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1N432 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)	**Can begin irregularly, but become regular in frequency** **Stronger, last longer, and are more frequent** **Felt in lower back, radiating to abdomen** **Walking can increase contraction intensity** **Continue despite comfort measures**	**Painless, irregular frequency, and intermittent** **Decrease in frequency, duration, and intensity with walking or position changes** **felt in lower back or abdomen above umbilicus** **Often stop sleep or comfort measures such as oral hydration or emptying of the bladder**
Cervical Dilation & Effacement	**Progressive change in dilation and effacement** **Moves to an anterior position** **Bloody show**	**No significant change in or effacement** **Often remains in a posterior position** **No significant bloody show**
Bloody show	**At the onset of labor or before, the mucus plug that fills the**	

	cervical canal during pregnancy is expelled as a result of cervical softening and increased pressure of the presenting part **ruptured cervical capillaries release a small amount of blood that mixes with mucus resulting in a pink-tinged secretion.**	
Fetus: Engagement	**Presenting part engages in pelvis**	**Presenting part is not engaged in the pelvis**

2. Define lightening.
   - **Occurs when the fetal presenting part begins to descend into the true pelvis. (About 14 days before labor)**
   - **The uterus lowers and moves into a more anterior position.**
   - **The shape of the abdomen changes as a result of the change in the uterus.**
3. Describe the Bishop score and the indications for doing it.
   - **Score system used to assess cervical ripeness**
   - **helps to identify women who would be most likely to achieve a successful induction**
   - **Duration of labor is inversely correlated with the Bishop score**
   - **A score over 8 indicates a successful vaginal birth.**
   - **A score of less than 6 usually indicates that a cervical ripening method should be used prior to induction**
4. What are Leopold's maneuvers (make sure to understand all 4 maneuvers) and what 4 questions do each maneuver answer?

- **Method for determining the presentation, position, and lie of the fetus.**
- **Involves inspection and palpation of the maternal abdomen**
- **Longitudinal lie is expected, and the presentation can be cephalic, breech, or shoulder**
    - **Maneuver 1: What fetal part (head or buttocks) is located in the fundus (top of the uterus)?**
    - **Maneuver 2: On which maternal side is the fetal back located? (Fetal heart tones are best auscultated through the back of the fetus)**
    - **Maneuver 3: What is the presenting part?**
    - **Maneuver 4: Is the fetal head flexed and engaged in the pelvis?**

5. List the “preprocedures” done on admission to labor and delivery.
    - **Leopold maneuvers**
    - **External electronic monitoring (tocotransducer)**
    - **External fetal monitoring (EFM)**
    - **group B strep test**
    - **Urinalysis**
    - **Blood tests**
6. State the 5 “P’s” of the labor progress and what each P is composed of.
    - **Passenger: Consists of the size of the fetal head, fetal presentation, fetal lie, fetal attitude, and fetal position affect the ability of the fetus to navigate the birth canal. The placenta can be considered a passenger because is also must pass through the canal.**
    - **Passageway: The birth canal is composed of the bony pelvis, cervix, pelvic, floor, vagina, and introitus (vaginal opening). The size and shape of the pelvis must be adequate to allow the fetus to pass through it. Cervix must dilate and efface in response to contractions.**
    - **Powers: Uterine contractions cause effacement (Shortening and thinning of the cervix) during the first stage of labor and dilation once labor has begun and the fetus begins descending.**
    - **Position: Client should engage in frequent position changes during labor to increase comfort, relieve fatigue, and promote circulation.**
    - **Psychological response: Maternal stress, tenssion, and anxiety can produce physiological changes that impair the progress of labor.**
7. Define fetal lie and fetal attitude.

- **Fetal lie: The relationship of the maternal axis (spine) to the fetal longitudinal axis (spine)**
- **fetal attitude: Relationship of the fetal body parts to one another**
    - **Fetal flexion: Chin flexed to chest, extremities flexed into torso**
    - **Fetal extension: Chin extended away from chest, extremities extended**

