N432 Focus Sheet #2 Fall 2019

Ricci, Kyle, & Carman Ch 13, 14, 21 and ATI Ch 11, 12, 13, 14, 15,16 Focused Reading

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

	TRUE LABOR	**FALSE LABOR**
Uterine Contractions (Braxton Hicks)	Contractions become regular, stronger and more frequent. Walking increases intensity	Changed with ambulation, irregular, often stop with sleep or comfort measures
Cervical Dilation & Effacement	Dilation and effacement of cervix	No dilation
Bloody show	Bloody Show	None
Fetus: Engagement	Fetus presenting part engaged	Fetus presenting part not engaged

2. Define lightening.

- Lightening occurs when the fetal presenting part begins to descend into the true pelvis. The uterus lowers and moves into a more anterior position.

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

- Cervical dilation
- Cervical effacement
- Cervical consistency (firm, medium or soft)
- Cervical position
- Station of presenting part

A score at 39 weeks, should be >8 for multiparous pt, >10 for nulliparous pt

Cervix	Score			
	0	1	2	3
Position	Posterior	Midposition	Anterior	---
Consistency	Firm	Medium	Soft	---
Effacement	0-30%	40-50%	60-70%	>80%
Dilation	Closed	1-2 cm	3-4 cm	>5 cm
Baby's Station	-3	-2	-1	+1, +2

4. What are Leopold's maneuvers (make sure to understand all 4 maneuvers) and what 4 questions do each maneuver answer?

Movement 1: on uterine fundus

- feel for buttocks (soft and irregular – indicative of vertex presentation) or head (hard, smooth, and round – indicative of breech position)

Movement 2: lateral sides of abdomen

- determine which side has: fetal back (feels hard and smooth) or side limbs (feels irregular nodules with kicking noted)

Movement 3: above symphysis pubis

- determine presenting part: head (round, firm and ballottable) or buttock (soft and irregular)

Movement 4: palpate abdomen

- if you palpate hard area on the **opposite side** of the fetal back, fetus is in flexion because you have palpated the chin.

- If the hard area is on the **same side** of the fetal back, fetus is in extension because you have palpated the occiput

5. List the "preprocedures" done on admission to labor and delivery.

- Leopold maneuvers: abdominal palpation of the number of fetuses, the fetal presenting part, lie, attitude, descent, and the probable location where fetal heart tones can best be auscultated on the woman's abdomen
- External electronic monitoring (tocotransducer): separate transducer applied to the maternal abdomen over the fundus that measure uterine activity
  - Also displays uterine contraction patterns
  - Is easily applied by the nurse but must be repositioned with maternal movement to ensure proper placement
- External fetal monitoring (EFM): transducer applied to the abdomen of the client to assess FHR patterns during labor and birth
- Group B strep: culture is obtained results from 35-37 week screening are unavailable → if positive IV prophylactic antibiotics are prescribed (exceptions include a planned c-section or if membranes are still intact)
- Urinalysis: clean catch sample obtained
  - Hydration status
  - Nutritional status via ketones
  - Proteinuria → can be indicative of gestational hypertension or preeclampsia
  - Glucosuria → can be indicative of gestational diabetes
  - UTI via bacterial count
- Blood tests
  - CBC
  - ABO typing and Rh-factor if not previously done

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

Passenger

- Fetus and placenta

Presentation:

- Part of the fetus entering the pelvic inlet that leads through the birth canal
  - Head (occiput), chin (mentum), shoulder (scapula), breech (sacrum or feet)

- Lie:
    - The relationship of mother's spine to fetus' spine
    - Transverse: +
    - Parallel or longitudinal: | |
- Fetopelvic or fetal position:
    - Relationship of presenting part to its directional position to the mother's pelvic quadrants
    - Either side of maternal pelvis:
        - Right (R) or Left (L)
    - Presenting part of fetus
        - Occiput (O), Sacrum (S), Mentum (M), Scapula (Sc)
    - References to the maternal pelvis
        - Anterior (A), Posterior (P), transverse (T)
- Station
    - Level of descent of the fetus
        - - is superior to ischial spines
        - 0 is at ischial spines
        - + is inferior to ischial spines

Passageway

- The birth canal
- Cervix must dilate and efface

Powers

- Contractions
- POWER HOUSE of contractions is the fundus of the uterus. Where they are strongest

Position

- The mother's position
- Gravity can aid in fetal descent

Psychological response

- Mother's stress, tension, and anxiety can impair process of labor and delivery

7. Define fetal lie and fetal attitude.

Fetal lie is what position the fetus' spine is to the mother's spine (page 74)

- transverse +

- parallel or longitudinal | |

Fetal attitude refers to the posturing (flexion or extension) of the joints and the relationship of fetal parts to one another.

