N432-Focus Sheet Unit 3—2020—Complications of Pregnancy, Labor, and Delivery

Ricci, Kyle & Carman Ch 19, 20 & 21; ATI Ch 7-10

Some of the problems which cause complications of Pregnancy as well as Labor and Delivery were discussed during Unit 1 e.g. some of the infections, and during Unit 2 on labor and delivery. So be sure and look at this information from Unit 1 & 2 as you work through this focus sheet. The information will be used to compare and analyze the normal versus the abnormal occurrences in order to make decision for nursing interventions. So, even while you fill out the focus sheet, be thinking about assessments and actions you "as a nurse" can make in the midst of these complications.

Bleeding during ; Medical Conditions; Early Onset of Labor

RKC Ch 19; ATI Ch 7, 9, 10 (Bleeding)

1. List 5 factors that can place a woman at risk during pregnancy.

1. Women under 20
2. Women over 35
3. Diabetes
4. Obesity
5. High blood pressure

2. Define abortion, miscarriage, and stillbirth.

Abortion - the loss of an early pregnancy, usually before week 20 of gestation

Miscarriage - the loss of a fetus resulting from natural causes, that is, not elective or therapeutically induced by a procedure.

Stillbirth - the loss of a fetus after the 20th week of development

3. Describe the following for spontaneous abortion: p687-689

Pathophysiology	Causes of spontaneous abortion are varied and often unknown. Most common cause for first trimester abortions is fetal genetic abnormalities

Nursing Assessment	Ask the client about the color of vaginal bleeding, the amount, and the passage of any clots or tissue. Instruct her to save any tissue or clots passed and bring them with her to the facility. Obtain a description of any other signs and symptoms the woman may be experiencing, along with description of their severity and duration. STAY CALM. assess vitals and observe characteristics of bleeding. As to rate pain level, evaluate amount and intensity of cramping.
Testing	Ultrasound, fetal heartbeat
Management	Observation - In time, the contents of the uterus will pass, usually within two weeks, although sometimes as long as 3 to 4 weeks later. Once the contents have been passed, an ultrasound is done to ensure that the miscarriage is complete. Medical treatment — In some cases, medications can be given to stimulate the uterus to pass the pregnancy tissue. The medicine can be given by mouth or vaginally, and works over several days. Surgical treatment — The cervix is dilated, and an instrument is inserted that uses suction and/or a gentle scraping motion to remove the contents of the uterus
Patient education needs	Make sure the client understands that there will be a lot of vaginal bleeding and to not use a tampon. Use pads and make sure that if you are bleeding through 6-7 pads in an hour, to call a doctor to be advised on what to do next.

4. Define threatened abortion, inevitable abortion, incomplete abortion, complete abortion, missed abortion and habitual abortion. P 689

Threatened abortion- when vaginal bleeding occurs, and the diagnostic for a spontaneous abortion has not been met

Inevitable abortion - the cervix has dilated, but the products of conception have not been expelled.

Incomplete abortion- involves vaginal bleeding, cramping (contractions), cervical dilatation, and incomplete passage of the products of conception.

Complete abortion - All of the products (tissue) of conception leave the body.

Missed abortion- a type of early pregnancy loss in which the dead embryo or fetus is retained in the womb for a period of time, during which the usual symptoms of miscarriage may not occur

Habitual abortion - 3 consecutive pregnancy losses prior to 20 weeks from the last menstrual period.

5. What are the actions and implications of the use of Cytotec, Cervidil (dinoprostone)/Prepidil(Gel), Rh Immunolglobulin Rhogam related to abortions (elective or spontaneous)? Chart p 690

Cytotec- Stimulates uterine contractions to terminate a pregnancy; to evacuate the uterus after abortion to ensure passage of all the products of conception.

Cervidil- Stimulate uterine contractions, causing content in the uterus to expel. Efface or dilate the cervix in a term pregnancy. Used to expel content during a fetal death or abortion during the second trimester.

Rhogam- MICRhoGAM is given to those who have abortions or miscarriages <12 wks unless the father is Rh negative or fetus is.

