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) Pg. 439	Are more commonly felt in the lower back. These contractions aid in moving the cervix from a posterior position to an anterior position. They also help in ripening and softening the cervix. However, the contractions are irregular and can be decreased by walking, voiding, eating, increasing fluid intake, or changing position. These contractions usually last about 30 seconds but can persist for as long as 2 minutes. As the birth draws near and the uterus becomes more sensitive to oxytocin, the frequency and intensity of these contractions increase. If the contractions last longer than 30 seconds and occur more often than four to six times an hour, advise the woman to contact her care provider so that she can be evaluated for possible preterm labor, especially if she is less than 38 weeks pregnant.	Women may have been experiencing throughout the pregnancy, may become stronger and more frequent. These contractions are typically felt as a tightening or pulling sensation of the top of the uterus. They occur primarily in the abdomen and groin and gradually spread downward before relaxing.
Cervical Dilation & Effacement Pg. 438	As labor approaches, the cervix changes from an elongated structure to a shortened, thinned segment. Cervical collagen fibers undergo enzymatic rearrangement in	The rigid cervix of pregnancy must become distensible to expel the fetus. Before labor begins, cervical softening and possible cervical dilation with descent of the presenting part

	smaller, more flexible fibers that facilitate water absorption, leading to a softer, more stretchable cervix. These changes occur secondary to the effects of prostaglandins and pressure form braxton hicks contractions.	into the pelvis occur. These changes can occur 1 month to 1 hour before actual labor begins.
Bloody show Pg. 439	The mucus plug that fills the cervical canal during pregnancy is expelled as a result of cervical softening and increased pressure of the presenting part. The ruptured cervical capillaries release a small amount of blood that mixes with mucus, resulting in the pink-tinged secretions.	The mucus plug that fills the cervical canal during pregnancy is expelled as a result of cervical softening and increased pressure of the presenting part. The ruptured cervical capillaries release a small amount of blood that mixes with mucus, resulting in the pink-tinged secretions.
Fetus: Engagement Pg. 447 Definition: entrance of the largest diameter of the fetal presenting part into the smallest diameter of the maternal pelvis.	The largest diameter of the fetal head is the biparietal diameter. It extends from one parietal prominence to the other. It is an important factor in the navigation through the maternal pelvis. Engagement typically occurs in primigravidas 2 weeks before term, while multiparas may experience engagement several weeks before the onset of labor or not until labor begins.	The fetus is said to be engaged in the pelvis when the presenting part reaches 0 stations.

2. How does lightening relate to labor? Pg. 438

When the fetal presenting part begins to descend into the true pelvis. The uterus lowers and moves into a more anterior position. The shape of the abdomen changes as a result in the uterus. with this descent, the woman usually notes that her breathing is much easier and that there is a decrease in the gastric reflux. May complain of increased pelvic pressure, leg cramping, dependent edema in the lower legs, and lower back discomfort. Notice an increase in vaginal discharge and more frequent urination. In primiparas, lightening can occur 2 weeks or more before labor begins; among multiparas, it may not occur until labor starts.

3. Describe the Bishop score and the indications for doing it. Pg.101

-A bishop score is used to determine maternal readiness for labor by evaluating whether the cervix is favorable by rating the following.

a. Cervical dilation
b. Cervical effacement
c. Cervical consistency (firm, medium, or soft)
d. Cervical position (posterior, midposition, or anterior)
e. Station of presenting part

- The five factors are assigned a numerical value of 0 to 3, and the total score is calculated

4. What are Leopold's maneuvers (make sure to understand all 4 maneuvers) and what 4 questions does each maneuver answer? Pg. 470-471

A method for determining the presentation, position, and lie of the fetus through the use of four specific steps

Maneuver 1: Place the woman in the supine position and stand beside her.

-Perform the first maneuver to determine presentation.

a. Facing the woman's head, place both hands on the abdomen to determine fetal position in the uterine fundus.
b. Feel for the buttocks, which will feel soft and irregular; feel for the head, which will feel hard, smooth, and round

Maneuver 2: Determine Position

a. While still facing the woman, move hands down the lateral sides of the abdomen to palpate on which side the back is located (feels hard and smooth).
b. continue to palpate to determine on which side the limbs are located (irregular nodules with kicking and movement).

