experience is limited. Mackey and Stepans (1994) found that nurses’ interpersonal skills were the deciding factor for labouring women in evaluation of nursing care. Labouring women who positively evaluated their nurse were pleased with the manner in which nurses provided and carried out their care during their labour. Elements of nursing care that were positively evaluated by labouring women were the nurses’ participation, acceptance, information giving, encouragement, presence and competence (Mackey and Stepans, 1994). The nursing behaviours perceived by labouring women as the most helpful included: giving praise, following birth plans, appearing
calm/confident, assisting with breathing/relaxing, accepting the woman’s behaviour, and treating the woman with respect (Kintz, 1986; Bryanton, Fraser-Davey and Sullivan, 1993; Fleming, Smart and Eide, 2011). Labouring women perceived emotional support as making them feel cared about as an individual and rated this form of nursing support as the most helpful and important (Bryanton, Fraser-Davey, Sullivan, 1993; Corbett and Callister, 2000; Winfield Manogin, Bechtel and Rami, 2000).

The limitations of studying labour support from the perspective of the labouring women are that labouring women tend to describe nursing care activities that are the most important to them (Mackey and Lock, 1989). In the research studies addressing the labouring woman’s perceived helpfulness of nursing labour support it is unclear if the labouring women are evaluating the nurses’ labour support activities or the nurses’ interpersonal skills (Kintz, 1987).

Furthermore women’s expectations of labour support provided by nurses are influenced by past experience and knowledge. Bowers (2002) and Mackey and Lock (1989) studied labouring women’s expectations of labour support provided by nurse. They noted that multigravidas expectations were influenced by previous childbirth experiences; whereas primigravidas preconceived ideas of labour and birth were influenced by information provided during prenatal classes, media exposure, and attendance at the labour/birth of friends or relatives. Labouring women’s evaluation of nursing labour support is also influenced by institutional processes, such as nursing staffing levels, and nurse/women/fetus ratio that is provided in particular hospitals.

The epidural rate and the use of technology (i.e. electronic fetal monitoring) also influence the labouring women’s perception of the supportive care provided by nurses.
Women who had initially experienced giving birth without medication and who for their subsequent births received an epidural identified a loss of independence and a reliance on nurses to inform and guide them on their pushing technique and progress (Fleming, Smart and Eide, 2011). In this study, the women’s perception of nursing care after the insertion of the epidural was that nurses were less attentive to their overall needs.

**The meaning of the nurse’s presence during childbirth**

MacKinnon, McIntyre and Quance (2005) research was the only study found that explored the meaning of the nurse’s presence during labour and birth. Labouring women highly valued the presence and support work of the intrapartum nurse. The meaning of the nurse’s presence was based on a mutual relationship where the labouring woman gets to know and trust the nurse. The authors emphasise that “the women’s experiences of the nurse’s presence cannot be understood apart from institutional structures and work process of the hospital that shape their birthing experience.” (MacKinnon et al., 2005, p.33). Institutional discourses, structures and work processes can render invisible the work performed by nurses to promote and foster a trusting and mutual relationship with the labouring women. Without such relationship, the care provided by nurses would be ineffective in addressing the physical and emotional needs of the labouring women.

**Nurses’ work and epidurals**

The nursing literature addressing the work of perinatal nurse with regard to care of labouring women with an epidural is scant. The available nursing literature focused mainly on anatomy and physiology of the spine, pharmacology, indications and contraindications, side effects, risks and overall required nursing knowledge and assessment skills associated with the management of epidural infusion (Nicholson and
Davis, 1999; Bird and Wallis, 2002; Mayberry, Clemmens and De, 2002; Poole, J. H., 2003; Bird, Wallis and Charboeyer, 2009; Chumbley and Thomas, 2010).

One observational study (Gilder, Mayberry, Gennaro and Clemmens, 2003) identified multiple barriers to encouraging mobility or up-right positions for women labouring with an epidural. The researchers found that women labouring with an epidural require varying degrees of both physical and psychological support to achieve the goal of remaining upright during labour and birth. These researchers also surveyed perinatal nurses to learn more about nurses' practices of positioning and ambulating women with epidurals. They found that “hospital policies were either conservative or prohibitive with regard to women getting out of bed or walking” or “that most of the women were on pitocin and the doctors did not want them to ambulate” (Gilder, Mayberry, Gennaro and Clemmens, 2002, p.44).

In the review of the available nursing literature, only one research study was found to address the work performed by perinatal nurses when caring for labouring women in pain and how their work changed once an epidural is ordered (Quance, 2007). Quance (2007) found that the work performed by nurses while caring for labouring women with an epidural was influenced by biomedical and medico-legal discourses of healthcare institutions and the individual practices of the primary care provider. Quance (2007) further stated that the nurse’s work was invisible in patient documentation.

Biomedical and medico-legal discourses and the lack of understanding about the contribution of the perinatal nurse’s work associated with neuraxial analgesia are also prevalent within the medical research literature. The medical research literature addressing epidural anaesthesia and analgesia focuses on the anatomy and physiology
(Hawkins, 2010), indications and contraindications of epidural infusion (Skobel, 1996; Poole, 2003), risks and benefits (Lieberman, 1999), drugs used for epidural anaesthesia and analgesia (Harpen and Carvalho, 2009), mode of infusion for epidurals (Vallejo, Ramesh, Phelps and Sah, 2007; Bernand et al., 2010), and the effects of traditional/low-dose/combined spinal epidural on the labour process and maternal mobility (Roberts, Algert and Olive, 2004; Vallejo, Firestone, Mandell, Makishima and Ramanathan, 2001; Wilson, MacArthur, Cooper and Shennan, 2009; Halpen and Carvalho 2009). In the review of the available medical research literature, none of the studies made reference to the influence or potential impact of nursing care in relation to the management of neuraxial analgesia for women in labour.

**Nurse’s mobilization work**

The research literature addressing perinatal nurses’ work associated with mobilization to mitigate the risk of dystocia and potential caesarean section is limited. In woman labouring without an epidural, the potential advantages of mobilization during the first and second stage have been reported in several studies during past two decades (Mayberry, Strange, Dunphy Suplee and Gennaro, 2003). Numerous studies have shown the negative effects of supine positions on maternal circulatory function, placental perfusion and frequency/duration of contractions (Lawrence, Lewis, Hofmeyr, Dowswell and Styles, 2009). Mobility was also identified as the primary contributor to the labouring woman’s sense of control, self-regulation and perceived comfort during first stage of labour (Lawrence, Lewis, Hofmeyr, Dowswell and Styles, 2009).

However, the use and effects of various labour positions have not been studied in conjunction with the low dose epidural blockade analgesia which was initially designed
to permit increased labour mobility (Mayberry, Strange, Dunphy Suplee and Gennaro, 2003). No published studies were found about alternating maternal positions to increase maternal comfort when confined for long duration to the labour bed (Mayberry, Strange, Dunphy Suplee and Gennaro, 2003; Gilder, Mayberry, Gennaro and Clemmens, 2002). No research studies addressing how maternal position should be modified following epidural insertion were found (Gilder, Mayberry, Gennaro and Clemmens, 2002). The ability of women who receive neuraxial epidural analgesia to maintain mobility and assume various upright positions, has also not been studied (Mayberry, Strange, Dunphy Suplee and Gennaro, 2003; Gilder, Mayberry, Gennaro and Clemmens, 2002). As such, an important gap exists in the current research literature where the nurse’s mobilization work following epidural insertion is not well understood and requires further investigation.

In summary, this literature review has identified that epidural analgesia is a common medical intervention. There is, however, limited research which addresses how nurses conduct their work when caring for labouring women with an epidural. The degree to which nurses provide labour support decreases once the epidural is in place, as the nurses’ work changes and becomes focused on management of technology and monitoring. There was no research study found which effectively addressed the nursing care associated with the mobilization of labouring women with an epidural. There are hints in the literature of the effects of institutional and inter-professional relations on nurse’s work, however, there is no clear description of how these institutional processes coordinate and organize nurse’s work as she provides care to a labouring woman with a labour mobile epidural analgesia. This IE study will consider this question.
Chapter Three

In this chapter, the methodology of IE is discussed. The research questions, focus and significance of the study are further described as well as information addressing participant involvement, why the site of the study was chosen and how the data were collected.

Methodology

Institutional Ethnography as an Approach to Inquiry

Institutional ethnography (IE) is a qualitative approach to inquiry which is used to explore the work process of individuals and how their everyday activities, actions, or practices are shaped and coordinated within an institutional order (Smith, 2006; Quinlan 2009). IE is based on a realist ontology that is materialistic in nature and explores the social organization of individual everyday practices and the interaction of those practices with material objects such as written texts, pictures, video etc. (Smith, 2006; Quinlan 2009).

IE is inductive and moves from the everyday actualities and practices of individuals to an overall analysis of the translocal social relations (Quinlan, 2009). Smith (2006) refers to these translocal social relations as ‘ruling relations’ (p.17). “Ruling relations” refers to the socially-organized exercise of power that coordinates and shapes individual’s actions and their lives (Campbell and Gregor, 2004). These ruling relations or translocal relations represent forms of consciousness that objectify, organize and control the practice of individuals within an institutional order (Smith, 2006). The intent of IE is to focus on the everyday experiences of the informants while at the same time connecting the everyday practice to the social organization that governs or rules the local
setting (Quinlan, 2009; McCoy, 2006; Smith 2006). As such, the standpoint of IE or the entry point is the discovery of “the social while not subordinating the knowing subject to objectified forms of knowledge” (Smith, 2005, p.10).

Reproducible texts are essential to the practice of institutional ethnography as they allow one to move “beyond the locally observable into the translocal social relations and organization that permeate and control the local” (Smith, 2006, p.65). Texts are stable and read across time and place, reproducing in material form the ruling relations of the institution (Smith, 2006; Quinlan, 2009). “The constancy of texts provides for standardisation of people’s actions” (p.629) and renders visible the organization and coordination of institutional social processes (Quinlan, 2009). As such, individuals activate the texts while at the same time anchoring the local actualities into the translocal social relations or ruling relations (Smith, 2006).

The overall aim of IE is transformative in nature and seeks to make visible the social relations so they might be better understood. Each selected informant contributes to the discovery of the institutional social process and ruling relations which coordinate and shape their everyday experiences and activities. As such, IE contributes to progressive social change within an institutional order (Quinlan 2009).