6. Describe the following for ectopic pregnancy:

Pathophysiology	Is when the ovum implants in the fallopian tube,ovary, intestine, cervix, or the abdominal cavity.
Nursing Assessment	Does the client have abdominal pain, amenorrhea, vaginal bleeding? Make sure to answer questions and offer thorough explanations while going through all diagnostic testing.
Testing	Urine pregnancy test, Beta-hCG, transvaginal ultrasound
Management	Given methotrexate to help expel or surgery if a fallopian tube is ruptured and removal of the tube (salpingectomy).
Patient education needs	Make sure the client knows why multiple beta-hCG tests are necessary. Educate on what an ectopic pregnancy is. Educate on what a transvaginal ultrasound entails.

7. Describe the following for Gestational Trophoblastic Disease.

Pathophysiology	Tumor arises from gestational rather than maternal tissue
Nursing Assessment	Assess the woman for potential clinical manifestations at each visit.
Testing	hCG level testing/transvaginal ultrasound
Management	Prepare for D&C, provide emotional support, educate risk that cancer may develop after molar pregnancy, and educate the importance of a follow up.
Patient education needs	Educate patients about the disease and interventions. Educate the different stages of treatment.

When would you anticipate that Methotrexate would be prescribed?

Methotrexate may be prescribed to destroy the retained placental tissue.

8. Describe the following for Cervical Insufficiency:

Pathophysiology	The cervix is weak, structurally defective cervix dilates in the absence of uterine contraction in the second trimester/third trimester. The cervix may have less elastin, less collagen, and greater amounts of smooth muscle than the normal cervix and results in loss of sphincter tone.
Nursing Assessment	Health history to identify risk factors, previous cervical trauma, preterm labor, fetal loss in the second trimester, previous surgery
Testing	Transvaginal ultrasound, home uterine activity monitoring
Management	Monitor for signs of preterm labor, rupture of membranes, and uterine contraction. Provide emotional support.
Patient education needs	Educate patients about signs and symptoms. Educate them to report any changes immediately. Educate the patient that activity is restricted

9. Describe the following for Placenta Previa:

Pathophysiology	Implantation of the embryo in the lower uterus which may incite placental growth in the unscarred lower uterine segment.
Nursing Assessment	Assess possible risk factors: advancing maternal age, previous cesarean birth, multiparity, uterine insult/injury, cocaine use, etc. Provide a physical examination.
Testing	Transvaginal ultrasound MRI
Management	Monitor fetal status. Assess signs and symptoms of vaginal bleeding. Assess for fetal distress. Provide support and education to patient
Patient education needs	Bed rest, avoiding intercourse, and avoiding digital examinations. Patients with placenta previa should go to the emergency room if they have any episodes of vaginal bleeding.

10. Why is it important to know if a woman who is presenting to labor and delivery has a placental previa?

It is important to know because it may cause serious morbidity and mortality to the fetus and mother.

How would her care be altered?

Bed rest is recommended. A cesarean section is often needed.

11. Describe the following for Abruptio Placentae (Abruption):

Pathophysiology	Abruption starts with degenerative changes in the small maternal blood vessels, results in blood clotting, degeneration of the uterine lining and possible rupture of vessels. The blood clot forms between the uterine wall and placenta and creates pressure that results in the separation of

	placenta from the uterine wall.
Nursing Assessment	Assess for abdominal pain and/or experiencing vaginal bleeding (Especially concealed hemorrhage)*** Need to provide a rapid assessment to ensure prompt, effective interventions to prevent maternal and fetal morbidity and mortality.
Testing	CBC, Fibrinogen levels, PT and aPTT, type and crossmatch. Nonstress test, and biophysical profile
Management	Woman with abruptio placentae needs immediate care to provide good outcomes for mom and baby. Mom is to be on strict bed rest. Asses electronic fetal monitoring continuously.
Patient education needs	Educate about fetal well being Educate the different diagnostic test being performed

12. Describe shoulder dystocia **RKC Ch 13 p 464 Ch 21 p 797 & 806**

birth injury that happens when one or both of a baby's shoulders get stuck inside the mother's pelvis during labor

13. In your own words describe Disseminated intravascular coagulation (DIC).

Clumps of blood clots form inside of blood vessels. These abnormal clots use up the blood's clotting factors, which can lead to massive bleeding in other places.