Maneuver 3: Confirm presentation

a. Move hands down the sides of the abdomen to grasp the lower uterine segment and palpate the area just above the symphysis pubis.
b. Place thumb and fingers of one hand apart and grasp the presenting part by bringing fingers together.
c. Feel for the presenting part. If the presenting part is the head, it will be round, firm, and ballottable; if it is the buttocks, it will feel soft and irregular.

Maneuver 4: Determine attitude

a. Turn to face the client's feet and use the tips of the first three fingers of each hand to palpate the abdomen.
b. Move fingers toward each other while applying downward pressure in the direction of the symphysis pubis. If you palpate a hard area on the side opposite the fetal back, the fetus is in flexion, because you have palpated the chin. If the hard area is on the same side as the back, the fetus is in extension, because the area palpated is the occiput.

5. List the "preprocedures" done on admission to labor and delivery. Pg. 467-
   a. Leopold Maneuvers
   b. External electronic monitoring (tocotransducer)
   c. External fetal monitoring (EFM)
   d. Group B Streptococcus
   e. Urinalysis
   f. Blood Tests

6. State the 5 "P's" of the labor progress and what each P is composed of. Pg. 76

   a. Passenger (fetus and placenta)
   b. Passageway (birth canal)
   c. Powers (contractions)
   d. Position (of the woman)
   e. Psychological response

7. Define fetal lie and fetal attitude.
   a. Fetal Lie:
      i. spine to spine positioning of the baby to the mother (Direction the baby is laying)
   b. Fetal attitude:
      i. Flexion/extension is the relationship of the fetal body parts to itself

8. What role do the fetal skull suture lines and fontanelles play in identifying fetal position?
   a. The sutures help identify the fetal head position during the vaginal exam, and the degree of rotation that has occured
      i. Fontanelles allow for molding
      ii. Anterior fontanelle is the "soft spot"
         1. diamond-shaped and remains open for 12-18 months after birth to allow for brain growth
      iii. Posterior fontanelle is triangular
         1. closes within 8-12 weeks
      iv. Suboccipitobregmatic
         1. measured from the base of the occiput to the center of the fontanelle: identifies the smallest anteroposterior diameter of the fetal skull

v. Biparietal measure the longest transervese diabetes of the fetal skull
vi. In cephalic:
    1. flexed position with the chin resting on the chest- the optimal/small fetal dimensions
vii. Fetal head not full flexed:
    1. anteroposterior diameter increases

9. Define the various fetal presentations (RKC p 462-464 & ATI p 74).
    a. Cephalic (Head first): presents part of occipital portion of the head and referred to as vertex presentation: Variations include military, brow, facial presentations
    b. Breech: Feet enter maternal pelvis first and the fetal skull last
        i. skull may become hung up/stick in the pelvis
        ii. umbilical cord can become compressed and cut off supply to the baby
        iii. Buttocks are soft, there not as effective as a cervical dilator then hard fetal skull
        iv. Possibility of trauma to the head
    c. FRANK BREECH: buttock first with legs extended upward toward the face
    d. Full/complete breech: fetus sits cross-legged above the cervix
    e. Footing/incomplete breech: one or both legs are presenting
    f. Shoulder: Scapula first

10. What do each of the 3 letters associated with fetal positioning stand for?

ROP: right occipital posterior
ROT: right occipital transverse
ROA: right occiput anterior

LOP: left occipital posterior
LOT: left occipital transverse
LOA: left occipital anterior
OP: occipital posterior
OA: occipital anterior

11. Fetal station is assessed in relation to what?

The mothers pelvis.

12. Outline the rationale for and the pros and cons of external cephalic version.

- External cephalic version is done for patients who have a breech or transverse presentation.

- Pros:
    - positions baby for a vaginal delivery
    - successful in 50% of cases

- Cons:
  - risk for placental abruption
  - umbilical cord compression
  - emergent c/s

13. **Describe methods of cervical ripening and the indications for their use?**
    - Nonpharmacologic methods: herbal agents such as evening primrose oil, black haw, black and blue cohosh, red raspberry leaves, castor oil, hot baths, seual intercourse, and enemas
      - These methods are not likely to be used today but it is important for nurses to be aware of them and question clients about their use.

