N432 Focus Sheet #2 2020

Ricci, Kyle, & Carman Ch 13, 14, 21; ATI Ch 11, 12, 13, 14, 15,16 and online Fetal Monitoring program

1. Fill in the following table with associated s/s of each

	TRUE LABOR	**FALSE LABOR**
Uterine Contractions (Braxton Hicks)		Tightening or pulling sensation that typically occurs in the abdomen and groin.
Cervical Dilation & Effacement	The cervix is stretching and getting thinner.	
Bloody show	The mucus plug is expelled as a result of cervical softening and increased pressure of the presenting part.	
Fetus: Engagement	As the ligaments loosen — and you get closer to the end of your pregnancy — your baby's head will begin moving further downward into the pelvis	

2. **How does lightning relate to labor?**
   Lightning is when the fetal presenting part begins to descend into the pelvis. The uterus lowers and moves into the anterior position.

3. **Describe the Bishop score and the indications for doing it.**
   A system used by medical professionals to decide how likely it is that you will go into labor soon. They use it to determine whether they should recommend induction, and how likely it is that an induction will result in a vaginal birth.
4. **What are Leopold's maneuvers (make sure to understand all 4 maneuvers) and what 4 questions does each maneuver answer?**
   Maneuvers 1: what fetal part (head or butt) is located in the fundus (top of the uterus).

Maneuver 2: on which maternal side is the fetal back located (fetal heart sounds are best auscultated through the back of the fetus).
Maneuver 3: what is the presenting part?
Maneuver 4: is the fetal head flexed and engaged in the pelvis?

5. **List the "preprocedures" done on admission to labor and delivery.**
   Leopold maneuvers, external electronic monitoring (Tocotransducer), External fetal monitoring (EFM).

6. **State the 5 "P's" of the labor progress and what each P is composed of.**
   Passageway (birth canal), passenger (fetus and placenta), powers (contractions), position (maternal), psychological response.

7. **Define fetal lie and fetal attitude.**
   Fetal lie: refers to the relationship of the long axis (spine) of the fetus to the long axis (spine) of the mother.
   Fetal attitude: refers to posturing (flexion and extension) of the joints and the relationship of fetal parts to one another.

8. **What role do the fetal skull suture lines and fontanelles play in identifying fetal position?**
   The skull suture lines plays a role in determining the degree of rotation that has occurred. This will also determine how labor will go.

9. **Define the various fetal presentations (RKC p 462-464 & ATI p 74).**
   Breech: pelvis first. **Cephalic:** head first. **Shoulder:** scapula first.

10. **What do each of the 3 letters associated with fetal positioning stand for?**
    First letter: defines whether the presenting part is titled toward the left (L) or the right (R) side of the maternal pelvis.
    Second letter: Represents the particular presenting part of the fetus: O for occiput, S for sacrum, A for acromion process, D for dorsal.
    Third letter: Defines the location of the presenting part.

11. **Fetal station is assessed in relation to what?**

Fetal station refers to the relationship of the presenting part to the level of the maternal pelvic ischial spine.

12. **Outline the rationale for and the pros and cons of external cephalic version.**
    Pros- this would give the woman the opportunity to give a vaginal birth. Turns baby from breech to head first. Cons- might not work.

13. **Describe methods of cervical ripening and the indications for their use?**
    Cervical ripening can occur through sexual intercourse, breast stimulation, nerve stimulation, prostaglandins, misoprostol, mifepristone, and oxytocin.

14. **Use this chart to summarize the Stages & phases of labor. Write it so that it makes sense to you.**

Stage of Labor	***What is happening during this Stage/Phase ?***	***Expected effacement & dilation of cervix***	***Expected Frequency of Contractions***	***Expected duration of contractions***	***Anticipated Nursing assessments & interventions***
First Stage 1. Latent 2. Active 3. Transition	1. Start of regular contraction, rapid cervical dilation. 2. Increase rate of cervical dilation.	1. Slowly to approx. 6 cm. 2. cervix reaches 10cm.	1. 5-10 minutes. 2. 2-5 minutes.	1. 30-45 seconds. 2. 45-60 seconds.	1. Nurses will press down on the top of the fundus to see how severe the contraction is. 2. Pain management.
Second Stage	Cervix is completely dilated and ends with the birth of the newborn.	10cm	2-3 minutes.	60-90 seconds.	Pain management, breathing techniques.
Third Stage	Birth of the newborn and separation of the placenta.	NA	NA	NA	Watch for bleeding.

Fourth Stage	Expulsion of the placenta and the stabilization of the mother (1-4 hours).	NA	NA	NA	Watch for bleeding or any post labor and delivery complications.

