N432 Focus Sheet #2 2020

Ricci, Kyle, & Carman Ch 13, 14, 21; ATI Ch 11, 12, 13, 14, 15,16 and online Fetal Monitoring program

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

	TRUE LABOR	**FALSE LABOR**
Uterine Contractions (Braxton Hicks)	Strong, regular, increase in frequency and strength as labor progresses	Irregular, weak, unchanging
Cervical Dilation & Effacement	Rapid dilation and effacement, full dilation and effacement occur	Cervix becomes soft, partially effaced, minimal (if any) dilation
Bloody show	Expulsion of brownish/blood-tinged mucus plug from onset of dilation/effacement	No expulsion of cervical mucus plug
Fetus: Engagement	Fetus enters birth canal	Fetus may be changing position to ready for birth

2. Define lightening.

a. Fetus lowers into true pelvis around 14 days prior to labor causing the mother to feel the fetus has dropped

i. Easier breathing, increased pressure on bladder, urinary frequency

ii. More pronounced for primigravida

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

a. Used to determine maternal readiness for augmentation or induction

b. Evaluation of cervical position, consistency, effacement, and dilation as well as baby's positioning

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

a. Abdominal palpation of number of fetuses- how many babies are being delivered, what position are they in

b. Fetal presenting part/lie/attitude- how will the fetus be delivered

c. Fetal descent- readiness of fetus

d. Probable location of auscultation location for fetal heart- position of fetus, heart rate

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

a. Leopold Maneuvers

b. External electronic monitoring

c. External fetal monitoring

d. Group B streptococcus

e. Urinalysis

f. Blood tests

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

a. Passenger- fetus and placenta presentation, lie, attitude, position, and station

b. Passageway- birth canal composed of bony pelvis, cervix, pelvic floor, vagina, and introitus

c. Powers- uterine contractions causing effacement, dilation, involuntary urge to push present, voluntary bearing down

d. Position- client position changes to increase comfort, relieve fatigue, promote circulation

e. Psychological response- maternal stress, tension, anxiety affecting physiological changing impairing labor

7. Define fetal lie and fetal attitude.

a. Fetal lie- relationship of maternal spine to fetal spine

b. Fetal attitude- relationship of fetal body parts to one another

i. Flexion- chin to chest, extremities flexed into torso

ii. Extension- chin away from chest, extremities extended

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

a. Identification of positioning of fetus (vertex or breech)

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

a. Vertex- fetal heart tones assessed below client's umbilicus in right/left lower quadrant

b. Breech- fetal heart tones assessed above client's umbilicus in right/left upper quadrant

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

a. First letter- left or right hip

b. Second letter- baby's occiput

c. Third letter- anterior, posterior, transverse

11. Fetal station is assessed in relation to what?

a. Ischial spines

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

a. Rationale- used to manipulate fetus into cephalic lie when in breech/transverse position late in gestation

b. Pros- places fetus into proper positioning for birth

c. Cons- high risk of placental abruption, umbilical cord compression, emergent cesarean birth

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

a. Balloon catheter inserted into intracervical canal to dilate cervix; membrane stripping and amniotomy; hygroscopic dilators can be inserted to absorb fluid from surrounding tissues and enlarge

b. Failure of client cervix to dilate and efface; failure of labor progression

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. some dilation/effacement, talkative/eager	1. some effacement, 0-3	1. 5-30 minutes apart	1. 30-45 seconds long	1. Leopold maneuvers, external

1. Latent 2. Active 3. Transition	2. rapid dilation/effacement, some fetal descent, helplessness/anxiety/restlessness 3. tired/restless/irritable/out of control, nausea/vomiting, urge to push, increased rectal pressure, increased bloody show	cm dilation 2. rapid increase in effacement, 4-7 cm dilation 3. effaced, 8-10 cm dilation	2. 3-5 minutes apart 3. 2-3 minutes apart	2. 40-70 seconds long 3. 45-90 seconds long	electronic/fetal monitoring, lab testing 2. monitor maternal/fetal vital signs, assess contraction characteristic, intrauterine pressure catheter, vaginal exam 3. assist with preparation for birthing process
Second Stage	Full dilation progresses to intense contractions every 1-2 minutes, birth of fetus	Fully effaced and dilated	Every 1-2 minutes	45-90 seconds	Assist in birthing process
Third Stage	Delivery of neonate, placental separation and expulsion	Fully effaced and dilated	Intermittent	30-45 seconds	Instruct client to push when placental findings are present, administer oxytocis/analgeiscs, cleanse perineal area with warm water/apply pad/ice pack, promote baby-friendly family activities
Fourth Stage	Delivery of placenta, maternal stabilization of vital signs	No effacement, dilation closing	None	None	Monitor maternal and fetal vitals signs Monitor maternal fundus, lochia,

					perineum, urinary output

15. How can we confirm rupture of membranes?

a. Cervical examination, pH testing of fluid, ultrasound

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

a. auscultation of FHR

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

a. amount of fluid, color, odor

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

a. Mother or baby at risk, due date passed

b. Induction- deliberate initiation of uterine contractions before spontaneous labor

c. Augmentation- stimulation of hypotonic contractions after spontaneous labor beginning but progress is inadequate