8. What role do the fetal skull suture lines and fontanelles play in identifying fetal position?

ROA: Right occipital anterior

- Occipital bone is 'pointing' towards mother's right leg.
- The occipital bone is anterior, facing upward (so the fetal face is down)
- WORDS ARE IN RELATION TO OCCIPITAL BONE

LOP: left occipital posterior

- Occipital bone is pointing towards mother's left leg
- Occipital bone is posterior, facing downward (so the fetal face is up)

9. Define the various fetal presentations (RKC p 462-464 & ATI p 74).

fetal presentation:

- presentation coming out:
  - Occiput (O) – back of head, occipital bone
  - Sacrum (S) – butt
  - Mentum (M) – chin
  - Scapula (Sc) – shoulder
- Cephalic (head down, butt up – good)
  - Vertex: complete flexion (chin tucked in)
  - Military: moderate flexion
  - Brow: poor flexion (extension)
  - Face: full extension (chin extended)
- Breech (head is up, butt is down)
  - Frank: legs and feet up by head
  - Complete of full: legs crossed
  - Footling (single): one foot/leg out

Footling (double): both feet/legs out

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

1. Right (R) or Left (L) : the first letter references either the side of the maternal pelvis

2. Occiput (O), Sacrum (S), mentum (M), or scapula (Sc): the second letter references the presenting part of the fetus
3. Anterior (A), Posterior (P), or Transverse (T): the third letter references the part of the maternal pelvis

11. Fetal station is assessed in relation to what? Level of descent of the fetus, - is superior to ischial spines, 0 is at ischial spines, + is inferior to ischial spines

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

- Cons:
  - High risk of placental abruption
  - High risk of umbilical compression
  - High risk for emergent c-section
  - Cannot be done if pt previously had c-section
  - Can put high stress onto the baby
  - May cause mom pain
- Pros:
  - Will manipulate baby into proper birthing position (cephalic lie)
  - Guided by ultrasound
  - Done in a hospital setting
  - If baby is not in proper birthing position this can cause birthing complications and reasons for a change in the pt's original birthing plan

13. Describe methods of cervical ripening and the indications for their use?

Mechanical:

- Balloon catheter
  - Like the thing in a Foley. But put in vagina above cervix and every 30 minutes, tug on it. When the balloon comes out cervix should be ~ 3-4 cm dilated

Chemical:

- Cervical ripening agents
- Can cause contractions
- PO or vaginal suppository/gel

RN:

- Pt should remain side lying position
- Increase rate of IV fluid admin
- Monitor FHR and uterine activity
- Notify provider or fetal distress or uterine hyperstimulation
  - Admin 02, admin IV, notify provider

14. Use this chart to summarize the Stages & phases of labor. Write it so that it makes sense to you.1.

Stage of Labor	***What is happening during this Stage/Phase?***	***Expected effacement & dilation of cervix***	***Expected Frequency of Contractions***	***Expected duration of contractions***	***Anticipated Nursing assessments & interventions***
First Stage 1. Latent 2. Active 3. Transition	1.Onset of labor 2. Pain increases 3. complete dilation	1.0-3cm 2. 4-7 cm 3. 8-10cm	1.Irregular, mild to moderate, every 5-10 minutes 2. every 3-5mins 3.every 2-3 minutes	1.30-40 seconds 2. 40-70 seconds 3. 45-90 seconds	1.Breathing techniques, walk around 2. “What is your plan” Epidural/pain meds given 3. push, no pain meds – past the point
Second Stage	Full dilation	Full dilations	Every 1-2 minutes, intense	60 - 90 seconds	Coach Mom to push, laceration occurs
Third Stage	5- 30 minutes, delivery of the neonate	Birth of newborn - 2 phases follow: placental separation and expulsion.	Every 1-2 minutes continued	2-30 mins	Admin oxytocin for assistance of expulsion of placenta
Fourth Stage	Delivery of placenta 1-4 hours	Recovery	n/a	n/a	Monitor for hemorrhage (tachycardia, hypotensive)