IE is used as a method of inquiry in various health related research studies. Mykhalovsky and McCoy (2002), explore how the health work of people living with HIV/AIDS is shaped by the various health care and social services. Rankin (2003) investigated how a patient satisfaction survey in hospital was structured by a dominant consumer oriented healthcare discourse which displaced what the patient wanted to say about corrective actions to improve patient care. MacKinnon (2006) used IE to explore
women’s everyday experiences of living with the threat of preterm labour. MacKinnon (2008) also studied the complexity of rural nursing practice and described rural nurses’ everyday experiences of providing maternity care. Quinlan (2009) investigated how the ‘knowledge work’ of multidisciplinary health care teams is conducted and how it is coordinated across the hospital setting. As such each of these researchers have used IE to explore the work process of individuals (Mykhalovsky and McCoy, 2002), patients in hospital (Rankin, 2003), women experiencing preterm labour (MacKinnon, 2006), nurses (MacKinnon, 2008; Rankin 2003), members of a multidisciplinary team (Quinlan, 2009) and how their everyday activities, actions, or practices are shaped and coordinated within community health services and the hospital system. I employed IE as the method for my inquiry to explore the work of labour and delivery nurses associated with the care of women labouring with a mobile epidural analgesia. The IE methodology focuses on social relations and provides a structure to explore and understand the effects of institutional and interprofessional relations on nurses’ work and how they coordinate and organize nurse’s epidural work and their ability to mobilize the labouring woman following epidural insertion

**Purpose of the study**

My intent was to explore how labour and delivery nurses in hospital settings 1) care for a woman with an mobile or neuraxial epidural analgesia and 2) how the nurses’ work is shaped and coordinated by institutional discourses about the management of pain for women labouring with an epidural and by current management practices that focus on efficiency and measurable short term outcomes.

**Significance of the study**
The perinatal nurse’s work has been studied from various perspectives and methodologies, each contributing to the understanding of a particular aspect of nurses’ work (Quance, 2007). In addition to providing labour support, the nurses’ work also consists of developing a trusting relationship with the labouring woman while keeping both the mother and her unborn baby safe throughout the process of labour and birth (MacKinnon, 2006). As such, the perinatal nurses’ work is broad and complex and requires social aptitudes as well as the ability to think critically and to make appropriate clinical decisions when performing specific tasks. In addition, the environment or context within which the nurses’ work is conducted either inhibits or promotes the adoption of best practices (Angus, Hodnett and O’Brien-Pallas, 2003), reducing the effect of nursing supportive care on women’s birth outcomes (Hodnett, Lowe, Hannah et al, 2003) and limiting the amount of time nurses spend in the room with the labouring woman (Gagnon and Waghorn, 1996). Quance (2007) was the only researcher in this literature review who investigated the social organization of labour and delivery nurses’ work experiences by mapping the social process of nurses’ labour pain work and the discourses and texts that organize this work. As such the nurse’s labour pain work as it relates to the care of a labouring woman with mobile labour epidural analgesia is not well understood and has received very limited attention in the research literature. This study will contribute to the understanding of how the nurse’s pain management work is shaped and coordinated by institutional discourses about the management of pain for women labouring with an epidural and by current management practices that focus on efficiency and measurable short term outcomes.

**Investigative Methods**
In this IE study, I build on Quance’s (2007) previous research about the organization of labour and delivery nurses’ pain work. The work of labour and delivery nurses associated with the care of women labouring with a mobile labour epidural analgesia represents the entry point for understanding how the nurses’ work related to labour pain is socially organized as an everyday practice in this research setting.

The study begins from the standpoint of the labour and delivery nurse working in the Birthing Program at BCW Hospital in Vancouver BC. It is the everyday experience of labour and delivery nurses as they provide care to a labouring women following epidural insertion that provides the starting point of this research study. In this respect, this research study does not address the nurses’ attitudes associated with medicalization of birthing process or the pharmacological management of labour pain. Rather this study focuses on how labour and delivery nurses in hospital settings care for women in labour with mobile epidural analgesia and how their work is shaped and coordinated by institutional discourses about the management of pain for women labouring with an epidural. In this context, this study explores the labour and delivery nurse’s preparation work for the epidural procedure, the assessing and monitoring work following epidural insertion, the work associated with the decision to mobilize the labouring woman, and how epidurals change the way the nurse does her/his work.

**Nurse participant recruitment**

Recruitment of labour and delivery nurse participants was conducted via an announcement send through the hospital email network and flyers posted on the unit. The announcement and flyers described the goal and purpose of the study and invited all interested labour and delivery nurses working in the Birthing Program at BCW’s Women
Hospital (BCWH) to participate. Interested nurses who wanted to volunteer responded by email or phone and an individual meeting was scheduled to answer any questions they had regarding the research study. During the meeting, if the nurse agreed to participate, a consent form was signed and a date for the interview was identified. At any time during the interview process the nurse was able to withdraw from the research study.

**Data collection methods**

I use three key approaches to data collection: interviews, reflective journals and textual analysis. An interview session was conducted with each participating nurse. The interview explored the work nurses do when providing care to women labouring with a mobile epidural analgesia. The interview was guided by open-ended questions and focused on obtaining (1) a chronological description of the work nurses do when providing care for woman labouring with a mobile epidural analgesia, (2) the nurse’s description of the knowledge and skill required in order to care for a woman labouring with a mobile epidural analgesia, (3) the nurse’s description of the texts she draws on in her work, (4) the nurse’s description of how she activates, responds and integrates the various documents associated with the management of the mobile epidural into her work (5) and how the texts associated with the care of women labouring with epidural analgesia are utilized in the Birthing.

Nurses were encouraged to reflect on their most recent experience of providing nursing care. The opening question to initiate the interview was: “Thinking about the woman you were most recently providing care for, please describe the care you provide to a labouring woman following the insertion of an epidural”. The interview was recorded and transcribed. The audiorecording and transcript were essential in order to
achieve a detailed and systematic interpretation of the data collected. As this was an emergent design, some nurses were asked more specific questions about the forms they completed during their routine work.

In addition, I completed a reflective journal after each interview. This reflective journal provided me with an opportunity to further reflect on the contexts within which the nurse conducted her work when caring for a woman labouring with an epidural (Banks-Wallace, 2008). Insights gained by reviewing the reflective journal provided direction about which questions were asked during a subsequent interview (Banks-Wallace, 2008). Participants were asked in advance if the researcher could contact them by e-mail should she have further questions about their interview transcript to clarify what was said. Ongoing consent was affirmed before additional information was collected.

The second level of data collection addresses the translocal social relations. At this level, the translocal social relations reach beyond the actualities and local practices of the labour and delivery nurse. These social relations were explored by interrogating the written, replicable texts and various hospital forms associated with the management of mobile labour epidural analgesia. Using this second level of data collection I attempted to unveil the processing interchanges which link the nurse’s work with the social relations of the hospital. I also attempted to identify the way the texts worked to structure or textually organized the nurses’ work. The forms were identified by the nurses during the interviews. Only blank forms were collected for the data analysis.

Analytic Methods
This institutional ethnography analysis focuses on explicating nurses’ work when caring for a labouring woman with a mobile epidural analgesia and how the institutional discourses and practices addressing the management of pain for women in labour shape and coordinate the nurse’s work. Smith (2006) defines work as the fundamental grounding for understanding social organization. The notion of “work” is an empirically empty word and refers to “what people do that requires some effort that they mean to do, and that involves some acquired competence” (As cited by Smith (2006); Smith (1987), p. 165). MacKinnon (2006) emphasizes that institutional ethnography begins without a preconceived understanding of work and includes any activities considered to be ‘workful’ (p.702).

This analysis drew on the labour and delivery nurses’ knowledge of their work to identify, trace and describe the institutional work processes and social organization that extends beyond their everyday practices (Campbell and Gregor, 2002). The analysis of written documents focus on identifying specific sets of activities or practices associated with the management of mobile epidural analgesia in the Birthing Unit at BCW’s Hospital.

I used McCoy’s (2006) approach to data analysis as a guide. This analysis explored:

1. The nurse experiences providing care for a woman labouring with a mobile epidural analgesia

2. The knowledge and skill required by the labour and delivery nurse in order to care for a woman labouring with a mobile epidural analgesia
3. How the labour and delivery nurse activates, responds to and integrates the various documents associated with the management of mobile epidural analgesia into her work.

4. How the replicable texts and various hospital forms about the management of mobile epidural are organizing the work of the labour and delivery nurse.

5. How the management of mobile epidural analgesia is articulated in the institutional texts and work processes in an acute perinatal setting.

As such, this analysis bring to light how the nurses’ everyday activities, actions, and practices in relation to the overall care of women labouring with an epidural are shaped and coordinated within the institutional order at BCW’s Hospital.

**Ethical Considerations**

I received ethical approval for this study from the University of Victoria Human Research Ethics Board and the University of British Columbia/Children’s and Women’s Health Centre of British Columbia Research Ethics Board. This study took place at British Columbia Women’s Hospital where I hold the position of Perinatal Clinical Educator (PCE). As such, I investigated the professional practices of labour and delivery nurses with whom working relationships have been previously established. My working relationship with the labour and delivery nurses in the Birthing Program is structured around clinical practice support and learning.

In my current role as PCE, I am responsible for course development/management and inter-professional teaching at the BCW’s Hospital. I am involved in policy drafting, committee chairing and program development. I am also a clinical resource on the unit
and provide support for nurses working in the Acute Perinatal Care Program (Birthing Program & Postpartum/Antepartum Program). As a researcher, I did not evaluate the quality of the nursing care provided and the nurses did not have a direct reporting relationship to me.

Research conducted in this context raised two important ethical issues; the first one associated with my dual-role as clinical nurse educator and researcher, and the second the issue of protection of nurses’ privacy/professional status while they are participating in the research study. To mitigate the effects of a dual-role relationship and potential influence on the nurse’s feeling obliged to participate in a colleague’s research, the nurse participant recruitment was conducted via an announcement send through the hospital Birthing Program general distribution email list, a presentation at a staff meeting, and flyers posted on the unit.

The participating nurses were assigned a pseudonym by which they are “known” in the data, published or presented materials. Nurse participant’s privacy was protected in the data collected. Identifiers were not written into field notes and were deleted when audio-recordings were transcribed. No forms that contain identifiers were collected.

Data was stored on a password protected computer and/or secured filing cabinet. All data will be destroyed after a period of five years or when the thesis is completed. I am the only person who has access to the contact information (e-mails or phone numbers) of the nurse participants. The nurse participants were informed that selected quotations and/or descriptions from the interview may be used in scholarly publications including this Master’s Thesis and articles in scholarly journals, and for conference presentations.
The researcher plans to arrange feedback visits to the clinical units to present summarized findings.

BCW’s Hospital was chosen as the site for this research study because of the existence of a specific epidural policy offered in the Birthing Program which focuses on preserving/promoting mobility for women in labour. This mobile epidural analgesia is a new approach to neuraxial analgesia and is not common practice in hospitals offering obstetrical care in British Columbia. The ability to mobilize a labouring woman with an epidural is an important element in this research study which may potentially influence nurses’ work following epidural insertion.

**Reflections on the research process**

Data were collected over a three month period. Interviews were recorded and conducted every two to three weeks to provide sufficient time to transcribe and analyse the transcript between each interview. The interviews were conducted in a quiet room off the unit. As a researcher who has worked as a staff nurse and is now working as a clinical nurse educator, I am very familiar with the work of providing care to labouring woman with a mobile labour epidural analgesia. It was difficult at the beginning not to let my nursing experience and assumptions lead the interview and let the interviewed nurse explained how she conducts her work while providing care to a woman with an epidural. The first interview was the most difficult since having never done this type of work I did not really know how or what to expect. The subsequent interviews were easier using my notes collected from previous interviews to prepare relevant questions.

