

N432 Maternal Newborn  
Proctored ATI Remediation Template

Student Name: Brittney Burns  
Assessment Name: N432 Maternal Newborn Remediation  
Semester: 3

Instructions:

1. Download the report from your ATI product for the assessment you are completing this remediation template for
2. The report will be broken down into three (3) aspects:
  - a. Categories
    - i. These categories mimic the NCLEX-RN categories and include the following:
      1. Management of Care
      2. Safety and Infection Control
      3. Health Promotion and Maintenance
      4. Psychosocial Integrity
      5. Basic Care and Comfort
      6. Pharmacological and Parenteral Therapies
      7. Reduction of Risk Potential
      8. Physiological Adaptation
  - b. Subcategories
  - c. Topics
3. Complete the template on the following page by doing the following:
  - a. Main Category
    - i. Subcategories for each main category
      1. Topics for each subcategory → these will be the content areas you will be remediating on
        - a. Provide three (3) critical points to remember for each topic → these will come from the Focused Review module(s) within your ATI product
    - b. NOTE: You must remediate on all subcategories AND topics within the main categories listed under the "Topics to Review" section of the ATI report for this assessment.**
4. In the event you need additional space within the table, please add rows into the table to accommodate this
  - a. In the event, you need less space within the table than what is provided, you may delete those rows from the table to accommodate this OR put "N/A" → There may be main categories that you don't have to remediate on and that is OK – you can either delete the table OR put "N/A"
5. An example is provided below:

<b>SAMPLE Main Category: Management of Care</b>
<b>SAMPLE Subcategory: Case Management</b>
<b>SAMPLE Topic: Anemias: Discharge Teaching for a Client Who is Recovering from Sick Cell Crisis</b> <ul style="list-style-type: none"><li>• SAMPLE Critical Point #1: Anemia is the abnormally low amount of circulation RB, Hgb concentration, or both.</li><li>• SAMPLE Critical Point #2: When a patient is going through sickle crisis, the nurse should monitor oxygen saturation to determine a need for oxygen therapy.</li><li>• SAMPLE Critical Point #3: A patient should have their hemoglobin checking in 4 to 6 weeks to determine efficacy.</li></ul>

6. Once the template is completed **and** at least the minimum remediation time has been completed within the Focused Review module(s) in ATI, upload the template to the corresponding dropbox in E360.

## Main Category: Management of Care/ Clinical Judgement

### Subcategory: Postpartum Physiological Adaptations

#### Topic: Physical Changes

- Physiological changes consist of uterine involution; lochia flow; cervical involution; decrease in vaginal distention; alteration in ovarian function and menstruation; and cardiovascular, urinary tract, breast, and gastrointestinal tract changes.
- The greatest risks during the postpartum period are hemorrhage, shock, and infection.
- Oxytocin, a hormone released from the pituitary gland, coordinates and strengthens uterine contractions.
- Breastfeeding stimulates the release of endogenous oxytocin from the pituitary gland.
- Exogenous oxytocin can be administered postpartum to improve the quality of the uterine contractions. A firm and contracted uterus prevents excessive bleeding and hemorrhage.
- Uncomfortable uterine cramping is referred to as afterpains.
- After delivery of the placenta, hormones (estrogen, progesterone, and placental enzyme insulinase) decrease, thus resulting in decreased blood glucose, estrogen, and progesterone levels.
- Decreased estrogen is associated with breast engorgement, diaphoresis (profuse perspiration), and diuresis (increased formation and excretion of urine) of excess extracellular fluid accumulated during pregnancy.
- Decreased estrogen diminishes vaginal lubrication. Local dryness and intercourse discomfort can persist until ovarian function returns and menstruation resumes.
- Decreased progesterone results in an increase in muscle tone throughout the body.
- Decreased placental enzyme insulinase results in reversal of the diabetogenic effects of pregnancy, which lowers blood glucose levels immediately in the puerperium.
- Human chorionic gonadotropin (hCG) disappears from the blood quickly, but some can be detected for up to 4 weeks postpartum.
- Lactating and nonlactating clients differ in the timing of the first ovulation and the resumption of menstruation.
- In lactating clients, the blood prolactin levels remain elevated and suppress ovulation.
- The return of ovulation is influenced by breastfeeding frequency, the length of each feeding, and the use of supplementation.
- The newborn's suck is also believed to affect prolactin levels.
- Length of time to the first postpartum ovulation is approximately 6 months.
- In nonlactating clients, prolactin declines and reaches the prepregnant level by 3 weeks postpartum.
- Ovulation occurs 7 to 9 weeks after birth.
- Menses resume by 12 weeks postpartum.

