N432 Maternal-Newborn Care
Proctored ATI Remediation

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Assessment Name: Proctored ATI Remediation
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Individual Performance Profile

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Score Explanation

Main Category: Management of Care
Subcategory: N/A
Topic: N/A

Main Category: Safety and Infection Control
Subcategory: Standard Precautions/Transmission-Based Precautions/Surgical Asepsis - (1)
Topic: Nursing Care of Newborns: Teaching Infection Control Procedures in a Nursery • All personnel who care for a newborn must scrub with antimicrobial soap from elbows to fingertips before entering the nursery. • Health care professionals should use cover gowns or special uniforms to avoid direct contact with clothes. • In between care of the newborn, the nurse should follow facility hygiene protocols.

Main Category: Health Promotion and Maintenance
Subcategory: Ante/Intra/Postpartum and Newborn Care
Topic: Fetal Assessment During Labor: Locating Fetal Heart Tones • The nurse can use Leopold maneuvers to locate the fetus's back to assess for fetal heart tones. • When the fetus is in the vertex position, the fetal heart tones should be assessed below the client's umbilicus in either the left or right lower quadrant of the abdomen. • When the fetus is in the breech position, the fetal heart tones should be assessed above the client's umbilicus in either the right or left upper quadrant of the abdomen. **Topic: Nursing Care During Stages of Labor: Identifying the Need for Reassessment** • Stage one of labor lasts from the onset of regular contractions to full effacement dilation of the cervix. This stage focuses mainly on the rupture of membranes, bladder distention, temperature, and FHR. • Stage two of labor lasts from when the cervix is fully dilated to the fetus's birth. This stage focuses on BP, HR, and RR every 5-30 minutes, uterine contractions, pushing efforts by the client, an increase in the bloody show, and shaking of extremities. • Stage three of labor lasts from the fetus's birth until the placenta is delivered. This stage focuses on BP, HR, and RR every 15 min, clinical findings of separation of the placenta, and vaginal fullness exam. **Topic: Postpartum Disorders: Identifying Risk Factors for Postpartum Hemorrhage** • The nurse should know that uterine atony, overdistended uterus, prolonged labor, and high parity are

all risk factors for postpartum hemorrhage.
- The nurse should know that a ruptured uterus, placenta previa, precipitous delivery, and the administration of magnesium sulfate during labor are all risk factors for a postpartum hemorrhage.
- The nurse should know that lacerations, inversion of the uterus, subinvolution of the uterus, and retained placental fragments are all risk factors for postpartum hemorrhage.

Subcategory: Lifestyle Choices

Topic: Contraception: Contraindications for Use of Oral Contraceptives

- The nurse should know that oral contraceptives are contraindicated in patients with a history of thromboembolic disorders, stroke, heart attack, or coronary artery disease.
- The nurse should know that oral contraceptives are contraindicated in patients with gallbladder disease, cirrhosis or liver tumor, headaches with focal neurological findings, or uncontrolled hypertension.
- The nurse should know that oral contraceptives are contraindicated in patients with diabetes mellitus with vascular involvement, breast or estrogen-based cancers, pregnancy, or lactating.

Main Category: Psychosocial Integrity

Subcategory: Family Dynamics

Topic: Baby-Friendly Care: Responding to a Client's Concerns About Sibling Adaptation

- Encourage the parents to let the sibling be one of the first to see the infant.
- Encourage the parents to provide a gift for the sibling from the infant.
- Encourage the parents to arrange for one parent to spend time with the sibling while the other parent is caring for the infant.

Subcategory: Substance Use and Other Disorders and Dependencies

Topic: Assessment and Management of Newborn Complications: Caring for a Newborn Who Has Neonatal Abstinence Syndrome

- The nurse should reduce environmental stimuli.
- The nurse should monitor the newborn’s fluids and electrolytes with skin turgor, mucous membranes, fontanels, daily weights, and input and output.
- The nurse should offer the newborn non-nutritive sucking.

Main Category: Basic Care and Comfort

Subcategory: Non-Pharmacological Comfort Interventions

Topic: Postpartum Physiological Adaptations: Pain Management for Perineal Laceration

- The nurse should apply ice/cold packs to the perineum for the first 24 hours to reduce edema and provide an anesthetic effect. The nurse should not apply the ice pack directly on the perineum.
- The nurse can offer the patient hot packs, moist heat, and sitz baths to increase circulation and promote healing and comfort.
- The nurse should encourage sitz baths at a hot or cool temperature for at least 20 minutes twice a day.

Main Category: Pharmacological and Parenteral Therapies

Subcategory: Adverse Effects/Contraindications/Side Effects/Interactions

Topic: Pain Management: Monitoring a Client Following a Pudendal Nerve Block

- The nurse should instruct the client about the method.
- The nurse should assess the client’s ability to bear down because a pudendal nerve block lessens or inhibits the bearing down reflex.
- The nurse should assess the perineal and vulvar area postpartum for the presence of a hematoma.