15. **How can we confirm rupture of membranes?**
    A sample of fluid is taken from the vagina via nitrazine yellow dye swab to determine the fluids PH.
    What is our priority nursing intervention after confirmation of rupture of membranes?
    Assessing fetal heart rate.
    What information do we want to gather from the mother about rupture of membranes if we did not witness it?
    Ask when it occurred.

16. **Describe when an induction might be warranted and the difference between induction and augmentation?**
    An induction would be warranted if the mother was not progressing the way she was supposed to. **Induction**- stimulates the uterus to begin labor.
    Augmentation- stimulating the uterus during labour to increase the frequency, duration **and** strength of contractions.

17. **Describe what an amniotomy is, the indications for it to be done, and the considerations.**
    Artificial rupture of membranes. Inducing or expediting labor. Risks of amniotomy include injury to the fetus or surrounding tissues, **bleeding**, nonreassuring fetal testing, cord prolapse, and prolonged rupture of membranes (defined as longer than 18 hours), which is a risk factor for intra-amniotic **infection**. The optimal timing of amniotomy is not known.

18. <u>Medications:</u> ***What is each medication used for? What does it do? Nursing indications/interventions?***

Oxytocin	**This is a hormone that is responsible for signaling contractions of the uterus during labor. Produces cervical ripening.**

Misoprostol	**This medication can induce labor. Produces cervical ripening.**
Penicillin G	**Penicillin G can protect babies from infection during labor. This antibiotic protects from Group B Streptococcal disease.**
Methylergonovine	**This medication can be used to help control the bleeding after a child is born, as well as help deliver the placenta.**
Betamethasone	**This medication helps speed up lung development in underdeveloped fetuses. This helps stimulate the creation of surfactant, the lubrication of the lungs.**
Terbutaline Sulfate	**Terbutaline sulfate can delay premature contractions that could lead to preterm labor.**
Methotrexate	**This medicine should be avoided during pregnancy as it has teratogenic effects, unless specifically needed to abort an ectopic pregnancy.**
Indomethacin	**Effective in the second and early third trimester, this medication, a tocolytic, is given to stop a preterm labor.**
Magnesium Sulfate	**This medication is used to prevent seizures caused by preeclampsia, stop preterm labor, and prevent injuries to a preterm brain.**
Nalbuphine hydrochloride (Nubain)	**Nubain can prolong labor by reducing the strength and frequency of uterine contractions.**
Calcium Gluconate	**Given to clients who have hypocalcemia caused by pregnancy.**
Naloxone (Narcan)	**Naloxone is an opioid antagonist. This is given to client's who experience an acute opioid overdose.**

19. **List procedures done during labor ("intra partum").**

    Assess maternal vital signs, assess FHR, and assess uterine labor contraction characteristics.

20. **Define each of the 6 cardinal movements of labor (Mechanisms of labor).**

    Engagement: the presenting part or the diameter of the fetal head passes and is referred to station 0. **Descent:** the progress of the presenting part to the pelvis. **Flexion:** when the fetal head meets resistance of the cervix, pelvic wall, or pelvic floor. **Internal rotation:** the fetal occiput ideally rotates to a lateral anterior position as it progresses from ischial spines to the lower pelvis in a corkscrew motion. **Extension:** the fetal occiput passes under the symphysis pubis, and then the head is deflected anteriorly and is born by extension of the chin away from the fetal chest. **External rotation:** head is born. Birth by expulsion: after birth of the head and shoulders the trunk of the neonate is born.

21. **Describe the benefits for a woman to change position while in labor. Include what suggestions the nurse can give the laboring woman about position changes?**

    Changing positions can help relieve pain, can reduce the length of labor, and decrease surgical births. The nurse can encourage the patient to walk around, use a ball to bounce on, rock back and forth, and sway from side to side.

22. **What are the 4 techniques used to assess ongoing data during labor and birth?**

    Analysis of amniotic fluid, analysis of the FHR, assess uterine contractions, vaginal exam.

23. **What is a vaginal exam (SVE-sterile vaginal exam)? How often should it be done according to WHO (World Health Organization)?**

    A vaginal examination in labour is a sterile procedure if the membranes have ruptured or are going to be ruptured during the examination. It should pbe performed every two hours.

24. **Why is it important to assess frequency, duration and intensity of contractions?**

To see the progress of labor.

25. **What 2 ways can you assess uterine contractions?**

Electronic monitoring, palpation of the fundus.

26. To palpate uterine contraction intensity, a mild contraction feels like your __**nose**_____ , a moderate contraction feels like your __**chin**_____**,** and strong contraction feels like your **__forehead**_____**.**

27. **List the sources of pain during labor.**

Labor, birth. The baby is moving and pressing down to get the cervix to open.

28. **List how pain assessment is done during labor.**

Pain assessment is on a scale of 0-10.

29. **What should the nurse consider prior to administration of opioid pain medication during labor?**

That opioids can cause respiratory depression.

