

N432-Focus Sheet Unit 3—2020—Complications of Pregnancy, Labor, and Delivery

Ricci, Kyle & Carman Ch 19, 20 & 21; ATI Ch 7-10

Some of the problems which cause complications of Pregnancy as well as Labor and Delivery were discussed during Unit 1 e.g. some of the infections, and during Unit 2 on labor and delivery. So be sure and look at this information from Unit 1 & 2 as you work through this focus sheet. The information will be used to compare and analyze the normal versus the abnormal occurrences in order to make decisions for nursing interventions. So, even while you fill out the focus sheet, be thinking about assessments and actions you “as a nurse” can make in the midst of these complications.

Bleeding during ; Medical Conditions; Early Onset of Labor

RKC Ch 19; ATI Ch 7, 9, 10 (Bleeding)

1. List 5 factors that can place a woman at risk during pregnancy.

Gestational diabetes, hypertension, polycystic ovarian syndrome, autoimmune disease, and obesity.

2. Define abortion, miscarriage, and stillbirth.

Abortion: the loss of an early pregnancy, usually before 20 weeks gestation. Can be spontaneous or induced.

Miscarriage: The spontaneous loss of a woman's pregnancy before the 20th week that can be both physically and emotionally painful.

Stillbirth: the delivery, after the 20th week of pregnancy, of a baby who has died.

3. Describe the following for spontaneous abortion: p687-689

| | |
|--------------------------------|--|
| Pathophysiology | Most often unknown cause. Most common cause is fetal genetic abnormalities, usually unrelated to the mother. |
| Nursing Assessment | When the patient reports bleeding they must be seen as soon as possible. Assess her vital signs, observe the amount, color, and characteristics of the bleeding. Ask her to rate her current pain level. |
| Testing | Do continuous monitoring on the mother and the bleeding. |
| Management | Provide continuous monitoring and support. |
| Patient education needs | Explaining that she did nothing wrong and did not cause this abortion. |

4. Define threatened abortion, inevitable abortion, incomplete abortion, complete abortion, missed abortion and habitual abortion. P 689

Threatened: vaginal bleeding, no cervical dilation or change in cervical consistency, mild abdominal cramping, closed cervical OS, and no passage of fetal tissue.

Inevitable: vaginal bleeding, rupture of membranes, cervical dilation, strong abdominal cramping, possible passage of products.

Incomplete: intense abdominal cramping, heavy vaginal bleeding, and cervical dilation.

Complete: history of vaginal bleeding and abdominal pain, passage of tissue with subsequent decrease in pain and significant decrease in vaginal bleeding.

Missed: absent uterine contractions, irregular spotting, and possible progression to inevitable abortion.

Habitual: history of 3 or more consecutive spontaneous abortions.

5. **What are the actions and implications of the use of Cytotec, Cervidil (dinoprostone)/Prepidil (Gel), Rh Immunoglobulin Rhogam related to abortions (elective or spontaneous)? Chart p 690**

Cytotec: stimulates uterine contractions to terminate a pregnancy and to evacuate the uterus after abortion to ensure passage of all the products of conception. Monitor for side effects.

Cervidil: stimulates uterine contractions, causing expulsion of uterine contents.

RH immunoglobulin: suppresses immune response of non-sensitized RH-negative clients who are exposed to RH positive blood.

6. **Describe the following for ectopic pregnancy:**

| | |
|--------------------------------|--|
| Pathophysiology | The ovum is implanted outside the uterus. |
| Nursing Assessment | Focuses on determining the existence of the ectopic pregnancy and making sure it has not burst. |
| Testing | The use of transvaginal ultrasound and serum beta hCG will be low. |
| Management | Preparing the woman for treatment, providing support, and providing education on preventative measures. |
| Patient education needs | Reduce risk factors such as sexual intercourse with no protection or multiple partners, about contracting STI's, obtain early diagnosis, avoid smoking during child bearing years. |