15. How can we confirm rupture of membranes?

- A sample of fluid is taken from the vagina and tested with **Nitrazine paper to determine the fluids pH** → vaginal fluid is acidic while amniotic fluid is alkaline and will turn the Nitrazine paper blue
- Results may be skewed d/t blood contamination which is also alkaline
- Membrane are most likely still intact if paper remains yellow to olive green with pH between 5-6
- The membranes are probably ruptures in the test tape turns a blue-green to deep blue with a pH ranging from 6.5-7.5

- **If this test is inconclusive the fern test can be done** → a sample of fluid is obtained, applied across a microscopic slide, ad allowed to dry → slide is examined for characteristic ferm patterns that indicates presence of amniotic fluid

What is our priority nursing intervention after confirmation of rupture of membranes?

- Immediately after:
  - assess FHR (especially for deceleration which may indicate cord compression)
  - prolonged rupture of >24 hrs could lead to infection → odor or vaginal discharge or increased WBC count
  - labor/delivery usually occurs within 24 hours
  - Assess VS for fever and tachy

What information do we want to gather from the mother about rupture of membranes if we did not witness it?

- Whether there was a gush of fluid or a slow trickle
- Exact time this occurred

16. Describe when an induction might be warranted and the difference between induction and augmentation?

INDUCTION OF LABOR: Haven't started labor yet

Nipple stimulation- to trigger release of endogenous oxytocin

Admin IV of oxytocin (Pitocin is the synthetic version of oxytocin)

- Monitor FHR every 15 minutes and every change in dose
  - Typically increase in dose every 30 min

Indications:

- Chorioamnionitis = inflammation of chorion (outermost membrane of embryo) and amnion (innermost layer of amniotic sac)
- Prolonged rupture of amniotic sac
- Dystocia (prolonged, difficult labor)
- Postterm pregnancy
- Fetal demise

Augmentation is when you have already started labor

- Augment- stimulation of contractions once labor has started
- Induce-initiation of UC to stimulate labor before spontaneous onset

17. Describe what an amniotomy is, the indications for it to be done, and the considerations.

- The artificial rupture of the amniotic membranes (AROM) by the provider using an Amnihook or other sharp instrument
- Labor typically starts within 12 hours after the membrane ruptures and can decrease the duration of abor by up to 2 hours
- Increases risk for cord prolapse or infection

Indications:

- Labor progression is too slow and the augmentation or induction of labor is indicated
- An amnioinfusion is indicated for cord compression

Considerations:

- Ensure that the presenting part of the fetus is engaged prior to an amniotomy to prevent cord prolapse
- Monitor FHR prior to and immediately following AROM to assess for cord prolapse as evidenced by variable or late decelerations
- Assess and document characteristics of amniotic fluid including color, odor, and consistency
- Document time of rupture
- Obtain temp Q 2 hours
- Provide comfort measures such as frequently changing pads and perineal cleansing

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

Oxytocin	Use: **Start contractions** / induction of labor Action: stimulates labor before spontaneous onset to bring birth by chemical means RN Intervention: - Use infusion port closest to the client for admin - Should be connected PB to the main IV line and admin via an infusion pump - An intrauterine pressure catheter (IUPC) may be used to monitor frequency, duration, and intensity of contractions - Assess maternal BP, pulse, RR Q 30-60 min ad with every change in dose - Monitor FHR and contraction pattern Q 15 min and with every dose change - Assess fluid intake and output - A Bishop score rating should be obtained prior to starting any labor induction protocol - Increase dose until desired contraction pattern is obtained - DC if uterine hyperstimulation occurs RN Indications: - Make sure the fetus is engaged in the birth canal at a minimum of station o before admin - Post Term pregnancy > 42 weeks - Dystocia → prolonged difficult labor d/t inadequate uterine contractions - Prolonged rupture of membranes predisposes mom & baby to risk of infection - Maternal dx → Rh-isoimmunization, DM, pulmonary