I was very surprised with the candid nature of the conversation. Nurses were eager to share with me their thoughts about the care they provide to labouring women. I
had multiple “Ah ha” moments where I realised that my clinical practice as a staff nurse was coordinated and organized by the institutional processes that surround me when I provide care to labouring women. In my role as clinical nurse educator I am more aware of the impact of these institutional processes. In summary, the research design was sound and generated sufficient data to provide a clear understanding of the nurse’s epidural work and how the institutional processes and texts organize and coordinate their work.
Chapter Four

In this chapter I describe the context of nurse’s work on the two units at British Columbia Women’s Hospital (BCWH). The physical setting is described using information provided by the nurses during the interview process as well as my own observations of the nurses’ working environment at BCWH. An overview of the background of the nurses interviewed is also provided. The nurses’ epidural work is described chronologically starting with 1) preparation work for the epidural procedure, 2) supporting both the woman and the anaesthetist during the procedure while ensuring the woman and her baby remain safe, 3) monitoring the health of the woman and her baby after the procedure, 4) establishing priorities during the rest and recovery period, and 5) the work associated with mobilizing the labouring women. Lastly, I describe the textual organization of the nurses’ work by focusing on texts that directly coordinate the sequence of nurses’ action and texts that operate at a regulatory hierarchical level and organize the nurse’s work in a particular way.

Findings

Context of the nurse’s work

This research study was conducted at British Columbia Women’s Hospital (BCWH) which is the largest urban perinatal referral hospital located in British Columbia Canada. BCWH’s Maternity Care Program is composed of 2 birthing units, 4 operating room and recovery rooms, 4 postpartum units, 1 antepartum unit, Fir Square unit for substance-using women, an intermediate nursery and a neonatal intensive care unit. The two birthing units (Delivery Suite & Single Room Maternity Care Unit) conduct on average 6858 deliveries per year (British Columbia Women’s Hospital Performance
The Delivery Suite and Single Room Maternity Care Unit (SRMC) are two different units each with a distinct model of care. The Delivery Suite is the high risk labour and delivery unit located on the hospital’s first floor in close proximity to the 4 operating rooms and neonatal intensive care unit. This unit is used for both low and high risk pregnancy/labour and follows the traditional labour, delivery and recovery care model. As such, woman labour, deliver and spend one to two hours recovering following birth in the Delivery Suite before being transferred with her baby to one of the four postpartum units for the remainder of the hospital stay. The current length of stay for a woman who experiences an uncomplicated delivery is twenty four to forty-eight hours; for a caesarean section the length of stay is approximately forty-eight to seventy two hours (British Columbia Women’s Hospital Performance Measurement and Reporting Department, 2012).

The Delivery Suite is fully equipped with a central fetal monitoring system allowing nurses to view the fetal monitoring tracing at the nursing station on monitors located at the charting station and charge nurse’s station. The medication room is located behind the nursing station and is equipped with an automated medication delivery system (Pyxis), a cupboard containing various intravenous solution, needles syringes, glucometers, and a vacuum for assisted deliveries. Additional equipment such as birthing balls, birthing stools, and pillows are located in a storage room outside the Delivery Suite.

The Delivery Suite is composed of 10 labour rooms and 3 observation rooms that are organized in a U-shape around the nursing station. Each room is equipped with a labour bed, warmer/resuscitation newborn bed, maternal cart containing relevant
equipment for nursing care, epidural cart, delivery cart containing equipment required
during a delivery, fetal monitoring system and computer, IV and epidural pumps and
built-in nitrous oxide delivery system. Eight rooms out of the ten have a private shower.
The rooms have no decorations and no window. The general atmosphere conveys a sense
of urgency and high energy.

The second unit, the Single Room Maternity Care Unit (SRMC) is located on the
second floor of the hospital. SRMC is a low risk unit and follows a combined care model
where women remain with their baby in the same room after they delivered to receive
postpartum care. The current length of stay for a woman on SRMC is twenty four to
forty-eight hours (British Columbia Women’s Hospital Performance Measurement and
Reporting Department, 2012).

The SRMC Unit is composed of 18 rooms separated into two pods of nine rooms
each. The nursing station is used primarily used for charting and storing various hospital
forms and patient charts. There is no central monitoring on SRMC. A medication room
with an automated medication delivery system (Pyxis), a cupboard containing various
intravenous solution, needles syringes, glucometer, and small trolley with emergency
equipment (i.e. vacuum for assisted deliveries) is located in each pod. An equipment
room is located in each pod. The unit is a figure eight shape creating a more private and
intimate atmosphere. The hallways are decorated with pictures frames and there is
natural lighting from the various windows. A family lounge and kitchenette are available
on each pod for the woman and her family.

Each room on SRMC is equipped with a labour bed, warmer/resuscitation
newborn bed, a delivery cart containing equipment required during a delivery, a maternal
cart containing relevant equipment for nursing care, built in nitrous oxide delivery system and a large tub and rain shower. External fetal monitoring equipment, IV poles, epidural cart, and automatic sphygmomanometer must be brought in when required by the nurses. Birthing balls, birthing stools and pillows are located on the SRMC at the end of each pod in the equipment room. The rooms offer a welcoming environment to the labouring woman and her family by providing a sleeping area for the support person, a television, fridge and access to linen. Each room is decorated and has access to natural light via a window or sky light.

Maternity care offered to women in the Delivery Suite and SRMC is provided by a wide range of professionals including nurses, obstetricians, general practice physicians, midwives and anesthesiologists, pediatricians, neonatologists and their associated residents. Two anesthesiologists are on site 24 hours a day and seven days a week and provide all anesthesia and analgesia related care to pregnant/labouring women. The mobile labour epidural analgesia rate at this institution (include Delivery Suite and SRMC) is about 69% (British Columbia Women’s Hospital Performance Measurement and Reporting Department, 2012).

Nurses represent the largest group of professionals providing maternity care at this institution with 118 RN working in the (Birthing Program British Columbia Women’s Hospital Staffing Department, 2013). On any given shift nineteen nurses are assigned to work in the Assessment room/Triage area, the operating rooms/recovery rooms, the Delivery Suite or SRMC. Each birthing unit is led by a Charge Nurse. The nurses’ assignment varies as a function of patient flow and patient room availability.
Participants

Five nurses responded to the announcement sent through the hospital e-mail network and all agreed to share their experience as it relates to the care of woman labouring with a mobile labour epidural analgesia. All nurse participants had graduated from a baccalaureate in nursing program and worked full time in the Birthing Program at BCW’s Hospital. The nurse participant’s pseudonyms and demographics are as follows:

<table>
<thead>
<tr>
<th>Participant’s Pseudonym</th>
<th>Age group</th>
<th>Nursing Experience</th>
<th># of years worked at BCW Hospital Birthing Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mimi</td>
<td>20-29</td>
<td>&lt;5 years</td>
<td>&lt;5 years</td>
</tr>
<tr>
<td>Mia</td>
<td>30-39</td>
<td>&lt;5 years</td>
<td>&lt;5 years</td>
</tr>
<tr>
<td>Matty</td>
<td>20-29</td>
<td>5-9 years</td>
<td>5-9 years</td>
</tr>
<tr>
<td>Sue</td>
<td>20-29</td>
<td>&lt;5 years</td>
<td>&lt;5 years</td>
</tr>
<tr>
<td>Lili</td>
<td>&gt;50</td>
<td>&gt; 20 years</td>
<td>&gt; 20 years</td>
</tr>
</tbody>
</table>

*Figure 1: Participant Demographics*

Within the framework of IE, these five nurses do not constitute a sample but rather serve as a group of expert informants “whose experience provides the entry point into a set of institutional relations” (McCoy, 2006, p.109) as it relates to the care of labouring woman with a mobile labour epidural analgesia. These RNs work in a highly technological environment with a large number of medical and paramedical health care workers. They have many resources available for them to do their work including: two charge nurses, two anesthesiologists, one resident anesthesiologist and one fellow, two obstetricians, two resident obstetricians and one maternal/fetal medicine obstetrician on site 24/7. The anesthesiologists are responsible for the provision of neural epidural and spinal analgesia to the labouring woman in the Delivery Suite and Single Room Maternity Care Unit.
Because perinatal nurses usually don’t know the women and families they care for during childbirth prior to their admission to the hospital, the initial stages of their work focuses on establishing a therapeutic relationship by getting to know the woman (including her medical and obstetrical history, and her goals and expectations related to labour and birth) and her family or support person(s). This detailed assessment also enables the nurses to do their important work of keeping the woman and baby safe during childbirth.

Although the woman’s primary maternity care provider likely discussed pain management options with the woman during pregnancy, one aspect of the nurses’ work is to ensure that the woman is familiar with all the pain management options available to her at this institution. There is no printed information for women that describes all the pharmacological (includes nitrous oxide, morphine, fentanyl and mobile labour epidural analgesia) and non-pharmacologic pain relief options (includes hydrotherapy, positions changes…etc) but there is a printed information sheet available that explains the risks and benefits of neuraxial epidural anesthesia.

Many women at this hospital do request epidural anaesthesia so it is important that the RN also assesses whether the woman’s pain management plans include the possibility of epidural anesthesia. Assessing the woman’s understanding of the risks and benefits of epidural anesthesia lays the foundation for the institutional work process of “informed consent”. As women may experience considerable pain later in labour, initiating this discussion early helps promote informed decision making.

Nurses interviewed also identified giving out the Epidural Information Sheet to some women based on their nursing assessment of its appropriateness for the particular
woman and her unique needs and situation. Although all this preparatory work is very important for building trust and establishing the nurse as a knowledgeable care provider, this analysis begins from the moment in time when the woman requests epidural anesthesia.

**The Nurse’s epidural work**

The term “work” in IE is used in a generous sense where the word represents an intentional action and includes “anything done by people that take time and effort, that they mean to do, that is done under definite conditions and with whatever means and tools that they may have to think about.” (Smith, 2005, p.151). In this IE study the term “work” incorporates the nurse’s subjectivity and experiences of providing care to a woman labouring with a mobile epidural analgesia. The nurse is viewed as an expert who can provide a detailed description of the work associated with the promotion of mobility when a woman is labouring with a mobile epidural analgesia. In order to understand the work associated with the mobilization of labouring women with an epidural it is important to explicate the nursing work required from the starting point when the labouring woman requests an epidural. What becomes visible are the conditions under which the nurse provides mobile epidural care, the knowledge and skills required, and the time it takes for her to complete her work. As such, the institutional relations and organization that coordinate the nurses’ “everyday” and “everynight” mobile epidural work can be explicated (Smith, 2005). When the labouring woman decides to have an epidural, the nurse’s work becomes focused on the action and tasks necessary to activate the institutional process associated with the initiation of epidural procedure and the management of neuraxial analgesia.
1. **Preparation work for the epidural procedure**

The nurse’s epidural work begins when the labouring woman is first admitted to the unit. The nurse connects with the labouring woman and discusses a plan of care or birth plan. Once the labouring woman decides to have an epidural, the nurse’s work focuses on providing information and answering the woman’s questions. The nurse must relate this information about the epidural while at the same time continuing to provide obstetrical nursing care. The nurse must also ensure that the labouring woman is attentive and understands the information provided. Registered Nurse Lily describes her work as follows:

*I try to take these opportunities when she is not contracting to be able to make sure she is attentive to you and she is able to listen and comprehend what you are saying. So I try to choose small window of opportunity to be able to have that. So for someone who’s contracting often and really to work through her contractions you might only have 30 seconds between contractions... so your discussion might be quite long in order for her to be actually attentive to what you are actually saying.* *(Lily RN)*

Once the labouring woman decides to have an epidural, the nurse performs a series of assessments. The nurse’s assessments include evaluation of the labouring woman’s abilities to cope with her contractions, maternal fatigue, and maternal and fetal physiological status (i.e. vital signs and fetal heart rate). It is the nurse’s assessment work associated with the vaginal examination and the degree of cervical dilation which leads to the formal decision to initiate, or not, the institutional processes associated with the epidural procedure. The vaginal examination represents the predictive and repetitive step
that is expected to be performed by a nurse before the epidural insertion process can be initiated. As such the nurses’ work of performing a vaginal examination represents a standardized and objective way to legitimize the woman’s request for an epidural and the nurse’s clinical decision to initiate the chain of activities which constitute the institutional work associated with epidural analgesia.