7. **Describe the following for Gestational Trophoblastic Disease.**

| | |
|---------------------------|--|
| Pathophysiology | The maternal tumor arises from gestational rather than maternal tissue. |
| Nursing Assessment | Report early signs of pregnancy, anemia, brownish vaginal bleeding, inability to detect fetal heart rate after 10-12 weeks gestation, fetal parts not evident with palpation, absence of fetal heart rate. |
| Testing | Monitor hcg levels, and ultrasound. |
| Management | Prepare, educate, and provide support. |

| | |
|--------------------------------|--|
| Patient education needs | Teach the client about the condition and the interventions that are necessary to save her life. Explain each phase of treatment. |
|--------------------------------|--|

When would you anticipate that Methotrexate would be prescribed? 3 months after pregnancy.

8. Describe the following for Cervical Insufficiency:

| | |
|--------------------------------|---|
| Pathophysiology | Not known. There are theories that focus on the cervix. |
| Nursing Assessment | Know risk factors: previous cervical trauma, preterm labor, fetal loss, be alert for complaints of vaginal discharge or pelvic pressure. |
| Testing | Transvaginal ultrasound. |
| Management | Monitoring these women closely for signs of preterm labor: backache, increase in vaginal discharge, rupture of membranes, and uterine contractions. |
| Patient education needs | Bed rest, avoid heavy lifting, progesterone supplementation. |

9. Describe the following for Placenta Previa:

| | |
|--------------------------------|--|
| Pathophysiology | Unknown. Initiated by implantation of the embryo in the lower uterus. |
| Nursing Assessment | Thorough history, maternal age over 35, previous C-section, multiparity, uterine insult or injury, cocaine use, previous D & C, infertility treatments, smoking, endometrial ablation. |
| Testing | Transvaginal ultrasound, MRI. |
| Management | Monitoring maternal-fetal status, assess for signs and symptoms of vaginal bleeding and fetal distress. |
| Patient education needs | Teach the patient about placenta Previa. Bed rest teaching and physical exam teaching. |

10. Why is it important to know if a woman who is presenting to labor and delivery has a placenta previa?

It presents a risk for prenatal and postpartum hemorrhage.

How would her care be altered?

C-section is avoided If possible, woman and baby.

11. Describe the following for Abruptio Placentae (Abruptio):

| | |
|--------------------------------|---|
| Pathophysiology | Maternal vessels tear away from the placenta and bleeding occurs between the uterus lining and the maternal side of the placenta. |
| Nursing Assessment | Maternal hemodynamic status and fetal well-being. Assess for abdominal pain and or vaginal bleeding. |
| Testing | CBC, fibrinogen levels, PT, type and crossmatch, nonstress test, biophysical profile. |
| Management | Ensuring adequate tissue perfusion, providing support and education. |
| Patient education needs | Avoid drinking, smoking, or using drugs during pregnancy. |

12. Describe shoulder dystocia RKC Ch 13 p 464 Ch 21 p 797 & 806

After vaginal delivery of the head, the baby's anterior **shoulder** gets caught above the mother's pubic bone.

13. In your own words describe disseminated intravascular coagulation (DIC).

Condition affecting the blood's ability to clot and stop bleeding.

14. Describe the following for Hyperemesis Gravidarum

| | |
|--------------------------------|--|
| Pathophysiology | Exact cause is unknown but it affects decreased placental blood flow. |
| Nursing Assessment | history and physical exam to identify signs and symptoms associated with this disorder. |
| Testing | liver enzymes, CBC, urine ketones, TSH and T4, electrolytes and ultrasound. |
| Management | promoting comfort by controlling the client nausea and vomiting and promoting nutrition. |
| Patient education needs | treatment options. |

15. What three medications are commonly used for hyperemesis gravidarum? What nursing considerations should be addressed for each of these?

