Complicated Labour and Delivery Method NCLEX Review

I. Premature Rupture of the Membranes

A. Description

1. Premature rupture of the membranes refers to spontaneous rupture of the amniotic membranes before the onset of labor.

2. Gestational age usually determines the plan and intervention.

3. When the rupture of membranes is before term and birth is delayed, infection becomes a risk.

B. Assessment

1. Presence of fluid pooling in vaginal vault; nitrazine test is positive.
2. The amount, color, consistency, and odor of fluid need to be assessed.
3. Vital signs are monitored; an elevated temperature may indicate infection.
4. Fetal monitoring is necessary; tachycardia in the fetus may indicate maternal infection.

C. Interventions

1. Assist with tests to assess gestational age.

2. Avoid vaginal examinations because of the risk of infection.

3. Monitor maternal and fetal status for signs of compromise or infection.

4. Administer antibiotics as prescribed.

II. Prolapsed Umbilical Cord

A. Description:The umbilical cord is displaced between the presenting part and the amnion or protruding through the cervix, causing compression of the cord and compromising fetal circulation (Fig. 28-1).

B. Assessment

1. The client has a feeling that something is coming through the vagina.

2. Umbilical cord is visible or palpable.

3. Fetal heart rate is irregular and slow.

4. Fetal heart monitor shows variable decelerations or bradycardia after rupture of the membranes.

5. If fetal hypoxia is severe, violent fetal activity mayoccur and then cease.

III. Placenta Previa

A. Description

1. Placenta previa is an improperly implanted placenta in the lower uterine segment near or over the internal cervical os

2. Total (complete): The internal cervical os is covered entirely by the placenta when the cervix is dilated fully.

3. Partial:The lower border of the placenta iswithin 3 cm of the internal cervical os, but does not fully cover it.

4. Marginal (low-lying): The placenta is implanted in the lower uterus, but its lower border is more than 3 cm from the internal cervical os.

5. Management depends on the classification of the placenta previa and gestational age of the fetus.

B. Assessment

1. Sudden onset ofpainless,bright red vaginalbleeding occurs in the last half of pregnancy.

2. Uterus is soft, relaxed, and nontender.

3. Fundal height may be more than expected for gestational age.

C. Interventions

1. Monitormaternal vital signs, fetal heart rate, and fetal activity.

2. Prepare for ultrasound to confirm the diagnosis.

3. Vaginal examinations or any other actions that would stimulate uterine activity are avoided.

4. Maintain bed rest in a side-lying position as prescribed.

5. Monitor amount of bleeding (treat signs of shock).

6. Administer intravenous (IV) fluids, blood products, or tocolytic medications as prescribed; Rho(D) immune globulin may be prescribed.

7. If bleeding is heavy, a cesarean delivery may be performed.

Vaginal exams are contraindicated if the client is suspected of having or has a known placenta previa.

IV. Abruptio Placentae

A. Description: Premature separation of the placenta from the uterine wall after the twentieth week of gestation and before the fetus is delivered

B. Assessment

1. Dark red vaginal bleeding. If the bleeding is high in the uterus or is minimal, there can be an absence of visible blood.

2. Uterine pain or tenderness or both

3. Uterine rigidity

4. Severe abdominal pain

5. Signs of fetal distress

6. Signs of maternal shock if bleeding is excessive

C. Interventions

1. Monitor maternal vital signs and fetal heart rate.

2. Assess for excessive vaginal bleeding, abdominal pain, and an increase in fundal height.

3. Maintain bed rest; administer oxygen, IV fluids, and blood products as prescribed.

4. Place the client in Trendelenburg position if indicated to decrease the pressure of the fetus on the placenta, or place in the lateral position with the head of the bed flat if hypovolemic shock occurs.

5. Monitor and report any uterine activity.

6. Prepare for delivery of the fetus as quickly as possible, with vaginal delivery preferable if the fetus is healthy and stable and the presenting part is in the pelvis; emergency cesarean delivery is performed if the fetus is alive but shows signs of distress.

7. Monitor for signs of disseminated intravascular coagulation in the postpartum period.

Know the differences between placenta previa and abruptio placentae. In placenta previa, there is painless, bright red vaginal bleeding, and the uterus is soft, relaxed, and nontender. In abruptio placentae, there is dark red vaginal bleeding, uterine pain or tenderness or both, and uterine rigidity.

V. Supine Hypotension (Vena Cava Syndrome)

A. Description

1. Supine hypotension (also known as vena cava syndrome) occurs when the venous return to the heart is impaired by the weight of the uterus on the vena cava.