8. What role do the fetal skull suture lines and fontanelles play in identifying fetal position?
    - **Sutures help to identify the positions of the head during a vaginal examination. Palpitation of these sutures by the examiner reveals the position of the fetal head and the degree of rotation that has occurred.**
    - **The anterior and posterior fontanelles are also useful in helping identify the position of the fetal head.**
9. Define the various fetal presentations (RKC p 462-464 & ATI p 74).
    - **Cephalic presentation: The presenting part is usually the occipital portion of the fetal head. Also referred to as a vertex presentation.**
    - **Breech presentation: Occurs when the fetal buttocks or feet enter the maternal pelvis first and the fetal skull enters last.**
    - **Shoulder presentation: Also called shoulder dystocia, occurs when the fetal shoulders present first, with the head tucked inside)**
10. What do each of the 3 letters associated with fetal positioning stand for?
    - **Right (R) or left (L): The first letter references either the side of the maternal pelvis**
    - **Occiput (O), Sacrum (S), mentum (M), or scapula (Sc): The second letter the presenting part of the fetus.**
    - **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?
    - **This refers to the relationship of the presenting part to the level of the maternal pelvic ischial spine. Measured in cm and is referred to as plus or minus.**
    - **Zero (0) station: Designated when the presenting part is at the level of maternal ischial spines.**
    - **Minus station: When the presenting part is below the ischial spines, the distance is recorded as a minus.**
    - **Plus stations: When the presenting part is below the ischial spines, the distance is recorded as plus stations.**

12. Outline the rationale for and the pros and cons of external cephalic version.
    - **average success rate, noninvasive, minimal recovery time, quick, if successful mother will receive benefits of a vaginal delivery**
    - **average failure rate, serious complications, soreness, increased chance of emergency cscection**
13. Describe methods of cervical ripening and the indications for their use?
    - mechanical and physical methods
        i. **a balloon catheter is inserted into the endocervical canal to dilate the cervix**
        ii. **membrane stripping and an amniotomy may be performed**
        iii. **hygroscopic dilators may be inserted to absorb fluid from surrounding tissues and then enlarged. fresh dilators may be inserted if further dilation is required (laminaria tents are made from desiccated seaweed and synthetic dilators contain magnesium sulfate)**
    - **indications**
        i. **potential diagnosis- any condition in which augmentation or induction of labor is indicated**
        ii. **client presentation- failure of the cervix to dilate and efface, failure of labor to progress**

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

Stage of Labor	***What is happening during this Stage/Phase?***	***Expected effacement & dilation of cervix***	***Expected Frequency of Contractions***	***Expected duration of contractions***	***Anticipated Nursing assessments & interventions***
First Stage 1. Latent 2. Active 3. Transition	12.5 hr duration **1. irregular, mild to moderate contractions** Onset of labor;talkative and eager **2. More**	**1.** some dilation and effacement **2.** rapid dilation and effacement **3.** tire	**1.** 5-30 min **2.** 3-5 min **3.** 2-3 min	**1.** 30-45 sec **2.** 40-70 sec **3.** 45-90 sec	provide client/fetal monitoring, encourage frequent position changes, encourage voiding at least every 2 hr, encourage deep cleansing breaths before and after modified paced breathing, encourage

	regular, moderate to strong contractions, some fetal descent, feelings of helplessness, anxiety and restlessness increase as contractions become stronger 3. **Strong to very strong contractions,** tired, restless, and irritable, feeling out of control “cannot continue”, can have nausea and vomiting, urge to push, increased rectal pressure and feelings of needing to have a bowel movement, increased bloody show, **the**	d, restless, and irritable			relaxation, provide nonpharm comfort measures, provide pharm pain relief as prescribed.

	most difficult part of labor				
Second Stage	pushing results in **birth** of the fetus	full dilation	progresses to intense contractions every 1-2 min	n/a	● continue to monitor the client/fetus ● assist in positioning ● assist in partner involvement with pushing efforts and in encouraging in bearing down efforts during contractions ● promote rest between contractions ● provide comfort measures such as cold compresses ● cleanse the client's perineum as needed if fecal material is expelled during pushing ● prepare for episiotomy, if needed ● provide feedback on labor progress to the client ● prepare for care of the neonate. a nurse trained in neonatal resuscitation should be present

					at delivery
Third Stage	5-10 min delivery of the neonate and placenta, placental separation and expulsion, Schultze presentation: shiny fetal surface of placenta emerges first, Duncan presentation: dull maternal surface of placenta emerges first	n/a	n/a	n/a	● instruct the client to push once findings of placental separation are present ● administer oxytocics expulsion of the placenta to occur to stimulate the uterus to contract and thus prevent hemorrhage ● admin analgesics as prescribed ● gently cleanse the perineal area with warm water and apply a perineal pad or ice pack to the perineum ● promote baby-friendly activities between the family and the newborn
Fourth Stage	1-4hrs delivery of placenta and	n/a	n/a	n/a	● assess maternal blood pressure and pulse every 15 min for the first 2 hours and