Promethazine: relieves nausea, vomiting, and motion sickness. be alert for urinary retention, dizziness, hypotension, and offer hard candy for dryness. **Pyridoxine and Doxylamine:** relief of nausea. be alert for drowsiness, dizziness, headache, irritability, must be taken daily, not as needed. **Ondansetron:** blocks serotonin which blocks the vomiting reflex. monitor for diarrhea, constipation, abdominal pain, headache, dizziness, drowsiness, and fatigue.

16. What is the difference between chronic and gestational hypertension?

Chronic: appears before the 20th week of gestation or before the current pregnancy.

gestational: after the 20th week of pregnancy.

17. Please fill in the table below:

| | Mild Preeclampsia | Severe Preeclampsia | Eclampsia |
|-------------------------|--|---|---|
| Blood pressure | 140/90 or above | 160/110 or above | 160/110 or above |
| proteinuria | Greater than or equal to 1+ | Positive Greater than 3+ | Positive |
| Seizures/coma | Absent None | Seizures may occur | Seizures and coma Common |
| hyperreflexia | Absent Not common | Present Present with possible ankle clonus | Absent Present |
| Other signs or symptoms | Mild swelling of hands and feet. Transient headaches | Nausea, vomiting, thrombocytopenia, pulmonary edema, visual changes. Elevated | Abdominal pain, excessive weight gain, nausea and vomiting, headaches, elevated blood |

| | | | |
|----------------------|---|--|--|
| | | creatinine, headaches, edema, hepatic dysfunction. | pressure. Headache, epigastric pain, edema |
| Treatment/management | Treatment includes prophylactic or current use of beta-blockers and antihypertensive medications. | | |

18. We will discuss in class the protein/creatinine (P/C) ratio. This is not in your text. Here is a

Urine protein tests detect and/or measure protein being released into the urine. Normal urine protein elimination is less than 150 mg/day and less than 30 mg of albumin/day. Elevated levels may be seen temporarily with conditions such as infections, stress, pregnancy, diet, cold exposure, or heavy exercise. Persistent protein in the urine suggests possible kidney damage or some other condition that requires additional testing to determine the cause.

19. Medications used with preeclampsia and eclampsia

| Medication | Indications (why is this needed for THIS patient?) | Nursing Implications (what are you watching for?) | Dose |
|--|--|---|--|
| Magnesium Sulfate | This medication is used to treat eclampsia and is used prophylactically to prevent eclampsia in clients with preeclampsia. | Important to look for signs of magnesium overdose. | IV: 4-6 grams for 15-30 minutes, then 1-2 grams per hour. IM: 10 grams at the onset of labor, then 5 grams every 4 hours. |
| Hydralazine hydrochloride (Apresoline) | This medication is used to lower the mother's blood pressure. | Watch for dyspnea, rash, and tachycardia. | IV: 5-10 mg bolus. |
| Labetalol hydrochloride (Normodyne) | This medication is used to lower the mother's blood pressure. | Watch for bradycardia, hypotension, and ventricular arrhythmias. | IV: 20 mg with repeated doses every 10 minutes up to 300 mg. |
| Nifedipine (Procardia) | This medication is used to lower the mother's blood pressure. | Watch for bradycardia, hypotension, heart failure, GI bleeding, and thrombocytopenia. | PO: 10 mg every 10 minutes up to 30 mg. |

20. What are the signs of Magnesium toxicity? What is the therapeutic level for magnesium sulfate? What drug should always be at the bedside of a patient who has Magnesium sulfate infusing? (Look back at Focus sheet #2 as well in terms of the drugs. Most of what you had there also fits here.)

Loss of appetite, nausea, fatigue, and weakness, seizures. Normal is 1.8 to 2.2 mg/dL. Should have calcium gluconate if the patient has toxicity.

21. **When grading a deep tendon reflex, does the grading scale of 0-4 state no movement is graded as a 0 or a 4?**

22. 0 is no response and 4 means increased reflexes

When no movement of the tendon occurs, this is documented as 0.