2. The syndrome results in partial occlusion of the vena cava and aorta and in reduced cardiac return, cardiac output, and blood pressure.

B. Assessment

1. Pallor

2. Faintness, dizziness, breathlessness

3. Tachycardia, hypotension

4. Sweating, cool and damp skin

5. Fetal distress

C. Interventions

1. Position the client on her side to shift theweight of the fetus off the vena cava until the client's signs and symptoms subside and vital signs stabilize.

2. Monitor vital signs and fetal heart rate. To prevent supine hypotension, avoid the supine position; position the client by placing a pillow or wedge under the client's hip to displace the gravid uterus off the vena cava.

VI. Placental Abnormalities

A. Description: Placenta accreta is an abnormally adherent placenta; placenta increta occurs when the placenta penetrates the uterine muscle itself; placenta percreta occurs when the placenta goes all the way through the uterus.

B. Assessment:Maycause hemorrhage immediatelyafter birth because the placenta does not separate cleanly

C. Intervention

1. Monitor for hemorrhage and shock.
2. Prepare the client for a hysterectomy if a large portion of the placenta is abnormally adherent.

VII. Preterm Labor

A. Description

1. Preterm labor occurs after the twentieth week but before the thirty-seventh week of gestation.

2. Risk factors include a history of medical conditions; present and past obstetric problems; infection; and social and environmental factors, including substance abuse.

3. Additional risk factors include a multifetal pregnancy, which contributes to overdistention of the uterus; anemia, which decreases oxygen supply to the uterus; and age younger than 18 years or first pregnancy and age older than 40 years.

B. Assessment

1. Uterine contractions (painful or painless)

2. Abdominal cramping (may be accompanied by diarrhea)

3. Low back pain

4. Pelvic pressure or heaviness

5. Change in character and amount of usual discharge— may be thicker or thinner, bloody, brown or colorless, odorous

6. Rupture of amniotic membranes

7. Presence of fetal fibronectin in cervical canal

8. Shortening of cervical length

C. Interventions

1. Focus on stopping the labor: Identify and treat infection, restrict activity, and ensure hydration.

2. Maintain bed rest and a lateral position.

3. Monitor fetal status.

4. Administer fluids.

5. Administer medications as prescribed and monitor for side effects of tocolytics

6. Use of 17 alpha-hydroxyprogesterone caproate known as 17P injection to decrease risk of preterm delivery.

VIII. Precipitous Labor and Delivery

A. Description: Labor lasting less than 3 hours

B. Interventions

1. Have a precipitous deliverytray available (hemostats, scissors, and cord clamp).

2. Stay with the client at all times.

3. Provide emotional support and keep the client calm.

4. Encourage the client to pant between contractions.

5. Prepare for rupturingmembraneswhen the head crowns, if they are not already ruptured.

6. Do not try to prevent the fetus from being delivered.

7. If delivery is necessary before the arrival of the health care provider, do the following:

a. Apply gentle pressure to the fetal head upward toward the vagina to prevent damage to the fetal head and vaginal lacerations; support the perineal area. Both actions constitute the Ritgen maneuver.

b. Support the infant's body during delivery.

c. Deliver the infant between contractions, checking for the cord around the neck.

d. Use restitution to deliver the posterior shoulder.

e. Use gentle downward pressure to move the anterior shoulder under the pubic symphysis.

f. Bulb suction the infant'smouth first and then suction each naris.

g. Dry and cover the infant to keep the body warm.

h. Allow the placenta to separate naturally.

i. Place the infant on the mother's abdomen or breast to induce uterine contractions.

IX. Dystocia

A. Description

1. Dystocia is difficult labor that is prolonged or more painful.

2. Occurs because of problems caused by uterine contractions, the fetus, or the bones and tissues of the maternal pelvis.

3. The fetus may be excessively large, malpositioned, or in an abnormal presentation.

4. Contractions may be hypotonic or hypertonic.

5. Hypotonic contractions are short, irregular, and weak; amniotomy and oxytocin infusion may be treatment measures.

6. Hypertonic contractions are painful, occur frequently, and are uncoordinated; treatment depends on the cause and includes pain relief measures and rest.

7. Can result in maternal dehydration, infection, fetal injury, or death.

B. Assessment

1. Excessive abdominal pain

2. Abnormal contraction pattern

3. Fetal distress

4. Maternal or fetal tachycardia

5. Lack of progress in labor

C. Interventions

1. Assess fetal heart rate; monitor for fetal distress.

2. Monitor uterine contractions.

3. Monitor maternal temperature and heart rate.

4. Assist with pelvic examination, measurements, ultrasound, and other procedures.

5. Administer prophylactic antibiotics as prescribed to prevent infection.

6. Administer IV fluids as prescribed.

7. Monitor intake and output.

8. Maintain hydration.

9. Instruct the client in breathing techniques and relaxation exercises.

10. Perform fetal monitoring if oxytocin is prescribed for hypotonic uterine contractions (oxytocin is not prescribed for hypertonic uterine contractions).