    - Mechanical methods: application of local pressure stimulates the release of prostaglandins to ripen the cervix.
      - indwelling foley catheter: inserted into the endocervical canal to ripen and dilate the cervix from the inflated balloon used to hold the catheter in place.
      - Hygroscopic dilators: absorb endocervical and local tissue fluids. When they enlarge it expands the endocervical and provides controlled mechanical pressure
        - Natural osmotic dilators (laminaria, dried seaweed)
        - synthetic dilators with magnesium sulfate (

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	From onset of uterine contractions until 10cm dilation. It's the longest stage	1. 0-3 cm 2. 4-7cm 3. 8-10cm	1.irregular, q5-30 2. Q3-5 min 3. Q2-3 min	1. 30-45 seconds 2. 40-70 seconds	Leopold, vaginal exam, maternal VS, medications
Second	Pushing stage	full dilation	Q1-2 min	60-90	VS q5-30 min,

Stage	that results in the birth of the baby	and effacement		seconds	contractions, pushing efforts, perineal lacerations
Third Stage	Delivery of neonate	Full dilation	N/A	N/A	VS Q15 min, apgars, placental monitoring
Fourth Stage	Delivery of placenta	Full dilation	N/A	N/A	VS fundus & Lochia Q15 min, urinary output

15. How can we confirm rupture of membranes?
    a. Vaginal exam
        i. IF intact the membranes will feel like a bulge

    What is our priority nursing intervention after confirmation of rupture of membranes?
    - Assess the fetal heart rate
        - you want to identify a declaration which might indicate a cord compression secondary to cord prolapse

    What information do we want to gather from the mother about rupture of membranes if we did not witness it?
    - When the rupture occurred because the increased risk for infection if it has been ruptured awhile

16. Describe when an induction might be warranted and the difference between induction and augmentation?
    a. induction might be warranted for:
        i. spontaneous rupture of membranes and when labor does not start

ii. Large-size fetus not expected to navigate the maternal pelvis
iii. Fetal growth restriction where external intervention is needed
iv. A pregnancy of more than 42 weeks gestation
v. Maternal hypertension, diabetes, or lung disease
vi. A uterine infection

b. The difference between induction and augmentation is that induction is an initiation or the uterine contractions to stimulate labor before spontaneous onset. Augmentation is a stimulation of contractions once labor has started

17. Describe what an amniotomy is, the indications for it to be done, and the considerations.
    a. Amniotomy is the artificial rupture of the amniotic membrane by the provider using a hook, clamp, or another sharp instrument.
        i. indications:
            1. labor progression is too slow and augmentation or induction of labor is indicated
            2. Amnioinfusion is indicated for cord compression
        ii. Considerations
            1. Ensure presenting part of the fetus is engaged before an amniotomy to prevent cord prolapse
            2. Monitor fetal heart rate before and immediately after AROM to assess cord prolapse
            3. Assess and document characteristics of amniotic fluid, color, order, and consistency

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

Oxytocin	**Used for: (Postpartum hemorrhage)** **1. Uterine Stimulant** **ii. What does it do?** **1. Promotes uterine contractions** **iii. Nursing indications/interventions:** **1. Assess uterine tone and vaginal bleeding** **2. Monitor for adverse reactions of water intoxication**

	(lightheadedness, nausea, vomiting, headache, malaise). These **reactions can progress to cerebral edema with seizures, coma,** **and death**
Misoprostol	Used for: (Postpartum hemorrhage) Uterine Stimulant What does it do? Controls postpartum hemorrhage Nursing indications/interventions: Assess uterine tone and vaginal bleeding
Penicillin G	Used for: Antibiotic for Group B Streptococcus What does it do? Inhibits bacterial wall synthesis in susceptible organisms Nursing indications/interventions: Administer 5 million units IV initially, followed by 2.5 million units intermittent IV bolus every 4 hours during the intrapartum period
Nalbuphine hydrochloride (Nubain)	Used for: pain relief without causing significant respiratory depression in the mother or fetus. Both IM and IV routes are used. What does it do?: Act in the CNS to decrease the perception of pain without the loss of consciousness. Nursing indications/interventions: Prior to administering analgesic medications, verify that labor is well