23. **What does clonus evaluate and what does a positive clonus look like?**

Clonus is used as part of the neurological physical exam to evaluate the status of a patient's nervous system. It can be evaluated in many joints but is most commonly seen in the ankle joint by briskly dorsiflexing the foot. Set of involuntary and rhythmic muscular contractions and relaxations. People who experience clonus report repeated contractions that occur rapidly.

24. **What does HELLP stand for?**

H: Hemolysis - resulting in anemia and jaundice

EL: Elevated liver enzymes - resulting in elevated alanine aminotransferase (ALT) or aspartate transaminase (AST), epigastric pain, and nausea and vomiting.

LP: Low platelets - (less than 100,000/mm³), resulting in thrombocytopenia, abnormal bleeding and clotting time, bleeding gums, petechiae, and possibly disseminated intravascular coagulopathy.

25. **Describe the following for HELLP syndrome**

| | |
|--------------------|---|
| Pathophysiology | Variant of GH in which hematologic conditions coexist with severe preeclampsia involving hepatic dysfunction. |
| Nursing Assessment | <p>Assess for risk factors such as maternal age younger than 19 or older than 40 years, first pregnancy, extreme obesity, multifetal gestation, chronic renal disease, chronic hypertension, familiar history of preeclampsia, DM, rheumatoid arthritis, and systemic lupus erythematosus.</p> <p>Expected findings: severe continuous headache, nausea, blurring of vision, or flashes of lights or dots before the eyes.</p> <p>Physical assessment findings: hypertension, proteinuria, preorbital, facial, hand, and abdominal edema, pitting edema of lower extremities, vomiting, oliguria, hyperreflexia, scotoma, epigastric pain, right upper quadrant pain, dyspnea, diminished breath sounds, seizures, jaundice, or manifestations of progression of hypertensive disease with indication of worsening liver involvement, kidney failure, worsening hypertension, cerebral involvement, and developing coagulopathies.</p> <p>Assess LOC, obtain pulse oximetry, monitor urine output, obtain daily weights, monitor vital signs, encourage lateral positioning, perform NST and daily kick counts, and instruct the client to monitor I&O.</p> |
| Testing | Laboratory tests: liver enzymes, blood creatinine, BUN, uric acid, CBC, clotting studies, and chemistry profile. |

| | |
|-------------------------|---|
| | Diagnostic procedures: dipstick testing of urine for proteinuria; 24-hr urine collection for protein and creatinine clearance; nonstress test, contraction stress test, biophysical profile, and serial ultrasounds to assess fetal status; doppler blood flow analysis to assess fetal well-being; daily kick counts |
| Management | It is recommended that daily low dose aspirin therapy be initiated late in the first trimester for clients who have a history of early onset preeclampsia. Antihypertensive medications: methyldopa, nifedipine, hydralazine, or labetalol. anticonvulsant medications: magnesium sulfate |
| Patient education needs | Remain on bedrest and in the side-lying position Perform diversional activities (TV, visits from family or friends, gentle exercise) Avoid foods that are high in sodium. Avoid alcohol and tobacco and limit caffeine intake. Drink 6-8 ounce glasses of water a day. Maintain a patent airway in the event of a seizure. Take antihypertensive medications as prescribed. Maintain a dark quiet environment to avoid stimuli that can precipitate a seizure. |

26. What is Rh factor incompatibility? When is RhoGAM administered? Who is at risk if it is not given?

Rh factor incompatibility occurs when the mother is Rh negative and the fetus is Rh positive. If this occurs, the child can suffer from hemolytic anemia. Rhogam will be given once between 26-28 weeks to a mother who is Rh negative, and then again within 72 hours of delivery if the fetus is Rh positive. If the fetus is not Rh positive, no second dose will be given.

27. What fetal risks are associated with polyhydramnios and oligohydramnios?

Oligohydramnios can lead to underdeveloped lung tissue in the fetus and lead to death.