	maternal stabilization of vital signs, achievement of vital sign homeostasis, lochia scant to moderate rubra				determine the temp at the beginning of the recovery period, then assess every 4 hr for the first 8 hr after birth, then at least every 8 hr ● assess fundus and lochia every 15 min for the first hour and then according to the facility protocol ● massage the uterine fundus and/or administer oxytocics as prescribed to maintain uterine tone and to prevent hemorrhage ● encourage voiding to prevent bladder distention ● assess episiotomy or laceration repair for erythema ● promote an opportunity for a parental-newborn bonding ● after they have had a chance to bond with their baby and eat, most new mothers are

					ready for a nap or at least a quiet period of rest

15. How can we confirm rupture of membranes?
    - **To confirm their membranes have ruptured, a sample of fluid is taken from the vagina VA nitrazine yellow dice while to determine the fluids pH. Vaginal fluid is acidic, where is atomic fluid is alkaline and turns a nitrazine swab blue.the membranes are most likely intact if the night resigns why remains yellow to olive green, with a pH between 5 and 6. The membranes are probably ruptured swap turn a blue-green to deep blue with a pH Ranger from 6.5 to 7.5**

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

- **When membranes rupture, the primary focus should be on assessing the fetal heart rate first to identify a declaration which might indicate cord compression secondary to cord prolapse**

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

- **When did it occur, because prolonged ruptured membranes increase the risk of infection as a result of ascending vaginal pathologic organisms for both mother and fetus. Sign of intrauterine infection to be alert for include maternal fever, fetal and maternal tachycardia, foul odor or vaginal discharge, and increase in white blood cell**

16. Describe when an induction might be warranted and the difference between induction and augmentation?
    - **Induction of Labor is the delivery initiation of uterine contractions to stimulate labor before spontaneous onset to bring about the birth by chemical or mechanical means**
    - **augmentation of Labor is the stimulation of hypotonic contractions once labor has spontaneously begun, but progress is inadequate.**
    - **And adduction might be wanted when:**
        i. **spontaneous rupture of membranes and when labor does not start**
        ii. **large size feet is not expected to navigate the maternal pelvis**
        iii. **fetal growth restriction where external intervention is needed**
        iv. **a pregnancy of more than 42 weeks gestation**
        v. **maternal hypertension, diabetes, or lung disease**

vi. a uterine infection

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

- **An amniotomy is the artificial rupture of the amniotic membrane by the provider using it and me hook or other sharp instrument**

Indications

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

Conderations

- **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 a AROM to assess for cord prolapse and evidence by variable or late declaration**
- **Assess and document characteristics of amniotic fluid including color, odor, and consistency**

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

Oxytocin- **acts on uterine myofibrils to contract/ to initiate or reinforce labor**	● **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 the frequency, duration, and strength of contractions frequently** ● **notify HCP of any uterine hypertonicity or abnormal FHR patterns** ● **maintain careful and I&O, being alert for water intoxication** ● **keep client informed of labor progress** ● **monitor for possible adverse effects**
Misoprostol- **ripens cervix/ to induce labor**	● **instruct client about purpose and possible adverse effects of medication** ● **ensure informed consent is signed per hospital policy** ● **assess VS and FHR patterns frequently**

	● **monitor client's reaction to drug** ● **initiate oxytocin for labor induction at least 4 hours after last dose was administered** ● **monitor for possible adverse effects such as nausea and vomiting, diarrhea, uterine hyperstimulation, and category II FHR patterns**
Penicillin G- **treatment for Group B Strep**	**IV at least 4hr before birth for adequate levels** **Close monitoring for severe allergic reactions** **Review women's prenatal hx and previous infection**
Methylergonovine-**tx postpartum hemorrhage**	**0.2mg IM injection, may be repeated in 5 min, thereafter q2-4hr** **Assess baseline bleeding, uterine tone, and VS q15min** **Offer explanation, monitor for adverse effects, report % chest pain** **Contraindications: HTN**
Betamethasone-**promotes fetal lung maturity**	**Stimulates surfactant production** **Prevents risk of respiratory distress syndrome, and intraventricular hemorrhage in preterm neonate** **Admin 2 doses IM 24 hr apart** **monitor maternal infection/edema** **Educate about drug to preterm infant** **Assess maternal lung sounds**
Terbutaline Sulfate- **prevention of bronchospasm in patients 12 years of age and older with asthma**	**Vials for subq injections only, not IV** **Protect from light** **Watch for adverse effects**