	disease, gestational HTN - Fetal demise - chorioamnionitis
Misoprostol	Use: induces labor Action: ripens cervix → cervix becomes shorter, centered, softened, and partially dilated RN Intervention: - Educate client about purpose and possible adverse reactions - Ensure informed consent is signed - Assess VS & FHR patterns frequently - Monitor clients reaction to drug→ N/V/D, uterine hyperstimulation, non-reassuring FHR - Initiate oxytocin for labor induction at least 4 hours after the last dose was administered RN indications: - Contraindicated in women with prior uterine scarring - Contraindicated in women attempting a VBAC - Post term pregnancies
Penicillin G	_Use: Group B Streptococcus (GBS) Action: IV 4 hr before birth to rich adequate levels in serum and amniotic fluid to reduce the risk of newborn colonization RN Intervention: Close monitoring during the administration of IV antibiotics d/t severe allergic reactions occurring rapidly -Ensure preg. Women between 35-37 wks gestation are screened for GBS infections -Record and notify the birth attendant if the woman has tested positive for GBS -During labor, be prepared to admin. IV antibiotics RN indications: Report any maternal fever greater than 100.4 F (38 C) -Determine if the woman’s amniotic membranes have ruptured and the time of rupture → more than 18 hr increases r/o infection.
Methylergonovine	_Use: Prevents and treats postpartum hemorrhage d/t atony or subinvolution Action: Stimulates the uterus RN Intervention: Assess baseline bleeding, uterine tone, and vital signs q 15 min or according to protocol -Offer explanation to pt. About what is happening and the purpose of the meds -Monitor for possible adverse effects, such as HTN, seizures, uterine cramping, N/V, and palpitations. -Report any complaints of C/P promptly RN indications: Contradiction: HTN

Betamethasone	_Use: Prevents or reduces r/o respiratory distress syndrome and intraventricular hemorrhage in the preterm neonate less than 34 wk gestation Action: Promotes fetal lung maturity by stimulating surfactant production RN Intervention: Admin 2 doses IM 24 hr apart -Educate parents about potential benefits of drug to preterm infant -Assess maternal lung sounds and monitor for signs of infection RN indications: Monitor for maternal infection or pulmonary edema
Terbutaline Sulfate	_Use: Stop or delay preterm labor Action: decrease hyperstimulation RN Intervention: Monitor VS RN indications: Not for long term use or for more than 72 hr
Methotrexate	_Use: Ectopic pregnancy Action: Terminates the pregnancy by inhibiting cell division and embryo RN Intervention: Monitor VS RN indications: Do not give PO form with dairy products
Indomethacin	_Use: Inhibits uterine activity to arrest preterm labor Action: Inhibits prostaglandins which stimulate contractions RN Intervention: Continually asses VS, uterine activity, and FHR -Do not give to women with PUD -Schedule ultrasound to assess amniotic fluid volume and function of ductus arteriosus before initiating therapy; monitor for signs of maternal hemorrhage -Be alert for maternal adverse effects such as N/V, heartburn, rash, prolonged bleeding time, oligohydramnios, and HTN RN indications: Contraindicated in >32 wk gestation, fetal growth restriction, hX of asthma, urticaria, or allergic type reactions to aspirin or NSAIDS
Magnesium Sulfate	_Use: Inhibits uterine activity Action: Relaxes smooth muscle of the uterus RN Intervention: Monitor for mg sulfate toxicity hourly such as loss of DTRs, uterine output less than 30 mL/hr, respiratory depression, PE, C/P RN indications: Give to pt. With high BP to prevent seizures
Naloxone	_Use: Opioid analgesic overdose Action: Antagonizes action of narcotic agents by reversing respiratory depression RN Intervention: Administer via IV or IO route at a dose of 1 mg/kg; max 5 mg/kg or 100 mg/dose -Monitor ECG continuously -Monitor for hypotension RN indications: Contraindicated in complete heart block

Calcium Gluconate	_Use: Counteract magnesium toxicity Action: Maintain calcium balance RN Intervention: RN must be at bedside for any pt. Receiving mg sulfate RN indications: Pt. in VFib or has hypercalcemia
Narcan	_Use: Opioid analgesic overdose Action: Antagonizes action of narcotic agents by reversing respiratory depression RN Intervention: Administer via IV or IO route at a dose of 1 mg/kg; max 5 mg/kg or 100 mg/dose -Monitor ECG continuously -Monitor for hypotension RN indications: Contraindicated in complete heart block

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

-Assess maternal vital signs q 1-2 hr
-Assess FHR
-Assess uterine labor contraction characteristics (freq., duration, intensity, resting tone of uterine contractions)
-Intrauterine pressure catheter
-Vaginal examination
-Mechanism of labor in vertex presentation --> engagement, descnet, flexion, internal rotation, extension, external rotation, birth by expulsion.