Polyhydramnios can lead to cord prolapse, placental abruption, preterm delivery, and unstable lie.

28. Define multiple gestation and explain why it may be concerning for the mother/fetus.

Refers to twins, triplets, or more infants within a single pregnancy. The most common maternal complication is postpartum hemorrhage resulting from uterine atony. The risk for perinatal morbidity and mortality is markedly increased in multiple gestation. There is also a huge concern for a preterm delivery with multiple gestation which could lead to low birth weights along with feeding and breathing difficulties in the newborns.

29. What do monozygotic and dizygotic mean?

Monozygotic - identical twins, result from the fertilization of a single egg that splits into two.

Dizygotic - fraternal twins, results from the fertilization of two eggs by two separate sperm during the same pregnancy

30. Describe the following for Premature rupture of membranes:

| | |
|-------------------------|--|
| Pathophysiology | Spontaneous rupture of the amniotic membranes prior to the onset of true labor. For most clients, PROM signifies the onset of true labor if gestational duration is at term. |
| Nursing Assessment | Assess for risk factors such as infection, prior preterm birth, shortening of the cervix, second/third trimester bleeding, pulmonary or connective tissue disorders, low BMI, copper or ascorbic acid deficiency, or tobacco or substance use. Expected findings: client reports a gush or leakage of clear fluid from the vagina. Physical assessment findings: presence of clear fluids Assess for a prolapsed umbilical cord; abrupt FHR variable or prolonged deceleration; and visible or palpable cord at the introitus. Prepare for birth if indicated, obtain vaginal/rectal cultures for streptococcus beta hemolytic, assess vital signs every 2 hours, monitor FHR and uterine contractions, encourage hydration, obtain a CBC, provide reassurance to reduce anxiety |
| Testing | Laboratory tests: positive nitrazine paper test (blue, pH 6.5 - 7.5) or positive ferning test is conducted on amniotic fluid to verify rupture of membranes. |
| Management | Ampicillin - antibiotic used to treat infection Betamethasone - enhance fetal lung maturity and surfactant production |
| Patient education needs | Adhere to limited activity with bathroom privileges Hydrate. Conduct a self-assessment for uterine contractions. Record daily kick counts for fetal movement. Monitor for foul-smelling vaginal discharge. Refrain from inserting anything into the vagina. Abstain from intercourse. Avoid tub baths. Wipe the perineal area from front to back after voiding and fecal elimination. take temperature every 4 hours when awake and report a temperature that is greater than 100 degrees F Depending on gestation age, treatment is conservative, and hospitalization can prolong pregnancy while monitoring for risk factors. |

RKC Ch 20; ATI Ch 9

1. Discuss each of the following for Gestational Diabetes:

| | |
|--------------------|---|
| Pathophysiology | An impaired tolerance to glucose with the first onset or recognition during pregnancy. |
| Nursing Assessment | Assess for hypoglycemia or hyperglycemia Physical assessment findings: hypoglycemia, shaking, clammy pale skin, shallow respirations, rapid pulse, hyperglycemia, vomiting, and excess weight gain during pregnancy. Assess for risk factors such as obesity, hypertension, glycosuria, maternal age older than 25 years, family history of DM, and previous delivery of an infant that was large or stillborne. Monitor the client's blood glucose. Monitor the fetus. |