Subcategory: Expected Actions/Outcomes

Topic: Postpartum Disorders: Caring for a Client Who Is Experiencing Uterine Atony Following Delivery

- The nurse should ensure that the patient’s bladder is empty.
- The nurse should monitor the patient’s fundal height, consistency, and location.

- The nurse should perform a fundal massage if indicated. If uterine atony persists, the nurse should anticipate surgical intervention.

Subcategory: Medication Administration

Topic: Medical Conditions: Administering Medication to a Client Who Has Gestational Diabetes Mellitus

- Patients who have gestational diabetes are managed initially with diet and exercise, but if glucose levels are consistently high, insulin begins.
- Oral hypoglycemic therapy is an alternative to insulin in clients with gestational diabetes mellitus who require medication in addition to the diet for blood glucose control.
- Most oral hypoglycemic agents are contraindicated for gestational diabetes mellitus, but there is limited use of glyburide.

Main Category: Reduction of Risk Potential

Subcategory: Changes/Abnormalities in Vital Signs

Topic: Newborn Assessment: Nursing Interventions for Hypothermia

- The nurse should monitor the newborn's axillary temperature. Health newborn temperature range is 36.5℃ to 37.5℃.
- If the newborn's temperature is unstable, the nurse should place the newborn in a radiate warmer and maintain skin temperature at approximately 36.5℃.
- The nurse should be sure to assess the newborn's temperature every hour until the newborn's temperature is stable.

Subcategory: Diagnostic Tests

Topic: Assessment of Fetal Well-Being: Monitoring a Client Who is Undergoing a Nonstress Test

- The nurse should instruct the patient to press the button on the handheld event marker each time they feel the fetus move.
- If there are no fetal movements, vibroacoustic stimulation can be activated for three seconds on the maternal abdomen over the fetal head to awaken the sleeping fetus.
- The nurse should inform the patient that this test is typically completed within 20 to 30 minutes.

Subcategory: Potential for Complications of Diagnostic Tests/Treatments/Procedures

Topic: Newborn Assessment: Identifying Priority Finding

- The nurse should know that airway obstruction related to mucus is a priority finding. The nurse should suction the mouth and then the nose with a bulb syringe.
- The nurse should know that hypothermia is another priority finding and should monitor the newborn's axillary temperature.
- The nurse should know that inadequate oxygen supply is another priority finding. The nurse should monitor the newborn's respirations and monitor for any indications of cyanosis.

Subcategory: System Specific Assessments

Topic: Medical Conditions: Clinical Findings that Indicate Hyperglycemia

- The nurse should know that polydipsia and polyphagia are both manifestations of hyperglycemia.
- The nurse should know that polyuria and nausea are both manifestations of hyperglycemia.
- The nurse should know that abdominal pain, flushed, dry skin, and fruity breath are all signs of hyperglycemia.

Main Category: Physiological Adaptation

Subcategory: Alterations in Body Systems

Topic: Assessment and Management of Newborn Complications: Caring for a Newborn Who Has Necrotizing Enterocolitis

- The nurse should anticipate the administration of a nasogastric tube to keep the newborn's stomach empty.
- The nurse should anticipate an order for IV fluids and nutrition.
- The nurse should anticipate using supplemental oxygen or a ventilator due to the newborn's impaired

ability to breathe properly.

Topic: Bleeding During Pregnancy: Manifestations of Ectopic Pregnancy

- The nurse should know that expected findings of an ectopic pregnancy include unilateral stabbing pain and tenderness in the lower abdominal quadrant and delayed menses that is lighter than usual.
- The nurse should know that scant dark red or brown vaginal spotting six to eight weeks after the last menses is an expected finding of an ectopic pregnancy. Red vaginal bleeding is a sign that rupture has occurred.
- The nurse should know that referred shoulder pain due to blood in the peritoneal cavity can occur after tubal rupture.

Topic: Complications Related to the Labor Process: Manifestations of Uterine Rupture

- The nurse should know that a ripping or tearing sensation reported by the client is a manifestation of uterine rupture.
- A non-reassuring FHR with indications of distress, such as late decelerations and minimal variability, is a finding consistent with uterine rupture.
- The nurse should also know that the cessation of contractions and the loss of fetal station is a known manifestation of uterine rupture.

Subcategory: Medical Emergencies

Topic: Assessment and Management of Newborn Complications: Planning Care for a Newborn Who Has a Myelomeningocele

- The nurse should protect the membrane with a sterile covering and plastic to prevent drying.
- The nurse should observe for leakage of cerebrospinal fluid.
- The nurse should handle the newborn gently by positioning them prone to prevent trauma.