Once the initial nursing assessments are completed the nurse’s work focuses on communicating her clinical assessments and recommendations to the other members of the interprofessional team. The Charge Nurse is the first member of the interprofessional team to be informed of the labouring woman’s request for an epidural. The Charge Nurse is responsible for the flow and overall patient care provided to all pregnant and labouring women on the unit. Informing the Charge Nurse hooks the nurse’s work of initiating the epidural process for her patient within the overall management of patient flow and care on the unit. As such the utilisation of resources, such as the anesthesiologist’s time, can be effectively prioritized in relation to the overall demands for analgesia (i.e. epidural for pain relief) and anesthesia care (i.e. caesarean section) on the unit.

The primary care provider is the second interprofessional team member to be contacted by the nurse. The nurse’s action of informing the primary care provider as it relates to the activation of the epidural process accomplishes two goals: 1) updates the primary care provider with a summary of the labouring woman’s current situation and labour progress and 2) initiates the medical consultation process associated with the epidural intervention. As such, the nurse facilitates the primary care provider’s labour management work by relaying important information and recommendations about the care and medical management of the labouring woman. The nurse also coordinates the
medical consultation process associated with the epidural intervention by receiving the authorization (i.e. physicians ‘order) from the primary care provider to consult with the anesthesiologist. The medical consultation process is completed when the nurse directly contacts the anesthesiologist and provides him/her with the epidural request and a summary of the labouring woman medical/obstetrical history and current labour progress.

During the communicating process with the interprofessional team, the nurse’s work occurs outside the labouring woman’s room at the nursing station. The process of paging, waiting for the primary care provider and the anesthesiologist to return the page and the provision of a brief report over the phone addressing the labouring woman progress status takes time. The nurse supports the institutional process for this time period so is not available in the room. During this time the labouring woman may be experiencing significant distress and must rely on a family member or support person to provide labour support.

The nurse also coordinates the institutional process of epidural administration and expedites the epidural preparation process by ensuring that all required equipment and forms are available upon the anesthesiologist’s arrival. The gathering/organizing activities coordinate the nurse’s work away from the labouring woman’s care at a time where the presence of the nurse is most needed.

*The patient would like to have an epidural... the gathering of paper, the nurse stamping paper, going to the machine and punching multiple times to get medications...do this and... putting things in the place right... we are furniture movers so your whole room needs to be reorganised every time something different needs to happen... we have to slide the cart around, we have to make*
sure that we have blood pressure [equipment] available to us. In a single room you have to find an anesthetic cart, you have to find an automatic blood pressure cuff... you have to walk significant distances... (Lili RN)

This ‘busy work’ is perceived by nurses as “wasted nursing care time” (Lili RN) as it is spent to support hospital processes as opposed to providing the labouring woman with much needed supportive nursing care. In the hospital setting the anaesthesiologist’s time is highly valued and takes precedence over the provision of nursing care and the supportive care needs of the labouring woman.

As the nurse is performing all these preliminary activities, she must also prepare the labouring woman for the epidural procedure. The epidural preparation work brings the nurse back to the bedside and reorganises the nurse’s work in specific procedural steps that are outlined by the institution epidural policy.

*Starting an intravenous in preparation for it and continuing to support her during her labour, doing the fetal heart, documenting, monitoring her vital signs... (Sue RN)*

The labouring woman is often distressed, unable to cope with her contractions, and may have difficulty following directions. These steps are executed at a time when the labouring woman requires the most supportive nursing care.

2. **Supporting both the woman and the anaesthetist during the procedure while ensuring the woman and her baby remain safe**

   Once the formal process of obtaining consent is completed the nurse’s work refocuses on tasks and activities required to assist the anesthesiologist with the epidural procedure. These activities include: adjusting the bed to a comfortable height,
positioning the support stool, positioning the support person in a way that is beneficial for the labouring women during the epidural procedure, providing further explanation about the position to be taken during the epidural procedure, providing a pillow for support and comfort and encouraging the labouring woman to relax. Throughout the procedure the nurse continues providing supportive care to the labouring woman.

So I give the mom a heads up that they will feel this sort of this sharp poke, scratching and this burning. And this should be worst part...after this they should only feel pressure. So after the freezing has gone through I will tell them to stay relaxed. I remind her to drop her shoulder. (Mimi RN)

The nurse continues to support the labouring woman by providing explanations and contextualizing the sensations felt by the labouring woman throughout the epidural procedure. The nurse ensures that both mother and fetus are safe by continuing to monitor the fetal heart rate every 15 minutes and by observing the labouring woman for signs of hypotension, major discomfort, labour progress or imminent delivery. As such, the nurse’s supportive and safeguarding work allows the anesthesiologist to focus on the tasks associated with the epidural insertion procedure.

3. Monitoring the health of the woman and her baby after the procedure

The Mobile Labour Epidural Analgesia Policy coordinates the nurse’s epidural work in terms of the specific assessment and monitoring parameters necessary to ensure the safety of the labouring woman and fetus following the epidural insertion procedure. In the period immediately following the epidural insertion, the nurse’s work focuses primarily on monitoring and documenting the physiological stability of the labouring woman and her fetus.
The first half hour period following epidural insertion involves an increased monitoring period where we check blood pressure every 5 minutes, times two, and every 10 minutes, times two. The fetal heart rate is monitored every 5 minutes for the first 30 minutes. If there were to be a reaction, whether it is mom’s blood pressure dropping or the fetal heart rate dropping related to mom blood pressure, it would happen during that time. (Mimi, RN)

During this intensive monitoring period the nurse is continually analyzing her assessment data ensuring that maternal vital signs and fetal heart rate are within normal range and that both the labouring woman and fetus are not negatively impacted by the epidural procedure and medication.

The activation and initiation of the post epidural monitoring guidelines coordinates nurse’s work in a series of invisible work processes. These invisible work processes involve repositioning the labouring woman on her side, applying the blood pressure cuff, obtaining the first blood pressure measurement and sharing the result with the anesthesiologist. If external fetal monitoring is required post epidural insertion, the nurse repositions the belts under the woman, palpates the abdomen and locates the area of maximum intensity for the fetal heart sound and contractions and reattaches the Doppler and tocodynamometer with the belt onto the labouring woman’s abdomen. If auscultation is the fetal monitoring method used to monitor fetal health, the nurse palpates the maternal abdomen and locates the area of maximum intensity for the fetal heart sounds and listens to the fetal heart rate for a full minute. The invisible work processes associated with fetal monitoring are repeated each time the nurse repositions the labouring woman. The RN then initiates the continuous epidural infusion by
reviewing the physician’s epidural order, programming the epidural pump, and reviewing the programming information in the pump with another person. These additional work processes are completed by the nurse during the post epidural monitoring period.

For the remainder of the woman’s labour the nurse continues to assess and monitor the maternal and fetal physiological stability. Lili described her work as follows:

*When that period of 30 minutes is done...every hour we are responsible for vital signs monitoring, checking motor function, checking sensory block, continuous monitoring of fetal heart, either by auscultation or by monitor, external electronic monitor.* (Lili RN)

If the epidural provides effective pain relief and achieves optimal sensory and motor block, such that the labouring woman does not feel pain, the nurse’s work focuses on the routine management and monitoring of the epidural as outlined by the hospital mobile labour epidural policy. Documenting assessments and observations are additional invisible work processes completed by the nurse during the post epidural monitoring period.

If the epidural does not provide effective pain relief the nurse’s work is re-organized in a sequence involving multiple evaluations, assessments, and interventions in order to identify and rectify the problem (i.e. sensory level below the optimum level, kink in the epidural tubing, epidural tubing not correctly inserted in the epidural pump etc.) As such the nurse facilitates the anesthesiologist’s epidural pain management work by closely monitoring the epidural infusion, and the physiological status of the labouring woman and fetus. The nurse coordinates the anesthesiologist’s management of the mobile
epidural by first strategizing solutions to rectify the problem. If the nurse is unsuccessful, she then requests assistance from the anesthesiologist.

Once in the room the anesthesiologist conducts her/ his own assessment, identifies a potential cause and carries out an intervention to rectify the problem. Depending on the anesthesiologist’s preference, the acuity level and the presence of other labouring women on the unit requiring the anesthesiologist expertise, a plan of care and intervention with the nurse is established. As such the nurse’s actions of paging/informing the anesthesiologist initiates the process to improve maternal comfort with the epidural within the overall management of patient flow and care on the unit. The nurses’ work allows the anesthesiologist’s time to be effectively prioritized in function of the overall demands for his/her expertise on the unit. If the anesthesiologist is unable to stay with the labouring woman until she is comfortable, he/ she leaves the nurse with specific guidelines on when to call back if the intervention to troubleshoot the epidural problem is ineffective.

If all attempts to rectify the problem with the epidural fail, a second epidural catheter is inserted. Replacing the epidural is the last resort option. The epidural replacement involves the discontinuation of the continuous epidural infusion, removal of the epidural catheter and the reinsertion of a new epidural catheter by the anesthesiologist. The nurse then repeats the process of epidural initiation for a second time and all associated nursing work previously described.

4. Establishing priorities during the rest and recovery period

The initiation of the institutional process associated with epidural insertion is described by the nurses as an intense period focused on the maternal and fetal safety,
technology/equipment and procedural support of the anesthesiologist which leaves many nursing care responsibilities undone. Following the intense monitoring period the nurses interviewed described their priority as encouraging maternal rest and sleep. This reorganization of nursing priorities serves three purposes: 1) promoting energy preservation/restoration for the labouring woman; 2) creating a ‘breathing space’ where the nurse is able to complete her documentation and 3) providing the nurse with an opportunity to reorganize her work and re-establish a routine or temporal plan of work which brings a sense of order to her nursing care. The nurse promotes maternal sleep and rest by using her expertise and professional knowledge while taking in consideration the monitoring requirement imposed by the hospital Mobile Labour Epidural Analgesia and the Fetal Health Surveillance policies.