| | |
|-------------------------|--|
| Testing | <p>Glucose screening test/1-hr glucose tolerance test: 50g oral glucose load, followed by plasma glucose analysis 1 hr later performed at 24 to 28 weeks of gestation; fasting not necessary; a positive blood glucose screening is 130 to 140 mg/dL or greater; additional testing with a 3-hr glucose tolerance test (OGTT) is indicated.</p> <p>oral glucose tolerance test: following overnight fasting, avoidance of caffeine, and abstinence from smoking for 12hr prior to testing; a fasting glucose is obtained, a 100g glucose load is given, and serum glucose levels are determined at 1, 2, and 3hr following glucose ingestion.</p> <p>Presence of ketones in urine: to assess severity of ketoacidosis.</p> <p>Biophysical profile to ascertain fetal well-being if nonstress test is nonreactive.</p> <p>Amniocentesis with amniotic fluid phosphatidylglycerol measured to determine fetal lung maturity.</p> <p>Nonstress test to assess fetal well-being.</p> |
| Management | Lifestyle changes such as a well balanced nutritional diet, daily exercise, and insulin depending on the client's glucose levels. |
| Patient education needs | <p>Perform daily kick counts.</p> <p>Adhere to the appropriate diet, including standard diabetic and restricted carbohydrate intake. Dietary counseling by a registered dietician should occur.</p> <p>Exercise.</p> <p>Perform self-administration of insulin.</p> <p>Understand the need for postpartum laboratory testing to include OGTT and blood glucose levels.</p> |

2. What effects can uncontrolled gestational diabetes have on the fetus/newborn?

Macrosomia, birth trauma, electrolyte imbalances, and neonatal hypoglycemia.

Infection (urinary and vaginal), related to increased glucose in the urine and decreased resistance because of altered carbohydrate metabolism.

Hydramnios, which can cause overdilatation of the uterus, placental abruption, preterm labor, and postpartum hemorrhage.

Ketoacidosis from diabetogenic effect of pregnancy (increased insulin resistance), untreated hyperglycemia, or inappropriate insulin dosing.

Hypoglycemia, caused by overdosing in insulin, skipped or late meals, or increased exercise.

Hyperglycemia, which can cause excessive fetal growth (macrosomia).

3. What cardiovascular changes are noted during pregnancy?

Heart rate increases while pregnant, blood volume increases

Why might these put a woman at risk for cardiovascular disease?

Cardiac output increases by 30 to 50%, and blood volume increases by 45%, heart rate increases preeclampsia and gestational diabetes are risks for cardiovascular disease while pregnant

4. Discuss each of the following for iron deficiency anemia.

| | |
|--------------------|---|
| Pathophysiology | Occurs during pregnancy due to inadequacy in maternal iron stores and consuming insufficient amounts of dietary iron. |
| Nursing Assessment | Assess for risk factors: less than 2 years between pregnancies, heavy menses, diet low in iron, and unhealthy weight loss programs. |

| | |
|-------------------------|---|
| | Expected findings: fatigue, weakness, craving unusual food (pica) |
| Testing | Laboratory tests: Hgb less than 11mg/dL in the first and third trimesters and less than 10.5mg/dL in the second trimester; Hct less than 33.0%; blood ferritin less than 12mcg/L in presence of low Hgb |
| Management | Ferrous sulfate iron supplements parenteral iron therapy |
| Patient education needs | Educate clients about ways to minimize gastrointestinal adverse effects. Educate the client about increasing dietary intake of foods rich in iron (legumes, dried fruit, dark green leafy veggies, and meat). Instruct the client to take the iron supplements on an empty stomach and take with orange juice to increase absorption. |

5. After reading about adolescence and pregnancy, discuss how you as the nurse would care for this patient. What would you do differently?

Adolescent clients need appropriate education regarding prenatal care, the importance of showing up to appointments, and ensuring that the client receives the mental and emotional support necessary throughout the pregnancy to ensure a healthy fetus. Education towards sexual protection is important as well in this client.

How would you approach topics?

Speak to the client as an adult. They are responsible for the healthy growth of their child. When speaking to the client, use language they can understand and reinforce ideas with evidence or using ideas they can easily understand.

Would you focus more on the support people?

Ensuring the support people also have proper education ensures that they can do their part in caring for the adolescent while providing mental and emotional support.

6. What changes would you incorporate in the nursing care of the advanced maternal age (AMA) woman?

For clients who are considered AMA, ensuring the client receives the appropriate prenatal care is essential in ensuring the fetus grows appropriately.