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

a. Amniotomy- artificial rupture of amniotic membranes

b. Indications- progression of labor is slow and induction/augmentation is recommended

c. Considerations- ensure presenting part of fetus is engaged to prevent cord prolapse, monitor FHR prior and immediately following to assess for cord prolapse, assess/document characteristics of amniotic fluid (color, odor, consistency)

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

Oxytocin- used to stimulate contractions; increases calcium levels in uterus resulting in contractions	**Assess character/frequency/duration of uterine contractions, uterine tone, FHR** **Assess fetal maturity, presentation, and pelvic adequacy**
Misoprostol- can produce uterine contractions; used to induce labor	**Assess safety, vital signs, and progression of labor in both mother and fetus**
Penicillin G- used to treat infection in mom (gonorrhea, syphilis, strep b) prior to birthing fetus through birth canal to prevent transmission	**Obtain vaginal, urine, and blood cultures prior to administration**
Methylergonovine- uterine stimulant; prevent and control bleeding in the uterus after childbirth	**Monitor BP and uterine response until postpartum period is stabilized** **Monitor for postpartum hemorrhage**
Betamethasone- steroid; used to speed up lung development in preterm fetuses if at risk for preterm birth	**Administer 24-48 hours prior to preterm birth** **Monitor client and neonate for pulmonary edema, hyperglycemia, and heart rate changes**

Terbutaline Sulfate- prevent or slow contractions of the uterus; used to stop or delay preterm labor	**Monitor maternal pulse/bp, frequency/duration of contractions, and FHR** **Monitor for signs of maternal or fetal distress**
Methotrexate- treatment of ectopic pregnancy; used to stop the growth of a fertilized egg before a rupture happens	**Monitor clients renal function, vital signs** **Monitor for bleeding**
Indomethacin- short-term treatment for preterm labor; reduces prostaglandin synthesis	**Monitor client closely for pulmonary edema** **Treatment shouldn't exceed 48 hours** **Only used if gestation is less than 32 weeks** **Monitor for postpartum hemorrhage closely**
Magnesium Sulfate- preeclampsia, slow/stop preterm labor, prevent injuries to baby's brain; prevent seizures, slow/stop labor	**Monitor for s/s of magnesium sulfate toxicity** **Educate client on complications (blurred vision, headache, n/v, difficulty breathing) and notify the nurse if these occur** -
Naloxone- opioid reversal; used for newborns who were exposed to opioids in the uterus	**Gather a complete social history from mother** **Monitor fetus for s/s of possible OD or opioid withdrawal**

Calcium Gluconate- magnesium sulfate reversal; used to reduce levels of magnesium sulfate if levels become too high or mother/baby are ready for delivery	**Monitor for s/s of magnesium sulfate toxicity** **Monitor vital signs following administration**

19. List procedures done during labor (“intra partum”).

a. Maternal vital sign monitoring, FHR assessment, uterine labor contraction characteristic assessment (frequency, duration, intensity, resting tone of uterine contractions), intrauterine pressure catheter (insertion of sterile, solid, or fluid-filled intrauterine pressure catheter into uterus to measure intrauterine pressure during contractions), vaginal exam (cervical dilation, descent of fetus, fetal position/presenting part/lie, membranes intact or ruptured), mechanism of labor in vertex presentation (engagement, descent, flexion, internal rotation, extension, external rotation, birth by expulsion)

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

a. Engagement- presenting part of fetus passes the pelvic inlet at the level of the ischial spines (station 0)

b. Descent- presenting part through the pelvis, considered positive or negative depending on positioning compared to station 0

c. Flexion- fetal head meets resistance of cervix, pelvic wall or floor; head flexes, bringing chin close to chest

d. Internal Rotation- fetal occiput rotates to a lateral anterior position as it progresses from ischial spines to lower pelvis in corkscrew motion

e. Extension- fetal occiput passes under symphysis pubis and head is deflected anteriorly, baby is born by extension of the chin away from the chest

f. External Rotation- head rotates to position it occupied when it entered the pelvic inlet in alignment with fetal body after the head is born

g. Birth by Expulsion- trunk of neonate is born by flexing toward the symphysis pubis

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?

a. Benefits- increase comfort, relieve fatigue, promote circulation

b. Suggestions- gravity can aid in fetal descentà recommend standing, sitting upright, kneeling, and squatting positions

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

a. Intermittent auscultation and uterine contraction palpation

b. Continuous electronic fetal monitoring

c. Continuous internal fetal monitoring

d. Intrauterine pressure catheter

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

a. SVE- done digitally to determine the progress and status of labor progression

b. Frequency- q4 during first stage of labor for low-risk women

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

a. Frequency, duration, and intensity of contractions will evaluate how far along labor has progressed, and if it is continuing to progress

