MATCHING KEY TERMS

Match the term with the correct definition.

1. ______ abruption placentae
2. ______ hydramnios
3. ______ placenta accreta
4. ______ shoulder dystocia
5. ______ tocolytic

a. Delayed or difficult birth of the shoulders after the head has emerged
b. Premature separation of a normally implanted placenta
c. Excessive volume of amniotic fluid
d. Placenta that is abnormally adherent to the uterine muscle
e. Medication to stop preterm or hypertonic labor contractions

KEY CONCEPTS

1. What are three characteristics of effective uterine activity?
   a. ____________________
   b. ____________________
   c. ____________________

2. Complete the following table to compare the characteristics of hypotonic and hypertonic labor dysfunction.

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<thead>
<tr>
<th></th>
<th>Hypotonic Dysfunction</th>
<th>Hypertonic Dysfunction</th>
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<tbody>
<tr>
<td>Contraction characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uterine resting tone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase of labor when it is most common</td>
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<td></td>
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<tr>
<td>Therapeutic management</td>
<td></td>
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3. What two measures may be used to stimulate labor that slows down after it is established?
   a. ____________________
   b. ____________________
4. What is the central principle of nursing actions when dysfunctional labor is a result of ineffective maternal pushing?

5. Why are upright positions good for women who have ineffective second-stage pushing?

6. List nursing measures to promote normal labor when maternal pushing is ineffective for each reason listed.
   a. Fear of injury
   b. Exhaustion

7. Why are upright maternal positions best to relieve persistent occiput posterior positions?

8. List four intrapartal problems that are more likely if a woman has a multifetal pregnancy.
   a. __________________
   b. __________________
   c. __________________
   d. __________________

9. What are the expected rates for dilation and fetal descent for the following?
   a. Nulliparas
   b. Parous women

10. List nursing measures for a woman having prolonged labor and for her fetus.

11. List nursing measures that may be used when a woman has precipitate labor.
    a. Promoting fetal oxygenation
b. Promoting maternal comfort

12. What factors may make a woman think her membranes have ruptured when they have not?

13. A client will be discharged with ruptured membranes at 32 weeks of gestation. Write a summary of client teaching in simple terms that you might use.

14. List side effects that may occur with beta-adrenergic drugs such as terbutaline. What drug should be available to reverse serious adverse effects of beta-adrenergic drugs, and what is its classification?

15. How do these drugs stop preterm labor? Give an example of each.
   a. Prostaglandin synthesis inhibitors

   b. Calcium antagonists

16. What are the primary nursing assessments related to each of these tocolytic drugs?
   a. Terbutaline

   b. Magnesium sulfate

   c. Indomethacin

   d. Nifedipine

   e. Corticosteroids
17. What are the two variations of prolapsed cord?
   a. 
   b. 

18. What are the two objectives if umbilical cord prolapse occurs or is suspected?
   a. 
   b. 

19. Describe three variations of uterine rupture.
   a. 
   b. 
   c. 

20. Why is it important that the nurse not push on the uncontracted uterine fundus after birth? What is the correct procedure?

21. Why may amniotic fluid embolism result in disseminated intravascular coagulation?

22. If a pregnant woman suffers trauma, why should medical and nursing care focus on her stabilization before fetal stabilization?

23. A woman at 32 weeks of gestation has had a car accident. Her vital signs are stable, and the fetal heart rate is 150 to 160 bpm. What should the nurse suspect if the woman’s uterus seems to be enlarging? What is the correct action?

**CRITICAL THINKING EXERCISES**

1. During clinical practice, observe and discuss with nurses what measures they use for women having back labor.

2. Practice the positions listed for back labor so that you will be familiar with them during clinical practice.

3. If you had to be on bed rest for preterm labor, possibly for 6 weeks, what adjustments would you and your family have to make to achieve that recommendation? What would be the single most important obstacle to adhering to bed rest in your life? What type of quiet activities could you do while maintaining bed rest?
CASE STUDIES

Ann Craig is admitted at 33 weeks of gestation saying that she thinks her “water broke.” This is her fourth pregnancy. Two of her infants were preterm, born at 32 and 27 weeks of gestation, and she has had one elective abortion. She has had regular prenatal care since 6 weeks of gestation.

1. What are the most important additional assessments that the nurse should make?

The nurse notes that a small amount of cloudy fluid is draining from Ann’s vagina. A nitrazine paper turns blue-black in color, and a fern test is positive. Maternal vital signs are temperature 37.2° C (99° F), pulse 86 bpm, respirations 22 breaths/min, blood pressure 132/80 mm Hg. The fetal heart rate is 162 to 170 bpm and has average variability. Ann occasionally has a contraction lasting 20 to 30 seconds.