I feel that (pause)… that getting someone up to ambulate with an epidural depends a lot on how tired she is. Because a lot of the time if the woman has been labouring for a while and she requests an epidural, especially with primigravida… she is so tired and maybe she was in prodromal labour or has not been sleeping well recently… and her first priority may to actually be to get some rest once she gets comfortable. I feel nurses can get in that routine a bit too much and once we reach that state within our nursing care, we don’t take the next step to ambulate the labouring woman. (Matty RN)

As labour progresses the promotion of sleep and rest can becomes a means to and end because having the labouring woman in bed facilitates the nurse’s charting/monitoring work, routine care, and adherence to the parameters and guidelines established by the hospital policies.. The fetal heart rate and the woman’s needs for sleep
are the most influential parameters influencing the nurse’s clinical decision making about mobilizing the labouring woman in or out of bed.

5. **The work associated with mobilizing the labouring women**

As indicated earlier, the nurse may not think to mobilize the woman unless the woman requests assistance or the RN notices that labour is prolonged….Although with a mobile epidural, the capacity to move is implied\(^1\), the woman’s ability to move is influenced by the degree of sensory and motor block, the woman’s energy level and physiologic status, and the ability to safely monitor the fetus. The labouring woman with a mobile epidural has the capacity to be mobile in bed by assuming various positions, and possibly out of bed by sitting on a birthing ball, chair or ambulating in her room or in the hallway.

The nurse’s work associated with repositioning/ mobilizing a labouring woman with an epidural in bed is coordinated and organized in function of various maternal and fetal assessments parameters which must be documented on the chart. The fetal heart rate, fetal position, cervical dilation, contraction patterns, motor block, sensory level, time since the last change in position, maternal position preferences and need for sleep are assessment parameters impacting when and how the nurse repositions a labouring woman with a mobile labour epidural analgesia in bed. The nurses identified the fetal heart rate patterns and the maternal need for sleep as the leading parameters guiding how a labouring woman is positioned in bed. Repositioning of the labouring woman was discussed by the nurses interviewed in relation to the limitations imposed by abnormal fetal heart rates or maternal tiredness or fatigue. Of the five nurses interviewed, only one

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\(^1\) The term mobile is defined as being “capable of moving” (Merriam-Webster’s Collegiate Dictionary, 1993)
nurse discussed extensively the need to position a labouring woman to promote labour progress and prevent labour dystocia.

The nurse’s work of repositioning a labouring woman with an epidural also involves numerous invisible work activities. Each time the labouring woman is repositioned the Doppler and toco-dynamometer and belt, the pillows, blankets and peripads needs to be readjusted. The IV tubing, IV pump, epidural tubing and epidural pump needs to shift around the woman’s bed to prevent pulling which could potentially dislodge the IV or epidural from their respective sites. The call bell needs to change sides in order to be accessible to the labouring woman. This process of adjusting equipment is repeated each time the nurse repositions the labouring woman with an epidural in bed. As such repositioning the woman in bed requires additional work for the busy nurse.

The nurse’s work of mobilizing a labouring woman with a mobile epidural out of bed is coordinated and organized by assessment and intervention activities focused on patient safety and fall prevention. The labouring woman requires close observation during ambulation to prevent falls.

*With the epidural and anesthesia on board I like walking with them... because I feel that the partner does not entirely know what is going on and I just like to be ready to catch her in an instant if she was unsteady on her feet and could potentially fall.* (Matty, RN)

The mobile labour epidural analgesia and physicians orders outline specific assessment parameters (sensory level, modified bromage score$^2$ and step test$^3$) to be used by the

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$^2$ Scale to assess the degree of motor block used when a labouring woman receives a mobile labour epidural analgesia
nurse prior to ambulating a labouring woman out of the bed. The nurse’s work associated with the evaluation of these various parameters is quite extensive and time consuming and may partially explain why nurses do not usually mobilize labouring woman with a neuraxial epidural out of the bed.

The nurse’s work of mobilizing a labouring woman with a mobile labour epidural analgesia increases when oxytocin is used to manage uterine contractions. The element of fetal safety and well-being directs whether the labouring woman can assume various positions in bed or can ambulate out of bed. The fetal heart rate tracing must always be in the nurse’s line of sight and a continuous recording of the fetal heart rate must be maintained to ensure that the oxytocin is not negatively impacting the fetus as per required by the hospital Fetal Health Surveillance policy. The movement of the labouring woman often interferes with the continuous recording of the fetal heart rate requiring numerous adjustments of the monitors on the maternal abdomen.

The mobile labour epidural analgesia policy outlines the assessment parameters associated with optimal sensory level and motor block but provides no specific information about how to preserve mobility and prevent the development of complete motor block when managing an epidural during labour and birth. The absence or lack of emphasis on the importance of preserving mobility in the mobile labour epidural analgesia policy positions the mobility assessment parameters (i.e. step test) at a lower level of priority within the nurse’s overall epidural management work.

An important gap exists between the assessment parameters and guidelines provided by the mobile labour epidural policy, physician’s orders, and the nurse’s clinical

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3 Test used to assess quadriceps & hamstrings muscles strength, balance and proprioception of a labouring woman with a mobile epidural analgesia prior to ambulation.
decision making about mobilizing a labouring woman with a mobile epidural out of bed. The nurses interviewed shared additional strategies that they have developed, based on their clinical knowledge and experience, to help ensure that the labouring woman possesses adequate motor strength and balance to stand and ambulate and to involve the partner to support and safeguard the labouring woman when mobilizing in or out of bed.

Many labouring woman would perceive near normal sensation in their feet but would not be able to stand up. I conduct a hip lift test while the woman is still in bed, where I can identify early in the evaluation process insufficient motor strength without exposing the labouring woman to unnecessary risk of falling.

(Sue RN)

The nurse’s work strategies involved changing the assessment sequence outlined by the mobile labour epidural policy, and adding additional evaluation processes to the ones already present on the physician’s order form. One nurse interviewed also identified that once a woman receives an epidural the focus of the nurse’s work changes dramatically from:

Being hands-on, intuitive, really paying attention to a lot of signs and what the woman is saying and doing ...to relying on our technology to provide some of that information. (Lily RN).

Lily refers to this shift as a “disconnect” where prior to the epidural her observations of the labouring woman’s behaviours combined with her nursing assessment (i.e. palpation of contractions) guided her nursing interventions (i.e. various position & ambulation) to promote the natural physiological process of birth. As such, the epidural creates a cascade of activities which leads the nurse toward relying more on technology and medical
directives to guide her work and decision making in relation to the care of the labouring woman. The technology (i.e. IV tubing, IV & epidural pump, external fetal monitor) inhibits the nurse’s ability to mobilize the labouring woman out of bed and limits the number of positions possible in bed. The additional monitoring and charting work also limits the time the nurse has available to provide supportive labour care.

Mobilizing a labouring woman with an epidural therefore has an additional layer of assessment and evaluations which require additional work on the part of the nurse. The nurse becomes saturated within her work and must choose and prioritize the care she provides to the labouring woman. Needing to focus more intensely on the safety of the labouring woman and her fetus (alongside ensuring the required epidural work processes are completed) results in mobility falling to the lowest priority level within the nurse’s epidural management work. In the next section of this chapter we will explore in more detail some of the institutional texts that structure the nurse’s work of caring for a labouring woman with neuraxial epidural analgesia.

**The textual organization of the nurses’ work**

The notion of text in this institutional research refers to “any words or sounds that are set into a material form that is replicable” (Smith, 2005, p.66). These texts can be found in written form (e.g. paper, print, and electronics), or images (e.g. photographs or video/ television). In this particular research study we are referring to the replicable text and pictures associated with documentation forms, the mobile labour epidural analgesia policy, and relevant provincial and national guidelines.

Nurses activate these texts by incorporating them within their ‘everyday’ and ‘everynight’ work environment. These texts coordinate and organize the nurses’ work in
particular ways translocally across different settings within the hospital (assessment room, Delivery Suite, Single Room Maternity Care Unit, operating & post recovery room & postpartum Units) and link the nurse’s work with regulatory texts including standards of care produced by the governing bodies of health care institutions (Perinatal Services BC, Provincial Health Services Authority and the Society of Obstetricians and Gynecologists of Canada).

During the interview with the nurses, two series of texts have been identified as having a significant effect upon the organization and coordination of nurse’s work when mobilizing a labouring woman with a mobile or neuraxial epidural analgesia. These two series of text are:

1. Text that directly coordinate the sequence of nurse’s actions when caring for a labouring woman
   - British Columbia Labour Partogram (2010)
   - Mobile Labour Epidural Analgesia Policy (2010)

2. Texts that operate in a regulatory hierarchy and organize the nurse’s work in a particular way (Smith, 2006, p.66)
   - British Columbia Women’s Hospital Fetal Surveillance Policy (2008)
   - Society of Obstetrician Gynecologist of Canada (SOGC) Fetal Health Surveillance in Labour – Clinical Practice Guideline

We will first explore the two texts mentioned by the nurses as directly influencing their everyday work; the Partogram and the Mobile Labour Epidural Analgesia Policy.
1. Texts that directly coordinate the sequence of nurse’s actions when caring for a labouring woman

   a. *British Columbia Labour Partogram*

   The provincial Labour Partogram represents a coordinating tool responsible for linking the various regulatory hierarchy text into the nurses ‘everyday’ and ‘every night’ work of caring for intrapartum woman. The Labour Partogram is the main intrapartum documentation form used by nurses across British Columbia. It is composed of 14 sections addressing specific elements of the nurse’s assessment work. The sections as they appear on the Partogram are: Page 1 - Demographic & background information, vaginal exam; Page 2 - Fetal assessment, contractions, meds procedure & treatments, maternal assessment, regional analgesia; Page 3 - Variances record/interprofessional notes; Page 4 - IV starts, intake & output, variances record/interprofessional notes (appears twice); Page 5 - Second stage, assisted vaginal birth summary and third stage.
Each section is further subdivided into more specific detailed items that are associated with a section subject, for example the contraction section is subdivided into frequency, intensity, duration and resting tone. Nurses are the main healthcare professionals documenting on the partogram, with the exception of midwives. The labour partogram coordinates the sequence of the nurse’s actions by structuring and standardizing the nurse’s assessment and documentation process. The partogram pre-identifies the intrapartum assessment requirements and organizes/prioritizes the nurse’s assessment work and intervention. Nurses are expected to adjust their work routines in ways that accommodate the timely completion of this documentation form.

At the bottom of the partogram multiple legends using standardized terminology and abbreviations indicate how the information should be documented by nurses in the various sections and subsections of the labour partogram.

**Figure 2: Labour Partogram – Section Legend**

The Partogram represents a standardized documentation platform which integrates and prioritizes the required assessment and intervention parameters outlined by hospital policy and various perinatal guidelines. The assessment and interventions parameters further organize the nurse’s work in function of time. The Partogram is divided into 1 hour time intervals and reflects the care provided to a labouring woman by nurses/other healthcare providers over a 12 hours period. Each 1 hour interval is further subdivided
into 15 minutes intervals. When the 12 hours period is completed a second partogram is initiated.