25. What 2 ways can you assess uterine contractions?

a. Palpation

b. Internal/External monitoring device

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

a. Mild- being stung by a bee, but all over your abdomen

b. Moderate- tight, being kicked where it hurts

c. Strong- going to poop

27. List the sources of pain during labor.

a. First stage- dilation/effacement/stretching of cervix, distension of lower segment of uterus, contractions with resulting uterine ischemia

b. Second stage- pressure/distension of vagina/perineum (burning, splitting, tearing), pressure/pulling on pelvic structures (ligaments, fallopian tubes, ovaries, bladder, perineum), lacerations of soft tissues (cervix, vagina, perineum)

c. Third stage- uterine contractions, pressure/pulling of pelvic structures

d. Fourth stage- distension/stretching of vagina and perineum during the second stage

28. List how pain assessment is done during labor.

a. Persistent questioning, astute observation

b. Presence of anxiety/fear

c. Assess beliefs/expectations related to pain, cultural beliefs

d. Assess level/quality/frequency/duration/intensity/location through verbal/nonverbal cues

29. What should the nurse consider prior to administration of opioid pain medication during labor?

a. Nonpharmacological methods

30. Describe the gate-control theory of pain control. Give examples.

a. Sensory nerve pathways allow a limited number of sensations to travel at any given time

i. Childbirth education

ii. Aromatherapy

iii. Walking/rocking

31. List 3 non pharmacologic pain intervention methods.

a. Cognitive strategies

b. Sensory stimulation

c. Cutaneous stimulation

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

a. Administration- administered into epidural space without using an anesthetic

b. Implications- desired pain relief by client but need to maintain ability to push

c. Analgesia vs. spinal- allows client to continue feeling contractions and maintain the ability to bear down while having pain relief

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

a. Client NPO status, application of antiembolic stockings, premedicate with an oral antacid, administration of histamine2-receptor antagonist, administration of metoclopramide, wedge under one hip to displace the uterus, maintain open airway and cardiopulmonary function, assess postpartum for decreased uterine tone

COMPLETE Q34 & Q35 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

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

a. Increment- beginning as intensity is increasing

b. Acme- peak intensity

c. Decrement- decline of intensity as contraction ends

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

a. Category I- rate (110-160), variability (moderate), accelerations (present or absent), variable or late decelerations (absent)

b. Category II- rate (tachycardia, bradycardia not accompanied by absent variability), variability (minimal, absent not accompanied by recurrent decelerations, marked variability), episodic/periodic decelerations (prolonged deceleration equal/greater than 2 min but less than 10 min, recurrent late decelerations with moderate variability, recurrent variable decelerations with minimal to moderate variability, overshoots, shoulders, slow return to baseline) accelerations (absence of induced accelerations after fetal stimulation)

c. Category III- sinusoidal pattern, absent baseline rate variability and recurrent variable decelerations/recurrent late decelerations/bradycardia, contractions with increment/acme/decrement, non-reassuring patterns associated with fetal hypoxia and brady/tachy-cardia//absence of variability, late/variable decelerations

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

a. Support- having support for mother and baby can improve the outcomes for both

b. Doula- not a medical professional, trained in childbirth who provides emotional, physical, and educational support to parents who are expecting, in labor, or recently given birth

c. CNM- certified nurse, delivers baby, provides health and wellness care to women including family planning, gynecological and prenatal care

37. What is “crowning”?

a. Baby’s head emerges bit by bit during each contraction in the second stage of labor

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

a. Second- bp/hr/rr every 5-30 minutes, uterine contractions, pushing efforts by client, increase in bloody show, shaking of extremities, FHR every 5-15 minutes, perineal lacerations

b. Third- bp/hr/rr Q15, swift gush of dark blood from introitus, umbilical cord appears to lengthen as placenta descends, vaginal fullness, 1 and 5 min APGAR scores

c. Fourth- maternal vital signs, fundus, lochia, urinary output, baby-friendly activities of the family

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

a. Signs- fundus firmly contracting, swift gush of dark blood from introitus, umbilical cord appears to lengthen as placenta descends, vaginal fullness

b. Time length- 30 minutes after delivery of baby

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

a. Laceration- occur as fetal head is expulsed, defined in terms of depth

b. Episiotomy- surgical incision to prevention lacerations

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

a. Vaginal- 500mL

b. Cesarean- 1000mL

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

a. Assess bp/hr q15 for 2 hours, temp at beginning of recovery then q4 for 8 hours, then q8; assess fundus and lochia q15 for 1 hour then according to protocol; massage the uterine fundus/administer oxytocic’s to prevent hemorrhage; encourage voiding to prevent bladder distension, assess episiotomy/laceration repair for erythema; promote parental-newborn bonding; rest-period

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

a. Suctioning of nares and mouth, skin-to-skin time, cord clamping/cutting, bathing

b. Facilitates the attachment process and encourages breastfeeding

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

a. BP/HR/RR q15, assessment for placental separation

b. Administer oxytocic's, analgesics