7. Define teratogen.

An agent or factor which causes malformation of an embryo.

8. Fill in the following table.

| Substance | Effects on pregnancy and fetus/newborn |
|-----------|--|
| Alcohol | Jitteriness, irritability, increased tone and reflex responses, seizures |
| caffeine | Excessive caffeine can lead to infertility, spontaneous abortion, and intrauterine growth restriction. |
| nicotine | Nicotine increases the risk of preterm birth, low birth weight, sudden infant death syndrome, and birth defects of the face. |

| | |
|-------------------|---|
| cocaine | Use of cocaine during pregnancy places the fetus at risk for preterm labor, spontaneous abortion, low birth weight, smaller head circumference, and shorter length. |
| marijuana | Preterm birth, intrauterine growth restriction Long-term effects such as deficits in attention, cognition, memory, and motor skills |
| Opiates/narcotics | Use of opiates during pregnancy can lead to preterm birth, the fetus being stillborn, defects such as spina bifida, hydrocephaly, and heart defects. |
| methamphetamines | The use of methamphetamines can lead to fetal tachycardia, preterm birth, SIDS, and low birth weight. |

9. List five possible characteristics of Fetal Alcohol Spectrum Disorder.

Delayed growth and development

Mircocephaly

Attention deficit disorder

CNS dysfunction

Feeding problem

10.

Poor coordination, lack of focus, hyperactivity, learning disabilities, heart problems, kidney defects and abnormalities.

RKC Chapter 21

- 1. Why is the term “failure to progress” often used?**
- 2. Failure to progress is used when labour slows down and delays the delivery of the baby**

This term is usually used after a labor has progressed longer than 20 hours (for first time mothers) and 14 hours for mothers who have previously given birth.

- 3. What factors are associated with an increased risk for dystocia?**

Risk factors for dystocia include uterine abnormalities, maternal age over 40, cephalopelvic disproportion, fetal macrosomia, multifetal pregnancy, and hypertonic or hypotonic uterus.

- 4. Familiarize yourself with the common Diagnosis and management of common problems associated with dystocia, their therapeutic management and nursing management i.e.what does this mean for the care delivered by the nurse (p799-804)**

Common problems associated with dystocia include infection, sepsis, and uterine rupture. Treatment using antibiotics to prevent infection and sepsis should be administered when appropriate. Uterine rupture can cause excess bleeding. In this case, a blood transfusion may be needed to prevent hypovolemic shock or other blood loss problems.

5. Define the following:

Hypertonic uterine dysfunction:

Occurs when the uterus never fully relaxes between contractions

Hypotonic uterine dysfunction:

Occurs when active labor (dilation more than 5-6 cm) when contractions become poor in quality and lack sufficient intensity to dilate and efface the cervix.

Uterine Atony:

Failure of the uterus to contract following delivery is the most common cause of postpartum hemorrhage.

Precipitate labor:

Labor that is completed in less than 3 hours from the start of contractions to birth.

6. Why is persistent occipital posterior positioning of the fetus an issue during labor and delivery?

Persistent Occiput Posterior. Persistent occiput posterior (OP) is associated with increased rates of maternal and newborn morbidity.

7. What risks increase with a persistent breech presentation?

The significance of breech presentation is its association with higher perinatal mortality and morbidity when compared to cephalic presentations.

8. What is a shoulder dystocia? What maneuvers are used to attempt a vaginal delivery when a shoulder dystocia is noted? Describe each.

Shoulder dystocia occurs when a baby's head passes through the birth canal and their shoulders become stuck during labor. This prevents the doctor from fully delivering the baby and can extend the length of time for delivery.

9. Macrosomia is defined as a newborn who weighs 4000 to 4500 grams.

10. Why is it important to monitor the bowel and bladder status during labor?

If the bladder or the bowels are full, this can make labor more difficult and the fetus will have difficulties evacuating the uterus due to insufficient space.