14. Describe the following for Hyperemesis Gravidarum

Pathophysiology	Severe type of nausea and vomiting during pregnancy.
Nursing Assessment	Onsent, duration, and course of nausea & vomiting. Ask about medications or treatments she used and how effectively they were in relieving her symptoms. Obtain diet history. Review client's history for

	possible risk factors. Assess the client's perception of the situation.
Testing	Liver enzymes, CBC, Urine ketones, TSH & T4, Urine specific gravity, Serum electrolytes, Ultrasound
Management	Promoting comfort by controlling the client's nausea and vomiting and promoting adequate nutrition. Supporting and educating the client and her family.
Patient education needs	Educate about condition and its treatment options. Teach the client about therapeutic lifestyle changes.

15. What three medications are commonly used for hyperemesis gravidarum? What nursing considerations should be addressed for each of these?

Ondansetron/ Zofran: May cause dizziness/ drowsiness. First line medication therapy for nausea during pregnancy.

Metoclopramide: May cause dizziness/ drowsiness

Protonix/ Pantoprazole: Last resort when other medications have failed. Pregnancy Risk B, this medication may be excreted in breast milk.

16. What is the difference between chronic and gestational hypertension?

Chronic hypertension is high blood pressure in a women before she becomes pregnant

Gestational Hypertension is high blood pressure in a woman that occurs during pregnancy.

17. Please fill in the table below:

	Mild Preeclampsia	Severe Preeclampsia	Eclampsia
Blood pressure	>140/90 mm Hg after 20 weeks gestation	> 160/110 mm Hg	>160/110 mm Hg

proteinuria	300 mg/24 hr or greater than 1+ protein on a random dipstick urine sample	> 500 mg /24 hour; greater than 3+ on a random dipstick urine sample	Marked proteinuria
Seizures/coma	No	No	Yes
hyperreflexia	No	Yes	Yes
Other signs or symptoms	Mild facial or hand edema Weight gain	Headache Oliguria Blurred vision; scotomata Pulmonary Edema Thrombocytopenia Cerebral disturbances Epigastric or RUQ pain HELLP	Severe headache Generalized edema RUQ or epigastric pain Visual disturbances Cerebral hemorrhage Renal failure HELLP
Treatment/management	Placed on bedrest at home Lay in the lateral recumbent position Antepartal visits CBC, clotting studies, liver enzymes, platelets are monitor frequent. Monitor BP daily Q4-6 hours	Complete bed rest in the left lateral position Ensure the room is dark and quiet to reduce stimulation Give sedatives and antihypertensives as ordered Institute and maintain seizure precautions such as padding the side rails and having oxygen, suction equipment, and call light readily available.	Client safety is the primary concern Turn client on her side and remain with her Make sure side rails are up and padded Dim the lights and keep the room quiet Ensure

	Daily weight Monitor protein in urine No sodium diet	Closely monitor BP Report changes in vision or complaints of headache High protein diet 8-10 glasses of water daily	continuous electronic fetal monitoring, evaluating fetal status for changes

18. We will discuss in class the protein/creatinine (P/C) ratio. This is not in your text. Here is a

Urine protein tests detect and/or measure protein being released into the urine. Normal urine protein elimination is less than 150 mg/day and less than 30 mg of albumin/day. Elevated levels may be seen temporarily with conditions such as infections, stress, pregnancy, diet, cold exposure, or heavy exercise. Persistent protein in the urine suggests possible kidney damage or some other condition that requires additional testing to determine the cause.