	established by performing a vaginal exam Administer antiemetics as prescribed Monitor maternal vital signs, uterine contraction pattern, and continuous FHR monitoring. Assess maternal vital signs and FHR and pattern and documented before and after administration of opioids for pain relief. Assess for adverse reaction (difficulty breathing) and be prepared to administer antidotes whenever medications are administered. Naloxone, and opioid antagonist, should be readily available for reversal of opioid-induced respiratory depression.
Naloxone (Narcan)	<u>Used for:</u> Opioid antagonist <u>What does it do?</u> Reversal of opioid-induced respiratory depression <u>Nursing indications/interventions:</u> Have the medication readily available in case of adverse effects (difficulty breathing)

19. List procedures done during labor ("intra partum").
    - Assess maternal vital signs- per agency protocol. Temp every 2hr if membranes are ruptured
    - Assess FHR- done to determine fetal well-being.
    - Assess uterine labor contractions characteristics by using palpation
        - Frequency- established from the beginning of one contraction to the beginning of the next.
        - Duration- time between the beginning of a contraction to the end of that same contraction
        - Intensity- strength of a contraction at its peak. Mild- slightly tense like pressing finger to tip of nose, moderate- firm like pressing a finger to chin, or strong- rigid like pressing finger to forehead.

    - resting tone of uterine contractions- tone of the uterine muscle between contractions. a prolonged contraction duration greater than 90sec or too frequent contraction more than five in 10min period without enough time for uterine relaxation can result in reduction of blood flow to the placenta resulting in fetal hypoxia and decreased FHR.
- Intrauterine pressure catheter - insert a sterile solid or fluid filled intrauterine pressure catheter inside the uterus to measure intrauterine pressure.
- Vaginal examination- performed digitally by provider or qualified nurse to assess: cervical dilation, descent of fetus through the birth canal, fetal position, presenting part and lie, membranes that are intact or ruptured.
- Mechanics of labor in vertex presentation- adaptation the fetus makes as it goes through the birth canal during the birthing process.

20. Define each of the 6 cardinal movements of labor (Mechanisms of labor).
    - Engagement- when the presenting part passes the pelvic inlet at the level of the ischial spines
    - Descent- the progress of the presenting part through the pelvis.
    - Flexion- when the fetal head meets resistance of the cervix, pelvic wall, or pelvic floor. the head flexes, bringing the chin close to the chest, presenting a smaller diameter to pass through the pelvis.
    - Internal rotation- the fetal occiput ideally rotates to a lateral anterior position as it progresses through from the ischial spines to the lower pelvis in a corkscrew motion to pass through the pelvis.
    - Extension- the fetal occiput passes through under the symphysis pubis, and then the head is deflected antiorly and is born by extension of the chin away from the fetal chest.
    - External rotation (restitution)-After the head is born, it rotates to the position it occupied as it entered the pelvic Inlet (restitution) in alignment with the fetal body and completes a quarter-turn two-faced transverse as the anterior shoulder passes under the symphysis.
    - Birth by expulsion- after birth of the head and the shoulders, the trunk of the neonate is born by flexing it toward the symphysis pubis.

21. What are the 4 techniques used to assess ongoing data during labor and birth?
    - Leopold maneuvers Consists of Performing external palpitations of the maternal uterus through the abdominal wall to determine the following.
        - presenting part, fetal lie, and attitude
        - degree of descent of the presenting part into the pelvis
        - location of the fetuses back to assess for fetal heart tones
    - Intermittent auscultation and uterine contraction palpitation- use of a handheld doppler ultrasound device, ultrasound stethoscope, or fetoscope to assess FHR. in conjunction, palpitation of the contractions at the fundus for frequency intensity duration and resting tone.