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

1. Engagement - occurs when the presenting part, usually biparietal (largest) diameter of the fetal head passes the pelvic inlet at the level of the ischial spines, referred to as station o
2. Descent - The progress of the presenting part (preferably the occiput) through the pelvis. Measured by station during a vagainal examination as either negative station measured in cm oif superior to the station o and not yet engaged, or positive measured in cm if inferior to station o
3. 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.
4. Internal rotation: the fetal occiput ideally rotates to a lateral anterior position as it progresses from the ischial spines to the lower pelvis in a corkscrew motion to pass through the pelvis.
5. Extension: The fetal occiput passes under the symphysis pubis, and then the head is deflected anteriorly and is born by extension of the chin away from the fetal chest
6. 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 to face transverse as the anterior should passes under the symphysis.

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

- Changing position frequently (q 30 min)- sitting, walking, kneeling, standing, lying down, getting on hands and knees, and using a birthing ball helps relieve pain, speeds up labor by adding the benefits of gravity and changing the shape of the pelvis.

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

BP, HR, RR:

- Latent phase: every 30 – 60 min
- Active phase: every 30 min
- Transition: every 15 – 30 min

Contractions:

- Latent phase: every 30 – 60 min
- Active phase: every 15 – 30 min
- Transition: every 10 – 15 min

FHR monitoring:

- Latent phase: every 30 – 60 min
- Active phase: every 15 – 30 min
- Transition: every 15 – 30 min

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

Performed digitally by the provider or qualified nurse q 4 hr for routine assessment and ID of a delay in active labor to assess for the following:

- Cervical dilation and effacement
- Descent of the fetus through the birth canal as measured by fetal station in cm
- Fetal position, presenting part, and lie
- Membranes that are intact or ruptured

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

When they are closer together, it indicates that the cervix is dilating and active labor is about to begin.

25. What 2 ways can you assess uterine contractions?

Toco monitor: placed on mother, measures contractions when they occur

IUPC: Intrauterine pressure catheter

- Measures how strong contractions are
- Internal toco monitor

26. To palpate uterine contraction intensity, a mild contraction feels like your __nose_____ , a moderate contraction feels like your __chin_____, and strong contraction feels like your ___forehead_____.

27. List the sources of pain during labor.

1. First stage: Internal visceral pain that can be felt as back and leg pain
    - Sources: Dilation, effacement, and stretching of the cervix; distention of the lower segment of the uterus; contractions of the uterus with resultant uterine ischemia
2. Second Stage: Pain that is somatic and occurs with fetal descent and expulsion
    - Sources: Pressure and distention of the vagina and 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).
3. Third Stage: Pain with the expulsion of the placenta is similar to the pain experienced during the first stage
    - Sources: Uterine contractions; pressure and pulling of pelvic structures
4. 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.

28. List how pain assessment is done during labor.

With persistent questioning and astute observation by the RN. The level, quality, frequency, duration, intensity, and location of pain is assessed through verbal and nonverbal cues.

29. List 3 non pharmacologic pain intervention methods.

Cutaneous stimulation strategies

- Effleurage: light, gentle circular stroking of pt’s abdomen in rhythm w breathing and contractions
- Sacral counter pressure: using heel of hand to press on sacrum
- Heat or cold application
- Hydrotherapy increase endorphin and oxytocin levels
- Frequent position changes

Cognitive strategies

- Education
- Doulas
- Don’t hyperventilate, if they do, breathe into paper bag or hands

Sensory stimulations strategies

- Imagery
- Music
- Aromatherapy
- Breathing

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

Local anesthetic (bupivacaine) with an analgesic (morphine or fentanyl)

Adverse effects

a. Maternal hypotension

b. Fetal bradycardia

c. Inability to feel the urge to void

d. Loss of bearing down reflex

RN:

e. Admin a bolus of IV fluids to help offset maternal hypotension as prescribed

f. Have pt in a sitting side lying modified sims' position

31. What added considerations are there for the nurse caring for a woman who has undergone general anesthesia?

- Used in the event of a delivery complication or emergency
- Used if there is a contraindication to nerve block analgesia or anesthesia
- Ensure NPO
- Ensure proper IV in place
- Apply antiembolic stockings or sequential compression devices
- Pre medicate with oral antacid to neutralize stomach acid
- H2 receptor antagonist such as ranitidine to decrease gastric acid secretion
- Admin metoclopramide to increase gastric emptying as prescribed
- Place a wedge under one of the clients hips to displace the uterus
- Maintain an open airway and cardiopulmonary function
- Assess the client postpartum for decreased uterine tone which can lead to hemorrhage and be produced by pharmacological agents used in general anesthesia

COMPLETE Q32 & Q33 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

32. Where in the contraction do the increment, acme and decrement happen?

Increment- the beginning of the contraction as intensity is increasing
Acme- the peak intensity of a contraction
Decrement- the decline of the contraction intensity as the contraction is ending

33. Briefly describe what Category I, Category II and Category III fetal heart rate tracings look like.

Category I

- Green.