The Fetal assessment & Contraction sections represents the largest portion on the Partogram, indicating that these parameters are priorities.

![Figure 3: Labour Partogram – Sections Fetal Assessment & Contractions](image)

This section is located at the top of page 2 (first stage) and page 5 (second stage) of the Partogram and was identified by all nurses interviewed as the primary parameters responsible for establishing the overall assessment pattern of the labouring woman. Every assessment (i.e. epidural assessment) and intervention (i.e. insertion of epidural, mobilization of the labouring woman) begins with the evaluation of the fetal heart rate and contraction pattern. The fetal heart rate and the maternal contraction pattern assessment and required documentation organize and coordinate the sequence of nurse’s actions in 15 minutes and then in 5 minute increments during the first and second stage of labour. This temporal organization of nurses’s work is significant, as such that the nurse has 15 minutes in the first stage of labour to complete her required assessment and intervention before the next fetal heart rate assessment must be recorded. In the second stage of labour, the 5 minutes interval between the fetal heart rate assessment structures
the nurse’s work and the time she has available to mobilize the woman in bed or out of
the bed. At this point, the nurse must prioritize fetal heart rate monitoring over
mobilization/repositioning of the labouring woman.

The provincial Labour Partogram is designed to standardize intrapartum fetal
health surveillance parameters established by Society of Obstetricians and Gynecologists
of Canada (SOGC, 2007) and not to promote mobility for women labouring with a
mobile epidural analgesia. Promoting mobility is simply not written into the Partogram,
the primary institutional text that directly organizes the nurse’s work.

The Meds/Procedural Treatment section of the Partogram is used to document
medication administration and treatment. Sue, RN often uses this section as a means to
temporally organize required interventions (i.e. time for the next dose of antibiotics, in &
out, time when the epidural procedure was completed etc.

Figure 4: Labour Partogram – Section Meds & Procedures Treatments

The Maternal Assessment section of the Partogram is subdivided into five broad
sections: maternal vital signs, respiration rate and oxygen saturation, non-
pharmacological method to assist with labour pain, maternal activity/position and blood
sugar measurement/urine test.
All nurses’ interviewed described this section of the Partogram as inadequate to document the nursing work as it relates to non-pharmacological methods, maternal activities and position changes. The small square and the standardized items identified in the legends do not accurately reflect the nursing work associated with the mobilization and labour support provided by the nurse to a woman labouring with or without a mobile labour epidural analgesia. Nurse Sue uses the Interprofessional Notes section to complete her documentation on maternal position/ mobilization. The documentation in the Interprofessional Notes usually addresses the safety component of the maternal mobilization/ repositioning with epidural; for example, the position changes and interventions taken to address abnormal fetal heart rate variances.

The “Regional Analgesia” section of the Partogram is used to document the hourly epidural assessment. This section addresses the assessment parameters associated with an epidural (sensory level, motor function & pain scale) as well as volume of medication infused.
In this section there is no subsection to document the ambulation, Modified Bromage Score or the “Step Test” parameters. All documentation relating to the mobilization of labouring woman with a mobile epidural has to be written in the Interprofessional Notes. A nurse must search through the Interprofessional Notes for the notations addressing the effects of the mobile epidural analgesia on the ability of the labouring woman to mobilize. The absence of these parameters on the primary documentation form confirms their relatively low status within institutional priorities, particularly when you consider that the form is primarily completed by nurses.

**b. British Columbia Women’s Hospital Mobile labour epidural analgesia policy**

The Mobile Labour Epidural Analgesia Policy focuses on the procedural and monitoring/assessing aspects of the epidural procedure. The main focus of the mobile labour epidural policy is to outline specific assessment and monitoring parameters necessary to ensure the safety of the labouring woman and fetus. This text can be analyzed both for what it includes and for what it does not address. Although the mobile labour epidural analgesia text is specific in outlining the assessment parameters, it does not provide any guidance about how to address parameters that fall outside the recommended range unless they are associated with an emergency situation. The epidural policy text does not provide any guidelines or set of interventions to preserve mobility and prevent the development of complete motor block when managing pain with
an epidural. The absence or lack of emphasis on the importance of preserving mobility in
the mobile labour epidural analgesia policy text positions the mobility parameters (i.e.
step test) to a lower level of priority within the nurse’s epidural management work.

Nurse Sue reported that there is no specific institutional text addressing the
process of mobilization with an epidural. Sue reviewed the mobile labour epidural policy
and stated that there are few details addressing mobility:

*It does say how to evaluate prior of ambulation and document those criteria and
then it says ambulate with assistance (pause)... it sort of insinuates mobility... but
does not say how to mobilize the patient (Sue RN).*

As such the mobile labour epidural analgesia policy outlines the assessment parameters
associated with optimal sensory level and motor block but provides no specific
information about how the nurse mobilizes the labouring woman in or out of bed or the
difficulties the nurse might encounter.

In the following section we will explore some of the regulatory texts, including
standards for professional practice, that influence the nurse’s work remotely. The British
Columbia Labour Partogram was represents the working platform by which all the
various institutional texts associated with the care of a labouring woman with or without
an epidural are activated and coordinated.

2. **Texts that operate in a regulatory hierarchy and organize nurse’s work in a
particular way**


   Columbia Partogram-BCPHP 1583*
The Perinatal Forms Guideline 4 – A Guide for Completion of the British Columbia Partogram-BCPHP 1583 is the regulatory text which explains and describes how to complete each section of the labour partogram using the standardized terminology and abbreviations establish by British Columbia Perinatal Services. This text emphasises the importance of structured and standardized documentation processes across all health authorities in British Columbia. This guideline states that the main purpose of the partogram is to “facilitate consistent and complete documentation, communication and continuity of care among health care providers and provides a guide for evidence-based intrapartum care” (BCPS, 2007, p.2). Interestingly, the intended reduction of legal liability that results from complete documentation is not included as a purpose for these guidelines. The Perinatal Form Guideline 4 and Labour Partogram therefore integrate into its format the current recommendations put forward by the SOGC Fetal Health Surveillance in Labour regulatory text and various additional evidence-based perinatal practice guidelines.

In addition, specific fields in the partogram are collected as part of a comprehensive database for British Columbia Perinatal Services (BCPS). BCPS is responsible to establishing standards and performance targets for service delivery and sustaining safe and high quality services for maternity care program across British Columbia. This data collected by BCPS is analyzed and then shared with the various healthcare institutions in order to improve health care services (i.e. Quality Improvement). The labour partogram makes certain variables and work activities visible within the larger institutional context but omits or obscures other parameters, such as the work involved in mobilizing women. Therefore this text represents an important vehicle
by which various regulatory hierarchical texts such as SOGC Fetal Health Surveillance in Labour Guidelines (2007) are integrated and activated into the nurses ‘everyday’ and ‘everynight’ work of caring for intrapartum woman.

**b. Society of Obstetricians and Gynecologists of Canada (SOGC) Fetal Health Surveillance in Labour – Clinical Practice Guideline, 2007**

Society of Obstetrician Gynecologist of Canada (SOGC, 2007) has outlined the Fetal Health Surveillance in Labour – Clinical Practice Guideline provides recommendations addressing the application and the documentation of fetal health surveillance during the antepartum and intrapartum period to decrease the incidence of birth asphyxia while maintaining the lowest possible rate of obstetrical intervention.

This regulatory hierarchical text outlines a classification system and a process for assessment and documentation of the fetal heart rate to promote clarity in communication and for managing both auscultated fetal heart rates and the electronic fetal heart rate tracing. The guideline is very specific on the terminology (i.e. normal, atypical & abnormal) with specific criteria used to describe the fetal heart rate. This terminology and criteria are intended to be used by health care professionals when communicating and documenting the fetal heart rate. The SOCG clinical practice guideline also delineates the parameters required to effectively and safely monitor the fetal heart rate during the first and second stage of labour. The guideline specifically states that electronic fetal monitoring records should be inspected and documented every 15 minutes in the active phase of labour and at least every 5 minutes in the second stage of labour. Ultimately this document acts as a standard of care that can be used in a court of law to hold nurses, physicians and institutions accountable for their actions.
c. British Columbia Women’s Hospital Fetal Health Surveillance policy

The Fetal Health Surveillance Policy integrates the recommendations put forward by the SOGC Guideline into a format that can be organized and coordinated at the hospital level. The BC Women’s Hospital (BCWH) policy states that Registered Nurses who are certified in fetal health assessment perform intermittent auscultation and interpret electronic fetal monitoring according to the parameters outlined by SOGC Guidelines. The BCWH’s policy summarizes the SOGC Guidelines in a format that is user friendly and accessible to the nurse working on the unit. In addition, BCWH’s policy on fetal health surveillance has been reformatted into pocket cards and distributed to every nurse and other healthcare provider working on the Delivery Suite and SRMC.

These two series of texts are complementary and overlap with each other but they also illustrate how the various institutions coordinate the nurse’s work when caring for labouring woman. The organization and coordination of the nurse’s work as directed by the two series of texts directly impacts the nurse’s work as it relates to the mobilization of a labouring woman with an epidural.

The findings presented in this chapter illustrate the complexity of the nurse’s epidural work in this particular setting. The nurses’ epidural work is provided on two physically different units each with a distinct model of care (i.e. SRMC low risk unit and Delivery Suite high risk unit). The labouring woman decision to have an epidural changes the nurse’s work. The nurse’s work becomes focused on the actions and tasks necessary to activate the institutional process associated with the initiation of epidural procedure and the management of neuraxial analgesia. The organizational procedural requirements associated with the epidural intervention and management take precedence
over the nurse’s supportive/labour progress work which results in prioritizing monitoring maternal/fetal status over nurses’ actions that promote labour progress (i.e. mobilization). The Labour Partogram and Mobile Labour Epidural policy text further coordinate the sequence of nurses’ actions by integrating and focusing on the regulatory monitoring requirements outlined by BCPS and SOGC hierarchical text (i.e. Perinatal Forms Guidelines and Fetal Health Surveillance in Labour – Clinical Practice Guideline).
Chapter Five

The nurse’s epidural work is organized by the institutional system and overarching discourses. In this chapter I will discuss the various discourses involved and illustrate their activation in the nurse’s epidural work. A discussion and summary of how the woman’s decision to have an epidural activates an institutional work process that initially pulls the nurse from the room and re-structures her work toward supporting the initiation and maintenance of the epidural, monitoring for and preventing side effects, promoting effective pain relief, documenting that safe care has been provided and standards of practice were met and mobilizing the labouring woman.

Summary, Discussion and Recommendations

Discourses and work processes organizing the work of the nurses

Institutional discourse in this research study refers to the ideas and directives that are transmitted in textual form. As such institutional discourse presents a distinct view of the interaction between the nurse and the institutional texts that coordinate and direct her work. The institutional discourses are set or fixed in the various hospital policies/guidelines and are activated through the nurses’ ‘everyday’ work. The institutional discourses construct the nurse’s experiences and work by establishing priorities within the nursing care.