19. Medications used with preeclampsia and eclampsia

Medication	Indications (why is this needed for THIS patient?)	Nursing Implications (what are you watching for?)	Dose
Magnesium Sulfate	Prevention & treatment of eclamptic seizures.	Monitor serum magnesium levels closely. Assess DTRs & check for ankle clonus. Monitor for s/s of toxicity, such as flushing, sweating, hypotension, & cardiac & central nervous system depression.	4-6 g by IV in 100mL of fluid administer over 15-20min, followed by a maintenance dose of 2 g as a continuous intravenous infusion.
Hydralazine hydrochloride (Apresoline)	Reduction in BP.	Monitor for adverse effects such as palpitations, HA, tachycardia, anorexia, nausea, vomiting, &	5-10mg slow intravenous bolus every 20min as needed.

		diarrhea.	
Labetalol hydrochloride (Normodyne)	Reduction in BP.	Monitor for possible adverse effects such as gastric pain, flatulence, constipation, dizziness, vertigo, & fatigue.	IV dose of 20-40mg every 15min as needed & then IV infusion of 2 mg/min until desired blood pressure value is achieved.
Nifedipine (Procardia)	Reduction in BP, stoppage of preterm labor.	Monitor for possible adverse effects such as dizziness, peripheral edema, angina, diarrhea, nasal congestion, cough.	10-20mg orally for three doses & then every 4-8hr.

20. What are the signs of Magnesium toxicity? What is the therapeutic level for magnesium sulfate? What drug should always be at the bedside of a patient who has Magnesium sulfate infusing?

Signs: respiratory rate less than 12 bpm, absence of DTRs, and a decrease in urinary output (<30 mL/hr).

Therapeutic level - 4-7 mEq/L

Have calcium gluconate readily available in case of toxicity.

21. When grading a deep tendon reflex, does the grading scale of 0-4 state no movement is graded as a 0 or a 4?

0= absent reflex

22. What does clonus evaluate and what does a positive clonus look like?

Clonus is a condition that results in involuntary muscle spasms. Several Nero conditions could be the cause of clonus — test done to see if it is clonus or another condition causing muscle spasms.

Perform rapid dorsiflexion on foot, if foot jerks over 5 times when pulled back and released, it is a positive clonus reaction

23. What does HELLP stand for?

Hemolysis; Elevated Lipids; Low Platelets

24. Describe the following for HELLP syndrome

Pathophysiology	Life-threatening breakdown of red blood cells that activates clotting factors and platelet consumption-- this will cause multi-organ failure quickly if not treated.
Nursing Assessment	Bleeding/ hemorrhage, bruising, nausea/ vomiting
Testing	CBC for low platelets, Liver enzymes, PT/INR, aPPT
Management	Manage bleeding, prevent injury, provide oxygen
Patient education needs	Pt may need an emergency C-section, blood transfusions may be necessary

25. What is Rh factor incompatibility? When is RhoGAM administered? Who is at risk if it is not given?

Rh factor incompatibility is when the mother is Rh negative and the baby gets the fathers Rh positive. Her body see's the fetus as an invader and starts to attack the baby. It can, in turn, attack her cells. RhoGAM is administered during all pregnancies in mothers who are Rh negative to help protect her. Who is at risk: mom is and so are future babies.

26. What fetal risks are associated with polyhydramnios and oligohydramnios?

Polyhydramnios - increased incidence of preterm births, fetal malpresentation, and cord prolapse.

Oligohydramnios - increased risk of perinatal morbidity and mortality, reduction in amniotic fluid reduces the ability of the fetus to move freely without risk of cord compression, which increases the risk for fetal death and intrapartum hypoxia.

27. Define multiple gestation and explain why it may be concerning for the mother/fetus.

Multiple gestation - pregnancy with two or more fetuses. It may be a concern because women who are expecting more than one infant are at high risk for preterm labor, polyhydramnios, hyperemesis, gravidarum, anemia, preeclampsia, and antepartum hemorrhage. Fetal/newborn risks or complications include prematurity, respiratory distress syndrome, birth asphyxia/perinatal depression, congenital anomalies, twin-to-twin transfusion syndrome, intrauterine growth restriction, and becoming conjoined twins.

28. What do monozygotic and dizygotic mean?

Monozygotic- twins derived from a single ovum also known as identical twins.

Dizygotic- twins derived from two separate ova also known as fraternal twins.