- Continuous electronic monitoring is accomplished by securing an ultrasound transducer over the client's abdomen, which records the fhr pattern, and a tocotransducer on the fundus that record to the uterine contractions.
- Continuous internal fetal monitoring with a scalp electrode is performed by attaching a small spiral electrode to the presenting part of the fetus to monitor the FHR

22. What is a vaginal exam (SVE-sterile vaginal exam)? How often should it be done according to WHO (World Health Organization)?
    - It should be done inIntervals of 4 hours for routine assessment and identification of a delay in active labor.
    - The purpose of a vaginal exam is to assess:
        - the amount of cervical dilation
        - the percentage of cervical effacement
        - the fetal membrane status
    - And to gather information on:
        - presentation
        - position
        - station
        - degree of fetal head flexion,
        - presence of fetal skull swelling or molding

23. Why is it important to assess frequency, duration and intensity of contractions?
    The frequency, duration, and intensity of the uterine contractions cause fetal descent and cervical dilation. if there is a prolonged contraction duration of greater than 90 seconds or too frequent contractions of more than 5 in 10 minutes without a sufficient time for uterine relaxation of less than 30 seconds in between can reduce blood flow to the placenta. This can result in fetal hypoxia and decrease FHR.
24. What 2 ways can you assess uterine contractions?
    - Palpation- by placing a hand over the fundus to assess contraction frequency, duration, and intensity of contractions
    - Use of external or internal monitoring.
25. 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_.

26. List the sources of pain during labor.
    - First stage-internal visceral pain that can be felt as back and leg pain.
        - Dilation, effacement, and stretching of the cervix
        - distention of the lower segment of the uterus
        - contractions of the uterus with resultant uterine ischemia
    - Second stage- pain that is somatic and occurs with fetal descent.
        - pressure and distension of the vagina and the perineum, described by the client as burning, splitting, and tearing

    - pressure and pulling on the pelvic structures (ligaments, Fallopian tubes, ovaries, bladder, and peritoneum)
    - lacerations of soft tissues (cervix, vagina, and perineum)
- Third stage- pain with expulsion of the placenta is similar to pain experienced during the first stage.
    - Uterine contractions
    - Pressure and pulling of pelvis structures
- pain is caused by distention and stretching of the vagina and perineum incurred during the second stage with a splitting, burning, and tearing sensation.

27. List how pain assessment is done during labor.

Through verbal and nonverbal cues.

28. What should the nurse consider prior to administration of opioid pain medication during labor?
    a. Verify that labor is well established by performing a vaginal exam
    b. Monitor maternal vital signs, uterine contraction pattern, and continuous FHR monitoring
    c. Assess for adverse reactions
    d. Opioids cross the placental barrier but do not affect labor in active phase
    e. They can cause newborn respiratory depression, decreased alertness, inhibited sucking, a delay in effective feeding, and a decrease in FHR
    f. Respiratory depression can occur in the mother also
    g. Other systemic side effects include nausea, vomiting, pruritus, delayed gastric emptying, drowsiness, hypoventilation, and newborn depression
    h. To reduce the incidence of newborn depression, birth should occur within 1 hour or after 4 hours of administration to prevent the fetus from receiving the peak concentration

29. Describe the gate-control theory of pain control. Give examples.
    a. The sensory nerve pathways in the brain will only allow a certain amount of pain sensation to travel at a certain amount of given time. By sending alternate signals to the brain the signals can be blocked from ascending neurological pathways. Non-pharmacological pain techniques can work to relieve pain.

30. List 3 non pharmacological pain intervention methods.
    a. Guided Imagery- thinking about relaxing mental images or using relaxing music
    b. Breathing Techniques- bradley method uses (Father initiating deep breathing), lamaze uses (Light blowing)
    c. Focus Techniques- focus on external object/picture

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

a. Administered: Catheter is inserted in the epidural space usually between the lumbar L3 and the thoracic T3 areas. The drug usually fentanyl or morphine diffuses into the cerebrospinal fluid and crosses the dura mater to the spinal cord.
b. Implication: Maternal hypertension, headache
c. spinal is injection into the fluid sac and the analgesia is the space outside the sac

32. What added considerations are there for the nurse caring for a woman who has undergone general anesthesia?
    a. General anesthesia can cause fetal depression, along with with uterine relaxation and potential maternal vomiting and aspiration
    b. The complications are usually due to maternal aspiration ot the inability to intubate the women
    c. Make sure the women is not taken anything by mouth and has patent intravenous line
    d. Administer a nonparticulate oral antacid or a proton pump inhibitor as order to reduce gastric acidity
    e. Assist with the placement of a wedge under the woman's right hip to displace the gravid uterus and to prevent vena cava compression in the supine position