Methotrexate-**antimetabolite that depletes DNA precursors**	**Do not give oral w/ dairy** **Tx of Arthritis- 3-6 weeks** **Protect IV from light** **Monitor CBC, renal/liver function, sx of infection** **Salicylates may delay clearance**
Indomethacin-**inhibits prostaglandins, stimulates contractions, inhibits uterine activity**	**Assess VS, uterine activity, and FHR** **Admin oral w/ food to reduce GI irritation** **DO NOT give if PUD** **Ultrasound for amniotic fluid** **Be alert for maternal adverse effects** **Alert for neonatal adverse effects** **Contraindicated in >32 weeks, gestations, asthma, allergic to NSAIDS**
Magnesium Sulfate- **relaxes uterine muscles to stop irritability and contractions, seizure prophylaxis**	**Admin IV 4-6g over 15-30min, infusion 1-4g/hr** **Assess VS, DTR's, LOC, I&O's, RR, side effects** **Electronic fetal monitoring** **Assess for mag toxicity** **Have calcium gluconate ready at bedside to reverse mag toxicity**
Naloxone- opioid	**an opioid antagonist, should be readily available for reversal of opioid-induced respiratory depression**
Calcium Gluconate-	**used as an antidote for magnesium sulfate toxicity**

Narcan	**opioid antagonist used for opioid overdose**

19. List procedures done during labor (“intra partum”).
    - **fetal monitoring, inducing labor**

20. Define each of the 6 cardinal movements of labor (Mechanisms of labor).
    - **Engagement: greatest transverse diameter of the head in vertex passes through pelvic inlet**
    - **Descent: downward movement of the fetal head until it is within the pelvic inlet**
    - **Flexion: vertex meets resistance from the cervix, the walls of the pelvis, or pelvic floor**
    - **Internal rotation: lower portion of head meets resistance from one side of the pelvic floor, head rotates 45 degrees anteriorly**
    - **Extension: the nucha becames impinged under the symphysis. resistance from the floor causes the fetal head to extend so that it can pass under the arch**
    - **External Rotation: after the head is born and free of resistance, it untwists causing the occiput to move about 45 degrees back to its original left or right position**

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?
    - **Helps influence pelvic size and contours, may facilitate fetal descent and rotation, squatting enlarges pelvic inlet and outlet diameters, reduce length in the first stage, reduce duration of second stage, reduce the number of assisted deliveries, reduce perineal tears, contribute to fewer abnormal fetal heart rate patterns**

22. What are the 4 techniques used to assess ongoing data during labor and birth?
    - **Leopold maneuvers**
    - **intermittent auscultation and uterine contraction palpation**
    - **Continuous electronic fetal monitoring**
    - **Continuous internal fetal monitoring**

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

24. Why is important to assess frequency, duration and intensity of contractions?
    - **So we know how often they are occuring, how long each one lasts, and the strength of the contraction**

25. What 2 ways can you assess uterine contractions?
    - **manual palpitation, internal intrauterine pressure catheter**

26. To palpate uterine contraction intensity, a mild contraction feels like **the tip of the nose** , a moderate contraction feels like **the chin**, and strong contraction feels like **the forehead**.

27. List the sources of pain during labor.
    - **First stage**
        i. **internal visceral pain that can be felt as back**
    - **Pain causes**
        i. **Dilation, effacement, and stretching of the cervix**
        ii. **distention of the lower segment of the uterus**
        iii. **contractions of the uterus with resultant uterine ischemia**
    - **Second stage**
        i. **pain is somatic and occurs with fetal descent and expulsion**
    - **Pain causes**
        i. **pressure and distension of the vagina and perineum, described by the client as burning, splitting and tearing**
        ii. **pressure and pulling on the pelvic structures (ligaments, Fallopian tubes, ovaries, bladder, and peritoneum)**
        iii. **laceration of soft tissues (cervix, vagina, perineum)**
    - **Third stage**
        i. **pain with the expulsion of the placenta is similar to the pain experienced during the first stage**
    - **Pain causes**

        i. **uterine contractions**
        ii. **pressure and pulling of pelvic structures**
    - **4th stage**
        i. **pain is caused by distention and stretching of the vagina and perineum and cure during the second stage with a splitting burning and tearing sensation**