29. Describe the following for Premature rupture of membranes:

Pathophysiology	Rupture of the bad of waters before the onset of true labor.
Nursing Assessment	. Institute continuous electronic fetal heart rate monitoring. Observe characteristics of the amniotic fluid.
Testing	Nitrazine test, fern test, or ultrasound, urinalysis and urine culture, cervical test or culture, vaginal culture, vaginal introital/rectal culture.
Management	Preventing infection & identifying uterine contractions.
Patient education needs	Monitor baby's activity, watch for signs related to the beginning of labor, maintain specific activity restrictions as recommended, call provider with changes in your condition.

RKC Ch 20; ATI Ch 9

1. Discuss each of the following for Gestational Diabetes:

Pathophysiology	Is an imparired tolerance to glucose with the first onset of recognition during pregnancy. Normal levels should be 60 to 99mg/dl
Nursing Assessment	Review history risk factors. Assess for S/S of GDM
Testing	Glucola screening test/1-hr glucose tolerance test, analysis 1 hr later

	performed at 24 to 28 weeks of gestation fasting not necessary Oral glucose tolerance test . presence of ketones in urine
Management	Monitor the client blood glucose, monitor the fetus
Patient education needs	Perform daily kick counts, adhere to the appropriate diet, include standard diabetes diet and restricted carbohydrate intake. Exercise, perform self administration of insulin

2. What effects can uncontrolled gestational diabetes have on the fetus/newborn?

Risk factors for the fetus include overweight or obesity, hypertension, hypoglycemia and respiratory issues

3. What cardiovascular changes are noted during pregnancy?

- Cardiac output increases approximately 20%
- Stroke volume increases to a maximum at 19 weeks and then plateaus.
- Cardiac output increases rapidly by 20%, then gradually increases 10%.
- Blood pressure gradually decreases 10% at 34 weeks then increases to pre-pregnancy values by birth.
- . Peripheral venous distention progressively increases to term.
- . Peripheral vascular resistance progressively decreases; restoration near term.
- Caused by progesterone which is a vascular dilator of smooth muscle.

Why might these put a woman at risk for cardiovascular disease?

These factors indicate that women are more likely to have a MI. They also have a risk of developing DVT.

4. Discuss each of the following for iron deficiency anemia.

Pathophysiology	Occurs when the body does not have enough iron to produce Hgb. The heme portion of Hgb consists of iron surrounded by protoporphyrin. When not enough iron is available to the bone marrow, Hgb production is reduced.
Nursing Assessment	Review the mother's history for factors that may contribute to the development of iron-deficiency anemia, including poor nutrition, hemolysis, pica, multiple gestation,

	limited intervals between pregnancies, and blood loss.
Testing	labst Hgb <11 Hct <35 iron <30 microcytic and hypochromic cells
Management	Intake iron rich food, encourage adherence to drug therapy, transport oxygen,
Patient education needs	Take your prenatal vitamin daily if you miss a dose take it once you remember.

5. After reading about adolescence and pregnancy, discuss how you as the nurse would care for this patient. What would you do differently?

To prepare the adolescent patient for newborn care, the nurse should provide anticipatory guidance. The nurse should also inquire about the patient's knowledge and experience of newborn care and assess their readiness to learn about newborn care. While providing the patient with information it is important that community resources are provided for the adolescent parents to assist with ongoing assessment and instruction when providing care for a newborn.

How would you approach topics?

To be effective, health care providers must be able to communicate with adolescents in a manner they understand and respect them as individuals. Nurses should feel that there is always hope and the chance of positive outcomes; nurses see that everyday, often in the faces in their youngest clients. Nurses have to believe in that and work toward “connecting” with their teen clients. Nurses are often the first to interact and build rapport with teenagers.

Would you focus more on the support people?

Nurses must support adolescents during the transition from childhood into adulthood, which is complicated by their emergence into motherhood. Assist the adolescent in identifying family and friends who want to be involved and provide support throughout the pregnancy.

6. What changes would you incorporate in the nursing care of the advanced maternal age (AMA) woman?

Assess the woman’s knowledge about risk factors and measures to reduce them. Educate her about measures to promote a positive outcome. Encourage her to get early and regular prenatal care. Advise her to eat a variety of nutritious foods, especially fortified cereals, enriched grain products, and fresh fruits and vegetables, and drink at least 6-8 glasses of water daily and to take the prescribed vitamin containing 400mcg of folic acid daily. Also stress the importance of avoiding alcohol intake during pregnancy, avoid exposure to secondhand smoke, and take no drug unless they are prescribed.