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

33. Where in the contraction do the increment, acme and decrement happen?
    a. Increment is the beginning of the contraction as intensity is increasing
    b. Aceme is the peak intensity of the contraction
    c. Decrement is the decline of the contraction intensity as the contraction is ending

34. Briefly describe what Category I, Category II and Category III fetal heart rate tracings look like.
    a. Category I
        i. baseline fetal heart rate of 110-160
        ii. Moderate variability
        iii. acceleration present or absent
        iv. Early decelerations present or absent
        v. Variable or late declarations absent
    b. Category II
        i. Fetal Tachycardia, bradycardia no accompanied but absent, minimal baseline variability, recurrent decelerations, marked baseline variability
    c. Category III
        i. Fetal bradycardia <110, Recurrent late decelerations, Recurrent variable decelerations-declining or absent, Sinusoidal pattern

35. Why is support vital for laboring women? What is a doula? What is a CNM?
    a. Women who have support have greater chance of spontaneous vaginal delivery, decrease in length of labor, required less analgesia, increased satisfaction with their birthing experience
    b. doula= non-medical birth companion who provides continuous emotional, physical, amd educational support to the woman and family during childbirth
    c. CNM= certified nurse midwife

36. What is “crowning”?
    a. When the baby’s head becomes visible in the birth canal

37. List a summary of assessments during second , third and fourth stages of labor.
    a. Second
        i. BP, pulse, respirations Q5-Q30 min
        ii. UC
        iii. Pushing efforts by the patient
        iv. Increase in bloody show
        v. Shaking extremities
        vi. FHR q15 min and immediately following birth
        vii. Perineal lacerations
    b. Third
        i. BP, Pulse, respirations Q 15 Min
        ii. Apgars
        iii. Clinical findings of placenta separation
    c. Fourth
        i. Maternal Vital Signs
        ii. Fundus & lochia
        iii. Q15
        iv. Urinary output
        v. Baby-friendly activities

38. What are the signs of placental separation and how long can it take for the placenta to be expelled?
    a. Placental Separation Signs
        i. The uterus rises upward
        ii. The umbilical rises upward
        iii. A sudden trickle of blood is released from vagonal opening
        iv. The uterus changes its shape to globular
    b. After Separation
        i. Expelled within 2-30 min

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

a. Episiotomy
    i. surgical cut that is made at the opening of the vagina delivery and prevent rupture of the tissues
b. Laceration
    i. when the perineum tears during birth

40. What are the normal blood loss amounts for a vaginal and a cesarean delivery?
    a. Vaginal: 500 ml
    b. Cesarean: 1000 ml
    c. Blood loss over 1000ml is considered severe

41. List “post procedures” done during the fourth stage of labor.
    a. Bp and pulse Q15 for first 2 hrs and temp every 4 hrs for the first 8 hrs
    b. Assess fundus and lochia q15 for the first hr and then according to protocol
    c. Massage fundus or administer oxytocin to maintain uterine tone and prevent hemorrhage
    d. Assess clients perineum and provide need comfort measures
    e. Promote an opportunity for maternal/newborn bonding
    f. Offer assistance with breast feeding and provide reassurance

42. What are important interventions for the newborn at birth? Why is skin to skin time with mom so important?
    a. Wrap in warmed blanket
    b. Place under a radiant warmer
    c. Place on the mother’s abdomen for warmth and closeness
    d. Skin to skin contact to promote bonding purposes, strengthens the uterine contractions to help the placenta separate from the uterus and prevent hypoglycemia in the baby

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

During the third stage of labor, the nurse should monitor for placental separation. Some signs that placental separation is occurring include: (1) A firmly contracting uterus; (2) A globular-ovoid uterine shape; (3) A sudden gush of dark blood from the introitus; (4) a lengthening segment of the umbilical cord protruding from the vagina; (5) Verifying that the placenta and fetal membranes are intact. **Note** The provider does this the first time.

The nurse should also assess for perineal trauma before the birth attendant leaves. Examples of indicators of perineal trauma include: (1) A firm fundus with bright red trickling (indicates laceration); (2) A boggy fundus with red blood flowing (indicates uterine atony); (3) A boggy fundus with dark blood and clots (indicates retained placenta); (4) Evaluate the state of the perineum if an episiotomy was done; and (5) Make sure the birth attendant has repaired any perineal lacerations if they are present.