28. List how pain assessment is done during labor.
    - **Pain level cannot always be assessed by monitoring the our expression of a client client pain assessment can require persistent questioning and astute observation by the nurse. Culture beliefs and behaviors of women during labor and delivery can affect the client's pain management**
    - **Anxiety and fear are associated with pain. As fear and anxiety increased, muscle tension increases, and thus the experience of pain increases, becoming a cycle of pain. Fear, tension, and paying slow the progression of Labor**
    - **Assess beliefs and expectations related to discomfort, pain relief, and birth plans regarding pain relief methods for clients and labor**
    - **Assess level, quality, frequency, duration, intensity, and location of pain through verbal and nonverbal cues. Use an appropriate Pain Scale allowing the client to indicate the severity of her pant on a scale of 0 to 10, with 10 representing the most severe pain**

29. List 3 non pharmacological pain intervention methods.
    - **Sensory Stimulation strategies- based on the gate-control theory to promote relaxation and pain relief**
        i. **Aromatherapy**
        ii. **Breathing techniques**
        iii. **Imagery**
        iv. **Music**
        v. **Use of focal points**
        vi. **Subdued lighting**
    - **Cutaneous stimulation strategies**
        i. **Therapeutic touch and massage**
        ii. **Walking**
        iii. **Rocking**
        iv. **Effleurage: light, gentle circular stroking of the client’s abdomen with the fingerprints in rhythm with breathing during contractions**
        v. **Sacral counterpressure: consistent pressure is applied by the support person using the heel of the hand or fist against the client’s sacral area to counteract pain in the lower back**
        vi. **application of heat or cold**

vii. **Transcutaneous electrical nerve stimulation (TENS) therapy**
viii. **Hydrotherapy**
ix. **Acupressure**
x. **Frequent maternal position changes to promote relaxation and pain relief**

- **Cognitive Strategies**
  i. **childbirth education**
  ii. **Childbirth preparation methods, such as Lamaze and patterned breathing exercises**
  iii. **Doulas can assist clients using methods for nonpharmacological pain management**
  iv. **Nursing implications include assessing for signs of hyperventilation, such as lightheadedness and tingling in the fingers**
  v. **Hypnosis**
  vi. **Biofeedback**

30. Describe how epidural analgesia is administered, what are the implications, and what is the difference between this and a spinal epidural?
    - **Injection of local anesthetic and opioid analgesic agent into the lumbar epidural space. Small area on back injected with local anesthetic to numb, needle is inserted into numb area surrounding the spinal cord and lower back, after that a small tube or catheter is threaded through the needle into the epidural space**
    - **Implications: pain relief**
    - **Spinal: injection of an anesthetic agent with or without opiods into the subarachnoid space to provide relief, frequently used for elective and emergent c sections.**

31. What added considerations are there for the nurse caring for a woman who has undergone general anesthesia?
    - **monitor maternal vital signs**
    - **monitor FHR patterns**
    - **ensure that the client has had nothing by mouth**
    - **ensure that the IV infusion is in place**
    - **apply antiembolic stockings or sequential compression devices**

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?
    - **Beginning, the peak, decrease after the peak**