2. What data from the aforementioned assessments are most relevant?

3. What is the main judgment you would make from these data? What is the basis for that judgment?

4. Would you perform a vaginal examination at this point? Why or why not?

Shawna is an 18-year-old primigravida admitted to the birth center at 27 weeks of gestation in probable preterm labor. Her membranes are intact. The physician writes these orders:

- NPO except ice chips
- Complete blood count
- Catheterize urine for routine analysis and culture and sensitivity
- IV fluids: Ringer’s lactate at 200 ml/hr for 1 hour, then 125 ml/hr
- Routine fetal monitoring and maternal vital signs

5. Which of these orders has priority? Why?

6. What position is appropriate for Shawna? Why?

Shawna will receive magnesium sulfate for tocolysis.

7. What nursing observations are essential related to magnesium sulfate? Why?

Contractions stop, and Shawna will begin taking oral terbutaline before she is discharged.

8. What teaching is appropriate related to home use of this drug?
9. What additional teaching is important before Shawna is discharged?

**REVIEW QUESTIONS**

Choose the correct answer.

1. A woman is having hypotonic labor and is very frustrated because this is her third trip to the birth center. What nursing measure is most appropriate for her?
   a. Do not allow any oral intake.
   b. Start oxytocin at a low rate.
   c. Offer her a warm shower or bath.
   d. Reassure her that her problem is common.

2. A woman has shoulder dystocia when giving birth. The nurse should expect
   a. immediate forceps delivery.
   b. application of suprapubic pressure.
   c. oxytocin labor augmentation.
   d. turning to a hands-and-knees position.

3. While in bed, a good position for the woman laboring with a twin pregnancy is
   a. supine.
   b. hands and knees.
   c. knee-chest.
   d. side-lying.

4. Choose the primary nursing measure to promote fetal descent.
   a. Remind the woman to empty her bladder every 1 to 2 hours.
   b. Assist fetal head rotation while doing a vaginal examination.
   c. Have the woman push at least three times with each contraction.
   d. Promote intake of glucose-containing fluids during labor.

5. An infant weighing 8 pounds 10 ounces is born vaginally. Shoulder dystocia occurred at birth. Because of this problem, the nurse should assess the infant for
   a. head swelling that does not extend beyond the skull bone.
   b. inward turning of the feet and/or legs.
   c. creaking sensation when the clavicles are palpated.
   d. limited abduction of one or both hips.

6. A woman is fully dilated, and the fetal station is 0. The fetus is in a right occiput posterior position. Choose the optimal maternal position for pushing.
   a. Squatting
   b. Left side-lying
   c. Hands and knees
   d. Semi-sitting

7. A woman is having very rapid labor with her fourth child. What nursing measure is most appropriate to help her manage pain?
   a. Offer meperidine (Demerol) when she reaches 5 cm cervical dilation.
   b. Keep her in an upright position until full cervical dilation.
   c. Avoid vaginal examinations during the peak of a contraction.
   d. Coach her to use breathing techniques with each contraction as it occurs.

8. Choose the nursing assessment that most clearly suggests intrauterine infection.
   a. Fetal heart rate of 145 to 155 bpm
   b. Cloudy amniotic fluid
   c. Maternal temperature of 37.8° C (100° F)
   d. Increased bloody show

9. A woman telephones the labor unit and says she has been having back discomfort all day. She is at 32 weeks of gestation. The nurse should tell the woman that she
   a. is having discomfort that is typical of late pregnancy.
   b. should come to the hospital if she has increased vaginal drainage.
   c. can increase her fluid intake to reduce Braxton-Hicks contractions.
   d. should come to the hospital for further evaluation.
10. A woman is receiving magnesium sulfate to stop pre-term labor. The essential nursing assessment related to this drug is
   a. for frequency and duration of uterine contractions.
   b. hourly vital signs, heart sounds, and lung sounds.
   c. for presence of fetal movements with contractions.
   d. vaginal examination for cervical dilation, effacement, and station.

11. A few minutes after a woman’s membranes rupture during labor, the fetal heart rate drops from an average of 140bpm to 75 to 80bpm. The nurse should immediately
   a. call via telephone the physician and report the decreased fetal heart rate.
   b. assess for other signs that indicate chorioamnionitis.
   c. perform a vaginal examination and palpate for prolapsed cord.
   d. insert an indwelling catheter to keep the bladder empty.

12. A woman telephones the labor unit saying that she has recent onset of pain between her shoulder blades that is worse when she breathes in. The nurse should
   a. ask her whether she has had a recent upper respiratory infection.
   b. explain that the growing fetus reduces space to breathe.
   c. have her palpate her uterus for frequent contractions.
   d. tell her that she should come to the hospital promptly.

13. Choose the nursing assessment that most clearly suggests hypovolemia.
   a. Urine output of 20 to 25 ml/hr
   b. Fetal heart rate of 155 to 165 bpm
   c. Blood pressure of 108/84 mm Hg
   d. Maternal heart rate of 90 to 100 bpm
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