7. Define teratogen.

Is an agent or factor which causes malformation of an embryo.

8. Fill in the following table.

Substance	Effects on pregnancy and fetus/newborn
Alcohol	Fetal alcohol syndrome. Fetal alcohol spectrum disorders. Alcohol-related birth defects.
caffeine	Increase cardiac output low birth weight in infants
nicotine	Impaited oxygenation of mother & fetus due to nicotine crossing placenta & carbon monoxide combining with hemoglobin. Increased risk for low birth weight, small for gestational age, and preterm birth. Increased risk for sudden infant death syndrome and chronic respiratory illness.
cocaine	Preterm birth & lower birthweight. Interferes w/ infant's cognitive development. Associated w/ congenital anomalies.
marijuana	Fetal growth restriction. Increased risk for small for gestational age. Altered responses.
Opiates/narcotics	It leads to medical, nutritional, and social neglect by the woman due to the long-term risks of physical dependence, malnutrition, compromised immunity, hepatitis, and fetal overdose. Places the woman at increased risk for preterm labor, fetal growth restriction, abruptio placenta, perinatal mortality, preterm rupture of membranes, and preeclampsia.
methamphetamines	Possible maternal malnutrition. Increased risk for preterm birth & low birthweight Infants may have withdrawal symptoms

9. List five possible characteristics of Fetal Alcohol Spectrum Disorder.

1. a small head.

2. below average height and weight.
3. hyperactivity.
4. lack of focus.
5. poor coordination.

RKC Chapter 21

1. Why is the term “failure to progress” often used?

Failure to progress (FTP) happens when labor slows and delays delivery of the baby. Before labor starts, the cervix thins out and starts to open. With FTP, this may not happen.

2. What factors are associated with an increased risk for dystocia?

- Epidural analgesia, excessive analgesia, multiple pregnancy, hydramnios, maternal exhaustion, ineffective maternal pushing technique, occiput posterior position, longer first stage of labor, nulliparity, short maternal stature, fetal birth weight, shoulder dystocia, abnormal fetal presentation or position, fetal anomalies, maternal age older than 34 years, high caffeine intake, overweight, gestational age more than 41 weeks, chorioamnionitis, ineffective uterine contractions, and high fetal station at complete cervical dilation.

3. Familiarize yourself with the common Diagnosis and management of common problems associated with dystocia, their therapeutic management and nursing management i.e.what does this mean for the care delivered by the nurse (p799-804)

Diagnosis and management: Emergency, often unexpected complication. Diagnosis made when newborn’s head delivers without delivery of neck and remaining body structures. Anticipate cesarean birth if no success in dislodging shoulders.

Therapeutic management: If anticipated, preparatory tasks instituted: alerting key personnel; education of women and family regarding steps to be taken in the event of a difficult birth; emptying of a woman's bladder to allow additional room for possible maneuvers needed for the birth. McRoberts maneuver. Suprapubic pressure (not fundal). Combination of maneuvers effective in more than 50% of cases of shoulder dystocia. Newborn resuscitation team readily available.

Nursing Management: Intervene immediately due to cord compression. Perform McRoberts maneuver and application of suprapubic pressure. Assist with positioning the woman in squatting position, hands-and-knees position, or lateral recumbent position for birth to free shoulder. Clear room for unnecessary clutter to make room for additional personnel and equipment. After the birth, assess newborn for crepitus, deformity, Erb palsy, or bruising, which might suggest neurological damage or a fracture.

4. Define the following:

Hypertonic uterine dysfunction: the uterus never fully relaxes between contractions.

Hypotonic uterine dysfunction: occurs during active labor when contractions become poor in quality and lack sufficient intensity to dilate and efface the cervix.

Uterine Atony: the uterus fails to contract after the delivery of the baby

Precipitate labor: completed in less than 3 hours from the start of contractions to birth.