#### Topic: Healing Processes

- Primary intention
- Secondary intention
- Tertiary intention
  -
- **Topic: Factors Affecting Wound Healing**
- Age: Increased age delays healing.
- Overall wellness: A wound in a young, healthy client that heals faster than a wound in an older adult who has a chronic illness.
- Malnourished clients: Nutrition that provides energy and elements for wound healing.

## Main Category: Safety and Infection Control

### Subcategory: Complications and Nursing Management

#### Topic: Hemorrhage

- Monitor for bleeding.
- Provide gentle pressure on the penis using a small gauze square. Gelfoam powder or sponge can be applied to stop bleeding. If bleeding persists, notify the provider that a blood vessel might need to be ligated. Have a nurse continue to hold pressure until the provider arrives while another nurse prepares the circumcision tray and suture material.
- Cold stress/hypoglycemia
- Monitor for excessive loss of heat resulting in increased respirations and lowered body temperature.
- Swaddle and feed the newborn as soon as the procedure is over.

### Subcategory: Interventions for Stabilization and Resuscitation of Airway

#### Topic: Airway

- Newborns delivered by cesarean birth are more susceptible to fluid remaining in the lungs than newborns who were delivered vaginally.
- If bulb suctioning is unsuccessful, use mechanical suction to clear the airway. Institute emergency procedures if the airway does not clear.
- The bulb syringe should be kept with the newborn, and the newborn's family should be instructed on its use. Family members should be asked to perform a demonstration to show that they understand bulb syringe techniques.
- Compress bulb before insertion into one side of the mouth.
- Avoid center of the mouth to prevent stimulating gag reflex.
- Aspirate mouth first, one nostril, then second nostril.

### Subcategory: Identification

#### • Topic: Identification

- The newborn, client, and client's partner are identified by plastic identification wristbands with permanent locks that must be cut to be removed. Identification bands should include the newborn's name, sex, date, and time of birth, and client's health record number. The newborn should have one band placed on the ankle and one on the wrist. In addition, the newborn's footprints and client's thumb prints are taken. The above information is also included with the footprint sheet.
- Each time the newborn is given to the parents, the identification band should be verified against the client's identification band.
- All facility staff who assist in caring for the newborn are required to wear photo identification badges.
- The newborn is not to be given to anyone who does not have a photo identification badge that distinguishes that person as a staff member of the facility maternal-newborn unit.
- Many facilities have locked maternal-newborn units that require staff to permit entrance or exit. Some facilities have a sensor device on the ID band or umbilical cord clamp that sounds an alarm if the newborn is removed from the facility.

## Main Category: Health Promotion and Maintenance

Subcategory: N/A

## Main Category: Psychosocial Integrity

Subcategory: Hypoglycemia

- An initial drop in blood glucose after birth is a common occurrence due to the cessation of the maternal supply of glucose. Healthy term newborns can compensate for this change by utilizing their glycogen stores to mobilize free fatty acids and ketones to provide energy.
- Healthy term newborns can tolerate a decrease in glucose levels to as low as 30 mg/dL within the first 2 hours after birth.
- Newborns who are at risk for inadequate glycogen stores to compensate for this physiological change should have their glucose levels closely monitored after birth.
- This includes newborns who are preterm, small or large for gestational age, newborns of diabetic clients, and any who display manifestations of hypoglycemia or had trouble transitioning to extra-uterine life.
- Interventions to raise blood glucose levels are usually indicated when glucose levels fall below 40 to 45 mg/dL.
- Untreated hypoglycemia can result in seizures and neurologic injury.