30. **Describe the gate-control theory of pain control. Give examples.**

Local physical stimulation can interfere with pain stimuli by closing a hypothetical gate in the spinal cord, thus blocking pain signals from reaching the brain.

31. **List 3 non pharmacologic pain intervention methods.**

Hydrotherapy, ambulation and position changes, and acupuncture/acupressure.

32. **Describe how epidural analgesia is administered, what are the implications, and what is the difference between this and a spinal epidural?**

A small catheter is passed through the epidural needle to provide continuous access to the epidural space throughout labor and birth. This is supposed to block pain. Epidural analgesia is continuous and spinal is removed and used for later use.

33. **What added considerations are there for the nurse caring for a woman who has undergone general anesthesia?**
    - Ensuring the woman is NPO, and her IV infusion is in place.
    - Administering a histamine receptor antagonist to decrease gastric acid production.
    - Administering metoclopramide to increase gastric content emptying
    - Assess the client postpartum for decreased uterine tone, which can lead to hemorrhage and be produced by pharmacological agents used in general anesthesia.
    - apply antiembolic stocking compression devices.

    COMPLETE Q34 & Q35 after you review R,K,C p 492-498 and ATI p86-89 for understanding of fetal monitoring and you complete the Online Fetal monitoring program

34. **Where in the contraction do the increment, acme and decrement happen?**
    Increment; The beginning of the contraction as intensity is increasing
    Acme; The peak intensity of the contraction
    Decrement; The decline of the contraction intensity as the contraction is ending

35. **Briefly describe what Category I, Category II and Category III fetal heart rate tracings look like.**
    Category I includes: baseline fetal heart rate of 110 / 60, baseline fetal heart rate variability: moderate, Accelerations: present or absent, early deceleration; present or absent, variable or late deceleration; absent.
    Category II: includes tracing of all fetal heart rate i.e Baseline rate, Baseline FHR variability, episodic or periodic deceleration, acceleration.
    Category III: includes sinusoidal pattern, absent fetal heart rate variability i.e recurrent variable deceleration, recurrent late deceleration, bradycardia.

36. **Why is support vital for laboring women? What is a doula? What is a CNM?**
    A doula is a person (non-healthcare worker) who is trained to help support a laboring woman but also women who are experiencing miscarriage or abortion.

CNM is a certified nurse midwife. Support is vital for laboring women because it helps them stay calm, and control their pain better.

37. What is “crowning”?

Crowning occurs when the child’s head becomes visible in the birth canal after becoming fully dilated.

38. List a summary of assessments during second , third and fourth stages of labor.

Second stage of labor; vital signs, uterine contraction, pushing by the client, increase in bloody show, shaking of extremities, FHR every 5 to 15 minutes.
Third stage of labor; Vital signs, clinical findings of placental separation; Fundus firmly contracting, swift gush of dark blood from introitus, umbilical cord appears to lengthen as placenta descends, vaginal fullness on exam.Assignment of 1 and 5 minutes apgar score to the neonates.
Fourth stage of labor; Maternal vital signs, fundus, Lochia, Urinary output, and baby friendly activities of the family

39. What are the signs of placental separation and how long can it take for the placenta to be expelled?

The uterus contracts and rises, the umbilical cord suddenly lengthens, or a gush of blood occurs. Delivery of the placenta usually happens within 5-10 minutes after delivery of the fetus, but it is considered normal up to 30 minutes after delivery of the fetus.

40. What is the difference between a laceration and an episiotomy?

An episiotomy is a minor incision made during childbirth to widen the opening of the vagina. A perineal tear or laceration often forms on its own during a vaginal birth

41. What are the normal blood loss amounts for a vaginal and a cesarean delivery?

Women will lose about 0.5 qt/500 mL of blood during a vaginal birth and 1 qt/1,000 mL during a C-section.

42. List “post procedures” done during the fourth stage of labor.

Monitoring vital signs, monitoring discharge “Lochia”, monitoring the fundus of the uterus for firmness, administering pain medication.

43. **What are important interventions for the newborn at birth? Why is skin to skin time with mom so important?**

Thermo-regulation is an important intervention for a newly born baby, along with immunization, promotion of hygienic cord, and skin care.

Skin to skin time between the mother and the baby can reduce the stress of both parties, while regulating and stabilizing the vitals of the baby, such as temperature, respirations, heart rate, and blood sugar.

44. **What important assessments as the nurse are you continuing to make, in relation to mom, during the third stage of labor?**

- Monitor blood pressure, pulse, and respiration every 15 minutes
- Clinical findings of placental separation from the uterus is indicated by : Fundus firmly contracting, swift gush of dark blood from introitus, umbilical cord appears to lengthen as placenta descends, vaginal fullness on exam.