During the interviews with nurses and subsequent textual analysis four institutional priorities were identified:

1. Ensuring that the woman and her baby remain safe
2. Documenting the care provided in a way that demonstrates that standards for care have been met which links the nurse’s work into legal risk protection
3. Supporting the epidural work processes so that the woman receives effective pain relief

4. Re-negotiating nursing care priorities and the maternal need for rest and sleep after epidural insertion.

Ensuring maternal/fetal safety was identified by all nurses interviewed as the primary focus guiding nursing care when initiating and managing a mobile labour epidural analgesia. The mobile labour epidural analgesia policy outlines very strict assessment parameters (i.e. frequency of maternal vital signs, fetal heart rate monitoring, sensory level and motor block) to ensure that maternal and fetus health safety is not compromised by the epidural procedure and/or associated medications. As such, nurses spend a significant amount of time assessing these parameters and ensuring that the labouring woman and fetus are safe.

Documenting the care provided in a way that demonstrates that standards for care have been met represents the second overarching priority establish by the institution texts. Perinatal nurses spend a considerable amount of time documenting assessment parameters in order to demonstrate that safe care was provided to the labouring woman. Previous work sampling studies conducted on obstetrical units measured nurses’ documentation time and found that it occupies 21.5% (Gagnon and Waghorn, 1996) and 17.5% (Gale, Fothergill-Bourbonnais and Chamberlain, 2001) of the nurses’ time. By demonstrating that the standards of care were maintained, the nurse’s documentation work contributes to the construction of a legally defensible patient chart. All nurses interviewed expressed concern about the amount of time spent documenting patient care which has no immediate value in addressing the labouring woman’s psychophysiological
needs. The documentation required when initiating or managing an epidural was perceived as a necessary “evil” to protect one’s own nursing practice and the institution in the event of a legal action. Quance (2007) also noted that nurses expressed frustration about the amount time spent in documenting care, feeling that it took them “away from working with the labouring woman. However, nurses in this earlier study also recognized the importance of documentation as a way to protect themselves in medico-legal proceedings.

Supporting the epidural work process so that the woman receives effective pain relief was recognized by nurses interviewed as the third work priority. Pain was medically constructed and defined as a pathological manifestation of labour and is treated separately from the labour process. Contraction pain then becomes an entity treated separately from the process of labour and birth. Once the epidural is inserted all manifestations of pain are perceived as problematic. The goal becomes taking every measure possible, within the context of epidural management, to alleviate the presence and reoccurrence of contraction pain. The mobile labour epidural analgesia policy text offers limited directives on how to manage contraction or labour pain using other techniques such as patient control led epidural analgesia. The management of contraction pain is inferred within the text of the policy. The strict adherence to the epidural assessment parameters and the monitoring of untoward effects reconstruct the nurse’s cognitive frame of the role of the epidural as a means to end (complete pain relief) as opposed to a tool used to assist the labouring woman cope with her painful labour contractions. This particular understanding of pain management also renders invisible the agency of the labouring woman and her ability/ inability to “bear” the pain of labour. Vangie Bergum (1997), a
nurse researcher who has conducted many studies with women during childbearing states:

*What do the pains of birth tell us about ourselves, about our sufferings and our joys? Is there something in the pangs of childbirth which holds true for all women: those who pleasure and ride above the pain? those who endure it? and those who suffer?*” (Bergum, 1997, p.54).

When the nurse re-negotiates priorities during the recovery phase, the women’s need for rest and sleep represents the fourth level of priorities organizing and coordinating nurses work. As outlined by the hospital policy, once the safety requirements of the epidural process are met and labour pain has been completely eliminated, the nurse reconstructs her nursing care to promote maternal rest/sleep and energy restoration. We know that childbirth is a period of physiological and psychological stress and that fatigue which may adversely impact woman’s wellbeing, and their capacity to cope with the arduous tasks associated with the process of labour and birth (Pugh and Milligan,1993). Maternal fatigue has been associated with dysfunctional labour; secondary arrest of cervical dilatation which generally results in medical intervention such as the use of forceps or vacuum (Peaceman and Socol 1996). The nurses’ actions are therefore understandable.

However, as labour continues immobility can also affect labour progress (Simkin, 2011). As nurses we need to be reminded that promoting sleep and rest also makes our work easier by facilitating the nurse’s monitoring/charting work, routine care and adherence to the parameters and guideline established by the hospital policies. Keeping the labouring woman with a mobile labour epidural analgesia immobile in bed can
become the norm and accepted nursing practice on the unit, despite the potential impact on labour progress and birth outcomes.

The institutional work processes required for the safe initiation and management of epidural directs the nurse’s attention away from promoting mobilization and labour progress and decrease the perinatal nurse’s time available for providing supportive care during active labour. Mobilizing the woman to promote labour progress falls to the bottom of the list of institutional priorities. Although promoting labour progress through balancing rest and mobility remains within the independent domain of nursing work, this study justifies further exploration to uncover how (and indeed if, given current conditions) nurses can do this work more effectively and in ways that promote the agency of childbearing women and their family members.

Summary and Discussion

A Registered Nurse is responsible for simultaneously caring for the labouring woman, her unborn baby and her family members. Initially the nurse’s work includes relationship building and negotiating nursing care, assessing for risk factors and ensuring the woman/fetus remain safe as labour progresses, providing labour support, and documenting perinatal care according to institutional standards. Although this work requires a highly skilled care provider, the nurse is usually present in the room and can tailor her supportive care to the woman’s needs and her responses to the physiologic processes of labour and birth. The woman’s decision to have an epidural activates an institutional work process that initially pulls the nurse from the room and re-structures her work toward:

- Supporting the initiation and maintenance of the epidural
• Monitoring for and preventing side effects

• Promoting effective pain relief

• Documenting that safe care has been provided and standards of practice were met

• Mobilizing the labouring woman

Supporting the initiation and maintenance of the epidural involves a constant re-prioritization of the nurse’s actions and interventions in order to attend to the multiple and sometimes conflicting demands associated with the care of a labouring woman. This nursing work is structured by institutional texts which hook the nurse into accomplishing institutional priorities. Participants in this study were interviewed as expert informants about their everyday work activities. They described in detail what their work entails and some of the difficulties they experience. The institution requires knowledgeable and skilled nurses who can accomplish epidural management safely. Some of these work activities are invisible but still require considerable nurses’ time. It is time over which nurses do not exercise effective control as they are dependent on the institutional processes already in place (forms to be filled, obtaining medication for the automated medication delivery system, collecting epidural cart and IV pole from equipment room etc.).

In addition, the nurse’s epidural work of gathering, finding and ensuring all medications and equipment are available, could be described as women’s work (Rankin & Cambell, 2006), where women pick up the pieces of whatever needs to be done in order to advance or expedite the institutional epidural procedures and management processes. In order to ensure that safe and effective care is provided to the woman labouring with a mobile labour epidural analgesia, the institutional process and the day
and night functioning of a unit relies “on nurses seeing what need doing and doing it, and seeing what is going wrong and correcting it” (Rankin & Cambell 2006, p.42) The “monitoring for and preventing side effects” aspect of the nurse’s work illuminates her extensive specialized knowledge which involves an awareness of the interplay of the epidural on maternal/fetal wellbeing and labour progress. This extensive nursing knowledge does not appear in the institutional texts because it is assumed that nurses simply follow medical and hospital policies, procedures and guidelines. Chinn & Kramer (2008) have also identified the invisibility of the nurse’s knowledge in the healthcare system.

“As nurses practice, they know more than they can communicate and use insights and understanding that they often take for granted. Much of what is known is expressed through actions, movements, or sounds. These everyday actions reflect the whole of knowing. What happens in practice can only be shared in the moment and typically is not available to a broader audience.” (Chinn & Kramer 2008, p.2).

As such, nurse’s work knowledge is shared between the nurses while they work on the unit but never reaches the institutional level where decisions are made that directly impact nursing work and changes to current forms or procedural text can occur. The nurse’s work associated with the management of the mobile epidural becomes invisible within the institution and does not appear in the Mobile Labour Epidural Policy or the Labour Partogram.

In the case of epidurals, the nurse’s work of “promoting effective pain relief” is managed separately from the process of labour and birth. Once the epidural is inserted and the contraction pain alleviated, all manifestations of pain are perceived as
problematic. Following the epidural insertion, contraction pain is constructed as a pathological manifestation of labour and is treated separately from the labour process. The goal is to take every measure possible within the context of epidural management to alleviate the presence and reoccurrence of contraction pain. The overall effect of the discourse of effective pain management as a technological accomplishment overshadows other discourses about the experience of pain as part of the natural physiologic process of labour and birth and the relative importance of supportive care during labour.

The discourse of effective pain management using epidural technology re-organizes the nurse’s work as a function of the monitoring parameters, management of technology and the efficient use of hospital resources (i.e. the anesthesiologist’s time). Initiation of epidural analgesia also re-estabishes the rules about personal boundaries between the nurse and the labouring woman so that the nurse seldom touches the labouring woman and will do so usually only to gather data (Quance, 2007). Perhaps this shift from high-touch to high-tech care may partly explain why in health care institution with high epidural rates (65-85%) the hands on supportive care provided by nurses was identified as being lowest (Gagnon and Wagner, 1996; Gale, Fothergill-Bourbonnais and Champlain, 2001; McNiven, Hodnett and O’Brien-Pallas, 1992).

The nurse’s work of mobilizing a labouring woman with an epidural involves an additional layer of assessment and evaluations which require additional work on the part of the nurse. The nurse must choose and prioritize the care she provides to the labouring woman. Needing to focus more intensely on the safety of the labouring woman and her fetus, alongside ensuring the required epidural work processes are completed, results in mobility falling to the lowest priority level within the nurse’s epidural management work.
The textually mediated work processes associated with epidural management reinforce this hierarchy of priorities and directly structures the nurse’s work time away from this important component of nurse’s care. A significant amount of the nurse’s work and time is spent assessing various biophysical parameters and ensuring that the labouring woman and fetus are safe. The nurse’s work of documenting that standards of care have been met takes precedence over finding alternative options to promote mobility. As such the discourse on mobile epidurals functions as a means to focus the nurse’s work on eliminating only pain and mobilizing the woman to promote labour progress falls off the nurses’ list of priorities.

The Labour Partogram is the main documenting tool used by nurses. The Partogram coordinates the sequence of nurse’s actions by structuring and standardising assessment, documentation and communication. The Partogram represents the vehicle by which evidence-based intrapartum care and procedural standards outlined by regulatory text are ‘translocally’ activated within the nurse’s work. The Partogram prioritizes fetal heart surveillance and positions other assessment parameters, such as repositioning and mobilizing, to a lesser degree of importance within the nurse’s work and the overall care of the labouring woman and fetus. The partogram further contributes to this dichotomy between the fetal heart rate assessment and other assessment parameters by allocating insufficient documentation space in the section associated directly with nursing interventions, such repositioning and mobilization. The partogram’s extensive biomedical focus further contributes to the invisibility of nursing care and the perinatal nurses’ contribution to labour outcomes. The narrative notes describing the nurse’s interventions becomes buried in the flow of notations in the interprofessional form. One
has to be knowledgable about the nurse’s work in order to search through the narrative documentation and find specific information associated with highly skilled epidural nursing care.