### Topic: Respiratory distress syndrome, asphyxia, and meconium aspiration

- RDS occurs as a result of surfactant deficiency in the lungs and is characterized by poor gas exchange and ventilatory failure.
- Surfactant is a phospholipid that assists in alveoli expansion. Surfactant keeps alveoli from collapsing and allows gas exchange to occur.
- Atelectasis (collapsing of a portion of lung) increases the work of breathing. As a result, respiratory acidosis and hypoxemia can develop.
- Birth weight alone is not an indicator of fetal lung maturity.
- Complications from RDS are related to oxygen therapy and mechanical ventilation.
- Pneumothorax
- Pneumomediastinum
- Retinopathy of prematurity
- Bronchopulmonary dysplasia
- Infection
- Intraventricular hemorrhage

## Main Category: Basic Care and Comfort

Subcategory: Uterus

### Topic: Patient-Centered Care

- Administer oxytocic's intramuscularly or IV after the placenta is delivered to promote uterine contractions and to prevent hemorrhage.
- Oxytocic's include oxytocin, methylergonovine, and carboprost. Misoprostol, a prostaglandin, also can be administered.
- Monitor for adverse effects of medications.
- Oxytocin and misoprostol can cause hypotension.
- Methylergonovine, ergonovine, and carboprost can cause hypertension.
- Encourage early breastfeeding for a client who is lactating. This will stimulate the production of natural oxytocin and prevent hemorrhage.
- Encourage emptying of the bladder to prevent possible uterine displacement and atony.

### Topic: Assessment

- Explain the procedure to the client.
- Position the client supine with their knees slightly flexed so that the fundal height is not influenced by positioning.
- Apply clean gloves and a lower perineal pad and observe lochia flow as the fundus is palpated.

### Subcategory: Lochia

#### Topic: Three Stages of Lochia

- Lochia rubra: Dark red color, bloody consistency, fleshy odor. Can contain small clots, transient flow increases during breastfeeding and upon rising. Lasts 1 to 3 days after birth. Remind the client that they can experience a surge of discharge upon arising after lying in bed for an extended period of time. This should not be mistaken for hemorrhage.
- Lochia serosa: Pinkish brown color and serosanguineous consistency. Can contain small clots and leukocytes. Lasts from approximately day 4 to day 10 afterbirth.
- Lochia alba: Yellowish white creamy color, fleshy odor. Can consist of mucus and leukocytes. Lasts from approximately 10 days to 6 weeks postpartum.

### Subcategory: Pain Management

#### Sources of pain during labor

##### Topic: First stage

- Internal visceral pain that can be felt as back and leg pain
- Pain causes
- Dilation, effacement, and stretching of the cervix
- Distention of the lower segment of the uterus
- Contractions of the uterus with resultant uterine ischemia

##### Topic: Second stage

- Pain that is somatic and occurs with fetal descent and expulsion
- **Pain causes**
- Pressure and distention 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)

##### Topic: Third stage

- Pain with the expulsion of the placenta is like pain experienced during the first stage.
- Pain causes
- Uterine contractions
- Pressure and pulling of pelvic structures

##### Topic: Fourth stage

- Pain is caused by distention and stretching of the vagina and perineum incurred during the second stage with a splitting, burning, and tearing sensation.

### Main Category: Pharmacological and Parenteral Therapies

N/A

### Main Category: Reduction of Risk Potential

#### Subcategory: Fetal Assessment During Labor

##### Topic: Leopold maneuvers

- Presenting part, fetal lie, and fetal attitude

- Degree of descent of the presenting part into the pelvis
- Location of the fetus's back to assess for fetal heart tones
- Vertex presentation: Fetal heart tones should be assessed below the client's umbilicus in either the right- or left-lower quadrant of the abdomen.
- Breech presentation: Fetal heart tones should be assessed above the client's umbilicus in either the right- or left-upper quadrant of the abdomen.

**Topic: Intermittent auscultation and uterine contraction palpation**

**Indications**

- Determine active labor
- Rupture of membranes, spontaneously or artificially
- Preceding and subsequent to ambulation
- Prior to and following administration of or a change in medication analgesia
- At peak action of anesthesia
- Following vaginal examination
- Following expulsion of an enema
- After urinary catheterization
- Abnormal or excessive uterine contractions

**Topic: Continuous electronic fetal monitoring**

**Advantages**

- Monitoring is noninvasive and reduces risk for infection.
- Membranes do not have to be ruptured.
- Cervix does not have to be dilated.
- Placement of transducers can be performed by the nurse.
- Provides permanent record of FHR and uterine contraction tracing.