5. Why is persistent occiput posterior positioning of the fetus an issue during labor and delivery?

Labor is usually much longer and more uncomfortable (causing increased back pain during labor) if the fetus remains in this position. Possible extensive caput succedaneum and molding from the sustained occiput posterior position.

6. What risks increase with a persistent breech presentation?

Cord prolapse and the possibility of fetal head entrapment

7. What is a shoulder dystocia? What maneuvers are used to attempt a vaginal delivery when a shoulder dystocia is noted? Describe each.

Shoulder Dystocia - obstruction of fetal descent & birth by the axis of the fetal shoulders after the fetal head has been delivered.

- McRoberts Maneuver - mother's thighs are flexed & abducted as much as possible to straighten the pelvic curve.
- Suprapubic Pressure - light pressure is applied just above the pubic bone, pushing the fetal anterior shoulder downward to displace it from above the mother's symphysis pubis.

8. Macrosomia is defined as a newborn who weighs 4,000 to 4,500 grams.

9. Why is it important to monitor the bowel and bladder status during labor?

A full bladder or rectum can impede descent.

10. What are 3 ways you can empower, inform and advocate for your patient?

- Assist the woman and partner in expressing their fears and anxieties.
- Provide encouragement to help them to maintain control.
- Support the client and her partner in their coping efforts.

11. Define preterm labor and list 3 risks that are associated with the infant due to preterm labor/birth.

Preterm Labor - occurrence of regular uterine contractions accompanied by cervical effacement and dilation before the end of the 37th week of gestation.

Risks - cerebral palsy, intellectual impairment, vision defects, and hearing loss

12. What factors influence the decision to intervene when a woman present with preterm labor?

Mother is obese, smoking, alcohol, and substance abuse. Clotting , preeclampsia, and increase BP.

13. When are tocolytics used?

Tocolytics are used to stop preterm labor (before 22 weeks)

14. Name 5 subtle symptoms of preterm labor.

1. Mild abdominal cramps
2. Consistent low, dull backache
3. Lower abdominal pressure
4. Light bleeding
5. Change in type of discharge

15. What does a fetal fibronectin test determine?

Tests pregnant women who are between 22 weeks and 35 weeks of pregnancy and are having symptoms of premature labor. The test helps predict the likelihood of premature delivery within the next 7-14 days.

16. Define prolonged pregnancy.

Pregnancy that extends 2 weeks or more beyond the estimated day of confinement, or 42 weeks

17. What is the difference between labor induction and labor augmentation?

Induction - stimulation of uterine contractions during pregnancy **before** labor begins on its own to achieve a vaginal birth.

Augmentation - stimulating the uterus to increase the frequency, duration and intensity of contractions **after** the onset of spontaneous labour.

18. What is the most common adverse effect of oxytocin?

Nausea and vomiting

19. When administering oxytocin what are the primary assessments that need to be made?

The induction or continuance of labor with oxytocin should be avoided when the following conditions or situations are present: evidence of fetal distress, fetal prematurity, abnormal fetal position, placenta previa, uterine prolapse, vasa previa, cephalopelvic disproportion

20. What does VBAC stand for?

Vaginal birth after C-section

21. What would you do if you encounter an umbilical cord prolapse?

Have the woman lay on her left side, start an IV, give her Oxygen, and notify the provider.

22. What is a typical sign of uterine rupture?

Sudden fetal heart rate abnormalities and abdominal pain

23. Why might an amnioinfusion be done?

Amnioinfusion is being used to treat intrapartum problems known to be associated with fetal compromise, including prophylactic treatment of oligohydramnios during labor and after premature rupture of the membranes, treatment of severe variable decelerations during labor and reducing the risk of meconium aspiration during labor in patients with thick meconium fluid.

24. What are the indications for use of forceps or vacuum extractor?

Prolonged second stage of labor, nonreassuring fetal testing, maternal exhaustion, elective shortening of second stage of labor

25. What are the leading indications for cesarean birth?

The most common indications for primary cesarean delivery include labor dystocia, abnormal or indeterminate fetal heart rate tracing, fetal malpresentation, multiple gestation, and suspected fetal macrosomia