- Good.
- All fetal HR tracings are good:
    - Baseline FHR: 110-160 bpm
    - Baseline FHR variability: moderate
    - Accels present or absent
    - Early decels: present or absent
    - Late or variable decels: absent

Category II

- Yellow.
- Precautionary FHR tracings
    - Baseline rate: tachycardia, bradycardia
    - Minimal /or marked baseline variability

Category III

- Red.
- Bad. Need to deliver
    - Recurrent variable /or late decels
    - Bradycardia

34. Why is support so vital for laboring women? What is a doula? What is a CNM?

Social support during birth has been proven to improve the whole birth experience. Women who receive social support during labor tend to have shorter labors, more confidence, better control of pain, and less need for medical intervention.
A doula is a person who provides emotional and physical support during pregnancy and childbirth.
A CNM is a certified nurse midwife who specializes in women's health and childbirth. They provide care during pre-conception, pregnancy, childbirth, and post-partum.

35. What is "crowning"?

When the top of the baby's head no longer regresses between contractions it is said that the baby is "crowning" → fetal head is visible at vaginal opening

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

- Second:
    - BP, pulse, RR Q 5-30 min
    - Uterine contractions
    - Pushing efforts by client

    - Increase in bloody show
    - Shaking of extremities
    - FHR Q 15 min and immediately following birth
    - Perineal lacerations
- Third:
    - BP, pulse, RR Q 15 min
    - Assess for placental separation from the uterus
    - Apgar scores of 1 & 5 min to the neonate
- Fourth:
    - Maternal VS
    - Fundus
    - Lochia (vaginal discharge)
    - Urinary output
    - Baby-Friendly activities of the family
    - Episiotomy or laceration repair for erythema
    - Allow time for rest

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

- Fundus firmly contracting
- Swift gush of dark blood from introitus
- Umbilical cord appears to lengthen as placenta descends
- Vaginal fullness on exam
- Placenta is expelled within 5-30 minutes

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

Episiotomy: an incision made in the perineum to enlarge the vaginal outlet and theoretically to shorten the second stage of labor

Lacerations: or tears can occur during the second stage when the fetal head emerges through the vaginal introitus → repaired during the third stage of labor

- First degree laceration- extends through the sin
- Second degree laceration- extends through the muscles of the perineal body
- Third degree laceration- continue through the anal sphincter muscle
- Fourth degree laceration- also involves the anterior rectal wall

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

Vaginal- 2 cups (500 cc)

C-Section-4 cups (1 quart)

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

- Lasts up to 4 hours after birth
- status of uterine fundus→ height, position and firmness Q 15 min during first hour → needs to remain firm to prevent excessive postpartum bleeding
- perineal area → episiotomy, hematoma, erythema, hemorrhoids
- Comfort level → pain on a scale of 1-10
- Lochia amount
- Bladder status
- VS taken Q 15 min for the first hour, then 30 min for the next hour if needed
- Assess for hemorrhage or preeclampsia
- Apply ice packs to perineum to promote comfort and reduce swelling
- Assist with hygiene and perineal care
- Offering fluids and nourishment
- assist mother with nursing

- Assist with ambulation

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

- Providing warmth to prevent heat loss by evaporation
- Apgar score a 1 and 5 min
- Secure 2 ID bands on the newborns wrist and ankle that match the band on the mothers wrist to ensure newborn's identity
- Skin to skin provides warmth and closeness between mom and baby → can also allow for nursing baby easily

42. What does Apgar stand for? What 5 parameters does it assess? How often is it assessed?

Appearance (Skin Color) , Pulse (HR), Grimace (Reflexes), Activity (Muscle Tone), Respiration(RR and effort)
Once one minute after birth, again at 5 minutes after birth

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

BP, HR, RR every 15 mins
Clinical finding of placental separation from the uterus
-Fundus firmly contracting
-Swift gush of dark blood from introitus
-Umbilical cord appears to lengthen as placenta descends
-Vaginal fullness on exam