**Disadvantages**

- Contraction intensity is not measurable.
- Movement of the client requires frequent repositioning of transducers.
- Quality of recording is affected by client obesity and fetal position.

**Subcategory: Nonreassuring Fetal Status Considerations**

**Topic: Three-tier system.**

**Category I**

All of the following are included in the fetal heart rate tracing:

- Baseline fetal heart rate of 110 to 160/min
- Baseline fetal heart rate variability: moderate
- Accelerations: present or absent
- Early decelerations: present or absent
- Variable or late decelerations: absent

**Category II**

Category II tracings include all fetal heart rate tracings not categorized as Category I or Category III.

Examples of Category II fetal heart rate tracings contain any of the following:

**Baseline rate**

- Tachycardia
- Bradycardia not accompanied by absent baseline variability

**Baseline FHR variability**

- Minimal baseline variability

- Absent baseline variability not accompanied by recurrent decelerations
- Marked baseline variability

### **Episodic or periodic decelerations**

- Prolonged fetal heart rate deceleration equal or greater than 2 min but less than 10 min
- Recurrent late decelerations with moderate baseline variability
- Recurrent variable decelerations with minimal or moderate baseline variability
- Variable decelerations with additional characteristics, including “overshoots,” “shoulders,” or slow return to baseline fetal heart rate

**Accelerations:** Absence of induced accelerations after fetal stimulation

### **Category III**

Category III fetal heart rate tracings include either:

- Sinusoidal pattern
- Absent baseline fetal heart rate variability and any of the following.
  - o Recurrent variable decelerations
  - o Recurrent late decelerations
  - o Bradycardia

Each uterine contraction is comprised of the following.

- **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

## **Topic FHR**

### **Topic: Accelerations**

Variable transitory increase in the FHR above baseline

### **Causes/Complications**

- Healthy fetal/placental exchange
- Spontaneous fetal movement
- Vaginal exam
- Uterine contractions
- Fetal scalp stimulation
- Vibroacoustic stimulation
- Fundal pressure

### **Topic: Fetal bradycardia**

FHR less than 110/min for 10 min or more

### **Causes/Complications**

- Uteroplacental insufficiency
- Umbilical cord prolapse
- Maternal hypotension
- Prolonged umbilical cord compression
- Fetal congenital heart block
- Anesthetic medications
- Viral infection
- Maternal hypoglycemia
- Fetal heart failure
- Maternal hypothermia

### **Topic: Fetal tachycardia**

FHR greater than 160/min for 10 min or more

### **Causes/Complications**

- Maternal infection, intrauterine infection
- Fetal anemia
- Fetal cardiac dysrhythmias
- Maternal use of cocaine, caffeine, or methamphetamines
- Maternal dehydration
- Maternal or fetal infection
- Maternal fever
- Maternal hyperthyroidism

## Main Category: Physiological Adaptation

### Subcategory: Neonatal substance withdrawal

- Substance withdrawal in the newborn occurs when the parent uses drugs that have addictive properties during pregnancy. This includes illegal drugs, alcohol, tobacco, and prescription medications.
- Fetal alcohol syndrome (FAS) results from the chronic or periodic intake of alcohol during pregnancy. Alcohol is considered teratogenic, so the daily intake of alcohol increases the risk of FAS. Newborns who have FAS are at risk for specific congenital physical defects and long-term complications.

#### Long-Term Complications

- Feeding problems
- Central nervous system dysfunction (cognitive impairment, cerebral palsy)
- Attention deficit disorder
- Language abnormalities
- Microcephaly
- Delayed growth and development
- Poor maternal-newborn bonding

#### Topic: Heroin withdrawal

- Low birth weight
- Small for gestational age (SGA)
- Manifestations of neonatal abstinence syndrome
- Increased risk of sudden unexpected infant death (SUID). Methadone withdrawal
- Manifestations of neonatal opioid withdrawal syndrome (NOWS): Increased incidence of seizures, sleep pattern disturbances, stillbirth, SUID, higher birth weights (compared to with heroin exposure)