The extensive biomedical focus as it relates to the care of labouring woman can also be observed within the mobile labour epidural analgesia policy text. The policy text focuses of the epidural procedure process and maternal and fetal monitoring. The epidural policy text does not provide any guidelines on ways to preserve the labouring woman’s mobility. The absence of guidelines for preserving mobility in the epidural policy text further positions the mobility parameter to a lower level of priority within the nurse’s epidural management work. As such the biomedical discourse on using an epidural as a means to treat pathological pain becomes the dominant organizer of nursing work and the discourse of maternal needs for recovery/rest after a painful experience emerges. Keeping the labouring woman with a mobile labour epidural analgesia immobile in bed is thus justified as acting on her behalf and considered the norm and the accepted nursing practice on the unit.

**Opportunities for further research**

This research has prompted many ideas for additional research. For example, how does the nurse’s perception of the labour process and the need for pain relief influence how she manages the mobilization and repositioning of the labouring woman? What discourses are the women drawing upon for their understanding about labour pain and the relative importance of mobility during labour and birth? What kinds of environments are most supportive of women who view labour as a normal process and labour pain as an indicator of progress in labour?
This study has contributed to our understanding of the complexity of nurse’s work when providing care to a labouring woman with a mobile labour epidural analgesia. The exploration of the various hospital forms and guidelines show how texts coordinate and organize the nurse’s epidural work in specific way and treat labour pain as pathological and minimize women’s ability to bear the pain of childbirth. If we really want to prevent unnecessary operative deliveries we need to re-visit the assumptions made about the normalcy of birth, the role of pain and mobility during labour, and the institutional requirements that structure nursing work.
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Appendix A

Nurse’s Interview Consent Form
Organization of Labour & Delivery Nurses’ Work Following Epidural Insertion

Principal Investigator:
Isabelle Baribeau
School of Nursing
University of Victoria

Thesis Supervisor:
Karen MacKinnon RN PhD
School of Nursing
University of Victoria
(250) 721-7966
kamackin@uvic.ca

Purpose:
The goals for this investigation are to explore how labour and delivery nurses in hospital settings care for a woman with a mobile or neuraxial epidural analgesia and how the nurses’ work is shaped and coordinated by institutional discourses about the management of pain for women labouring with an epidural and by current management practices that focus on efficiency and measurable short term outcomes. Specific objectives include:

1. To describe the work nurses do when providing care for a woman labouring with a mobile epidural analgesia.
2. To describe the knowledge and skill required by the labour and delivery nurse in order to care for a woman labouring with a mobile epidural analgesia.
3. To explore how the labour and delivery nurse activates, responds and integrates the various documents associated with the management of mobile epidural analgesia into her work.
4. To understand how the texts and various hospital forms addressing the management of mobile epidural are organizing the work of the labour and delivery nurse.
5. To understand how the texts associated with the care of women labouring with epidural analgesia are developed and utilized as sources of information in the Birthing Program.
6. To understand how the management of mobile epidural analgesia is articulated in the various forms and work processes at BCW’s Hospital.

You have been invited to participate in this research because you have personal experience and knowledge about nursing work associated with the care of women laboring with a mobile labour analgesia. This research study is part of Isabelle Baribeau’s Master Thesis at the University of Victoria. Karen MacKinnon, an Assistant Professor at University of Victoria, is the Thesis Supervisor for this research study.

Study Procedures:
Your participation in this project involves taking part in an interview which will be audio-recorded. The interview will be held at a place where you are comfortable and will last approximately one hour. Isabelle Baribeau, a Registered Nurse, will be conducting the interviews. Interviews with nurses will not occur while they are providing patient care.

You may refuse to answer any specific questions during the interview. You are also welcome to offer your ideas and information on issues or subjects not raised by the researcher that you think are relevant to this research. You may ask any questions you have about this process at any time. You are free to withdraw from participating at any time and may withdraw any statement you make from the research analysis. Once the data has been transcribed and analyzed, the researcher will arrange an information session for nurses working in the Birthing Program to share her summarised findings with interested staff (knowledge translation).

Benefits, Inconveniences and Risks:
This study will not benefit you directly but may be used to better support the nurses who provide maternity care. It may be inconvenient for you to learn about this study but the researcher will make every effort to answer your questions completely and with minimal disruption to your work. There are minimal risks for participating in this study. Precautions will also be taken to protect your identity and to maintain confidentiality about all the information you share.

**Confidentiality:**
The interview will be audio-recorded and transcribed into a written record. No information that can identify you will be recorded in the written transcripts. The transcripts will be prepared using pseudonyms rather than your real name unless you instruct us otherwise. Reports or publications resulting from the data collection will not contain any identifying information and anonymity will be protected. The researcher will hold all of the information collected from the interview session in strict confidence. All records from the interviews will be kept in a locked drawer in a private locked research office. The information will be kept for a period of five years, after which time it will be destroyed.

**Contact for information about the study:**
If you have any questions or desire further information with respect to this study, you may telephone Isabelle Baribeau at 604-943-6364 or Karen MacKinnon by e-mail or phone.

**Contact for information about the rights of research participants:**
If you have any concerns about your treatment or rights as a research participant, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca) or the Chair of the Woman’s Health Research Ethics Board (604-870-4649).

**Consent:**
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without penalty.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study. You do not waive any legal rights by signing this form.

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This second signature below indicates that you agree for the researcher to contact you to ask clarify information shared during the interview.

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Phone Number or email address
Appendix B

Interview Questions

“The goals for this investigation are to explore how labour and delivery nurses in hospital settings care for a woman with a mobile or neuraxial epidural analgesia. The study focuses on how the nurses’ work is shaped and coordinated by institutional discourses about the management of pain for women labouring with an epidural and by current management practices that focus on efficiency and measurable short term outcomes. You have personal experience and knowledge about nursing work associated with the care of women laboring with a mobile labour analgesia and I would like to hear about it in more details from you. There are minimal risks for participating in this interview or debriefing session. Precautions will also be taken to protect your identity and to maintain confidentiality about all information about you share with me. The interview will be audio-recorded and transcribed into a written record. No information that can identify you will be recorded in the written transcripts. The transcripts will be prepared using pseudonyms rather than your real name unless you instruct me otherwise. Reports or publications resulting from the data collection will not contain any identifying information and anonymity will be protected. I will hold all of the information collected from the interview session in strict confidence. Your participation in this study is entirely voluntary and you may refuse to participate or stop the interview at any time without penalty. Before we start do you have any questions?”

I’d like to take you back to your most recent experience where you provided nursing care to a woman labouring with a mobile epidural analgesia. Tells me with as many details as possible what you did when your patient first made the decision to have a mobile epidural.

Sample Questions
A. **Objective:** to obtain a chronological description of the work nurses do when providing care for woman labouring with a mobile epidural analgesia.

- Thinking about the woman you were most recently providing care for please describe the care you provide to a labouring woman following the insertion of an epidural. **Probe:** What did you do when you first learned that you would be caring for Ms. X? (Use your field notes to guide the interview)... What did you do next? Why did you do this? Who did you contact? Why? Etc.

B. **Objective:** to describe the knowledge and skill required by the labour and delivery nurse in order to care for a woman labouring with a mobile epidural analgesia.

- I have been thinking about the knowledge and skills an RN needs to care for a woman with a mobile epidural. **What knowledge were you drawing on when you provided care for the woman you described earlier today?** What were you thinking when you did that?

C. **Objective:** to explore how the labour and delivery nurse activates, respond and integrate the various documents associated with the management of the mobile epidural in her work.

- Can you describe in as much detail as possible what you do when a women request an epidural? **Probe:** who do you contact? What forms do you fill in?

- Can you describe in as much details as possible what you do once the mobile epidural is in place? **Probe:** How you monitor a laboring woman following epidural insertion?

- How do you decide if it is safe for a woman to mobile with her epidural? **What guide your decision?** How do you monitor laboring woman when she is mobilizing? **When do you decide to change her position?**
D. Objective: to gain a better understanding of how texts and various hospital forms addressing the management of mobile epidural are organizing the work of the labour and delivery nurse.

- Can you describe in as much detail as possible how you utilize these various forms while you are caring for a laboring woman with a mobile epidural? Probe: How do you complete them? Who else might use these forms? Where do they go?

E. Objective: to gain a better understanding of how the texts associated with the care of women labouring with epidural analgesia are developed and utilized as sources of information in the Birthing Program.

- Using a blank copy of a form that RNs complete when caring for these women ask the nurse how she completes it step by step for her patient but without any identifying information. Do you know why this form is needed for a woman having a mobile epidural or how it is used?

- 

F. Objective: to gain a better understanding of how the management of mobile epidural analgesia is articulated in the various form and work processes at BCW’s Hospital.

- When can a woman receive a mobile epidural? Who decide if it is appropriate for laboring woman to receive a mobile epidural? How does this work affect the work flow on your unit? Any additional comments?
G. Background information (demographics)

And finally I’d like to ask a few background questions about you so that I can describe in
general terms who participated in this study. I want to be sure that nobody can identify
who participated in this study.

1. How many years have you worked as an RN?
   - □ Less than 5 years
   - □ 5 – 9 years
   - □ 10 – 14 years
   - □ 15 – 19 years
   - □ Over 20 years

2. How many years have you worked at BC Women’s Hospital?
   - □ Less than 5 years
   - □ 5 – 9 years
   - □ 10 – 14 years
   - □ 15 – 19 years
   - □ Over 20 years

3. How many years have you worked in the Birthing Program at BC Women’s Hospital?
   - □ Less than 5 years
   - □ 5 – 9 years
   - □ 10 – 14 years
   - □ 15 – 19 years
   - □ Over 20 years

4. How much do you currently work? What is your Full Time Equivalent (FTE)?
   - □ 1 FTE
   - □ 0.5 – 0.9 FTE
   - □ Less than 0.5 FTE
   - □ Casual
6. What is your current age group?
   - □ 20 – 29
   - □ 30 – 39
   - □ 40 – 49
   - □ 50 and over

7. Which of the following best describes your highest education attained?
   - □ Diploma (RN)
   - □ Baccalaureate (BSN)
   - □ Graduate Education (e.g. Master’s degree)
   - □ Speciality qualification (e.g. Perinatal Nursing or Midwifery)

8. Do you have any other comments about this study?

Thank you for participating.
Appendix C

University of Victoria Human Research Ethics Board – Certificate of Approval

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**PROJECT TITLE:** Organization of Labour & Delivery Nurses' Work Following Epidural Insertion

**RESEARCH TEAM MEMBERS:** Supervisory committee: Lenore Marcellus (UVic), Becky Palmer (BC Children's Hospital and BC Women's Hospital & Health Centre)

**DECLARED PROJECT FUNDING:** None

**CONDITIONS OF APPROVAL**

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

- **Modifications**: To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol.
- **Renewals**: Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.
- **Project Closures**: When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.

**Certification**

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Participants.

Dr. Rachael Scarth  
Associate Vice-President, Research

Certificate Issued On: 04-Oct-12