33. Briefly describe what Category I, Category II and Category III fetal heart rate tracings look like.
    - **Category I: baseline fetal heart rate of 110-160/min, baseline fetal heart variability=moderate, accelerations are present or absent, early decelerations are present or absent, variable or late decelerations are absent**
    - **Category II: tracings include all fetal heart rate tracings not categorized as category I or category III.**
        i. **baseline rate: tachycardia and bradycardia not accompanied by absent baseline variability**
        ii. **baseline FHR variability: minimal baseline variability, absent baseline variability no accompanied by recurrent decelerations, marked baseline variability**
        iii. **episodic or periodic decelerations: prolonged fetal heart rate decelerations equal or greater than 2 min but less than 10 min, recurrent late decelerations with moderate baseline variability, recurrent variability decelerations with minimal or moderate baseline variability, variable decelerations with additional characteristics including "overshoots" "shoulders" or slow return to baseline fetal heart rate**
        iv. **accelerations: absence of induced accelerations after fetal stimulation**
    - **category III: sinusoidal pattern, absent baseline fetal heart rate variability and any of the following (recurrent variable decelerations, recurrent late decelerations, bradycardia), each uterine contraction is comprised of increment (the beginning of the contraction as intensity is increasing), acme (the peak intensity of the contraction), and decrement (the decline of the contraction intensity as the contraction is ending), and nonreassuring FHR patterns are associated with fetal hypoxia (including: fetal tachycardia, fetal bradycardia, absence of FHR variability, late decelerations, and variable decelerations).**

34. Why is support so vital for laboring women? What is a doula? What is a CNM?
    - **Many women are left alone, it provides emotional support, helps with a safe and satisfying birth**
    - **Doula: women servant or caregiver, woman who offers emotional and practical support to a mother or couple before during and after childbirth**
    - **CNM: certified nurse midwife**

35. What is "crowning"?
    - **appearance of the fetal head at the perineum**

36. List a summary of assessments during second , third and fourth stages of labor.
    - **2nd: increase in irritability, spontaneous rupture of membranes, sweat on upper lip, low grunting, % rectal pressure, contraction frequency, duration, intensity, VS**
    - **3rd: watching for placental separation, examining the placenta, assessing trauma**
    - **4th: Vital signs, fundal height, perineal area, comfort levels**

37. What are the signs of placental separation and how long can it take for the placenta to be expelled?
    - **Uterine muscle fibers shorten or retract, with each contraction leading to a gradual decrease in the size of the uterus which shears the placenta away, typically done within 30 minutes**

38. What is the difference between a laceration and an episiotomy?
    - **Episiotomy is an incision made into the perineum to enlarge the vaginal opening to facilitate birth and minimize soft tissue damage.**
    - **Laceration is a natural tear**

39. What are the normal blood loss amounts for a vaginal and a cesarean delivery?
    - **500ml/ 1000ml**

40. List “post procedures” done during the fourth stage of labor.
    - **Checking mothers vitals: q15min/hr, q30min/hr, BP stable (decrease=hemorrhage)**
    - **status of fundus: height, position, and firmness q15min/hr. SHOULD BE FIRM**
    - **perineal area: become quite stretched, edematous**
    - **comfort level: for the need of an analgesia**
    - **lochia amount (vaginal discharge): q15min/hr**
    - **bladder status: palpate for fullness**

41. What are important interventions for the newborn at birth? Why is skin to skin time with mom so important?
    - **Place under a radiant warmer, where they are dried assessed and wrapped in warm blankets and placed on the mother's abdomen**
    - **drying the newborn and providing warmth to prevent heat loss by evaporation**
    - **Assess APGAR score**

- **secure two identification bands on the wrist and ankle that match the mothers band**
- **Skin to skin time helps augment maternal oxytocin levels**

42. What does Apgar stand for? What 5 parameters does it assess? How often is it assessed?
    - **used worldwide to evaluate a newborn's physical condition at 1 minute and 5 minutes after birth. additional test done at 10 minutes if the 5 minute score was LESS THAN 7 points**
    - **A:** appearance (color)
    - **P:** pulse (heart rate)
    - **G:** grimace (reflex irritability)
    - **A:** activity (muscle tone)
    - **R:** respiratory (respiratory effort)
    - **Normal score should be 8 to 10 points so 2 points per parameter. 0 is indicative of an absent or poor response and 2 points is normal.**
    - **Scores 4 to 7 indicate moderate difficulty**
    - **scores 0 to 3 points represent severe distress in adjusting to extrauterine life**

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

    - **Monitoring placental separation by looking at the following signs: firmly contracting uterus, change in uterine shape from discoid to globular ovoid, sudden gush of dark blood from vaginal opening, lengthening of umbilical cord**
    - **Examine the placenta and fetal membranes**
    - **assessing for any perineal trauma such as:**
        - **Firm fundus with bright red blood trickling: laceration**
        - **boggy fundus with red blood flowing: uterine atony**
        - **boggy fundus with dark blood and clots: retained placenta**
    - **Inspect peritoneum**
    - **Assess for perineal lacerations**