11. Monitor color of amniotic fluid.

12. Provide rest and comfort as with a normal delivery, such as back rubs and position changes.

13. Assess client’s fatigue and pain, and administer sedatives and pain medications as prescribed.

14. Assess for prolapse of the cord after membranes rupture.

X. Amniotic Fluid Embolism

A. Description

1. Amniotic fluid embolism is the escape of amniotic fluid into the maternal circulation.

2. The debris-containing amniotic fluid deposits in the pulmonary arterioles and is usually fatal to the mother.

B. Assessment

1. Abrupt onset of respiratory distress and chest pain

2. Cyanosis

3. Fetal bradycardia and distress if delivery has not occurred at the time of the embolism

C. Interventions

1. Institute emergency measures to maintain life.

2. Administer oxygen, 8 to 10 L/minute, by face mask or resuscitation bag delivering 100% oxygen.

3. Prepare for intubation and mechanical ventilation.

4. Position the client on her side.

5. Administer IV fluids, blood products, and medications to correct coagulation failure.

6. Monitor fetal status.

7. Prepare for emergency deliverywhen the client is stabilized.

8. Provide emotional support to the client, partner, and family.

XI. Fetal Distress

A. Assessment

1. Fetal heart rate less than 110 beats/minute or greater than 160 beats/minute

2. Meconium-stained amniotic fluid

3. Fetal hypoactivity or hyperactivity

4. Progressive decrease in baseline variability

5. Severe variable decelerations

6. Late decelerations

B. Interventions

1. Discontinue oxytocin if infusing.

2. Place the client in a lateral position.

3. Administer oxygen, 8 to 10 L/minute, via face mask.

4. Monitor maternal and fetal status. In the event of fetal distress, prepare the client for emergency cesarean delivery.

XII.Intrauterine Fetal Demise

A. Assessment

1. Loss of fetal movement
2. Absence of fetal heart tones
3. Disseminated intravascular coagulation (DIC) screen (monitor for coagulation abnormalities because DIC is a complication related to intrauterine fetal demise)
4. Low hemoglobin and hematocrit; low platelet count; prolonged bleeding and clotting time
5. Bleeding from puncture sites (could indicate DIC)

B. Interventions

1. Encourage the client and her family to verbalize feelings; provide emotional support.

2. Incorporate religious and cultural health care beliefs and practices in the plan of care.

3. Allow the client choices relating to labor and delivery.

4. Administer IV fluids, medications, and blood and blood products as prescribed if DIC occurs.

XIII. Rupture of the Uterus

A. Description

1. Complete or incomplete separation of the uterine tissue as a result of a tear in the wall of the uterus from the stress of labor

2. Complete: Direct communication between the uterine and peritoneal cavities

3. Incomplete: Rupture into the peritoneum covering the uterus, but not into the peritoneal cavity

4. Manifestations vary with the degree of rupture.

5. Risk factors: Labor after previous cesarean section, overdistended uterus (e.g., multiple fetuses or hydramnios) after cesarean section, abdominal trauma

B. Assessment

1. Abdominal pain or tenderness

2. Chest pain

3. Contractions may stop or fail to progress

4. Rigid abdomen

5. Absent fetal heart rate

6. Signs of maternal shock

7. Fetus palpated outside the uterus (complete rupture)

C. Interventions

1. Monitor for and treat signs of shock (administer oxygen, IV fluids, and blood products).

2. Prepare client for cesarean delivery(possible hysterectomy may be necessary).

3. Provide emotional support for the client and partner.

XIV. Uterine Inversion

A. Description

1. Uterus completely or partly turns inside out.

2. This can occur during delivery or after delivery of the placenta.

3. Risk factors: Fundal implantation of the placenta, manual extraction of the placenta, short umbilical cord, uterine atony, leiomyomas, and abnormally adherent placental tissue

B. Assessment

1. A depression in the fundal area of the uterus is noted.

2. The interior of the uterus may be seen through the cervix or protruding through the vagina.

3. The client has severe pain.

4. Hemorrhage is evident.

5. The client shows signs of shock.

C. Interventions

1. Monitor for hemorrhage and signs of shock, and treat shock.

2. Prepare the client for a return of the uterus to the correct position via the vagina; if unsuccessful, laparotomy with replacement to the correct position is done.