11. What are 3 ways you can empower, inform and advocate for your patient?

Ensuring that the client has all of the proper information they require, while explaining to them their rights as a client. Listen to your client's concerns and actively listen to what they have to say about their treatment, and advocate for your clients when speaking with other care providers to ensure the client receives the care they want.

12. Define preterm labor and list 3 risks that are associated with the infant due to preterm labor/birth

Uterine contractions and cervical changes that occur between 20 and 36 weeks and 6 days of gestation (ATI); The occurrence of regular uterine contractions accompanied by cervical effacement and dilation before the end of the 37th week of gestation (textbook). Infants born prematurely are at risk for respiratory distress syndrome, infections, and congenital heart defects (many more pg. 779 textbook).

13. What factors influence the decision to intervene when a woman presents with preterm labor i.e. do we try to stop the labor or do we let it progress?

When determining whether labor should be stopped and the pregnancy should be extended, the care provider must determine how successful the use of tocolytics will be, and whether the time frame the tocolytics provide will help the fetuses maturation.

14. When are tocolytics used? (Some of these are listed on the Unit II Focus sheet and the Medications and Pain Management in Labor and Delivery PPT)

Tocolytics are used when uterine contractions occur too early within the pregnancy. They are used to delay the delivery of the fetus to prevent preterm labor and immature birth.

15. Name 5 subtle symptoms of preterm labor.

Contractions, backache, lower abdominal pressure, light bleeding, frequent need to urinate.

16. What does a fetal fibronectin test determine?

Used to check a woman's risk for preterm delivery. The test will either be negative or positive. A positive test means that fetal fibronectin is present in your cervical secretions. If you have a positive result between 22 and 34 weeks, you are at an increased risk of premature birth within seven days.

17. Define prolonged pregnancy.

Defined as a pregnancy that extends 2 weeks or beyond the estimated day of confinement, or 42 weeks.

18. What is the difference between labor induction and labor augmentation? (This was also in Unit II but we look at it again as we talk about complications that may require one of these techniques.)

Labor induction is the process of starting labor by stimulating the uterus and labor augmentation stimulates the uterus after labor has already begun to increase the frequency and duration of contractions.

19. What is the most common adverse effect of oxytocin? (See the Medications you looked up for Unit II)

Monitor for possible adverse effects such as hyperstimulation of the uterus, impaired uterine blood flow leading to fetal hypoxia, rapid labor leading to cervical lacerations or uterine rupture, water intoxication (if oxytocin is given in electrolyte-free solution or at a rate exceeding 20 mU/min), and hypotension

20. When administering oxytocin what are the primary assessments that need to be made? (See the Medications you looked up for Unit II)

Administer as an IV infusion via pump, increasing dose based on protocol until adequate labor progress is achieved; assess baseline vital signs and FHR and then frequently after initiating oxytocin infusion; determine frequency, duration, and strength of contractions frequently; notify health care provider of any uterine hypertonicity or abnormal FHR patterns, maintain careful I&O, being alert for water intoxication, keep client informed of labor progress

21. What does VBAC stand for?

Vaginal birth after cesarean

22. What would you do if you encounter an umbilical cord prolapse? (Carry over from Unit II)

You would get the patient ready for a cesarean. Until you can get them into surgery you can try to relieve cord compression by manually elevating the fetal presentation

23. What is a typical sign of uterine rupture?

Fetal bradycardia, constant abdominal pain, evidence of hypovolemia

24. Why might an amnioinfusion be done?

Treats problems related to fetal compromise, reduces the risk of meconium aspiration

25. What are the indications for use of forceps or vacuum extractor?

These are used when the second stage of labor is prolonged. It can also be used if the baby is coming out and the heart rate drastically drops and needs out quickly.

26. What are the leading indications for cesarean birth?

Labor dystocia, abnormal fetal heart rate, multiple gestation, suspected fetal macrosomia