Pregnancy: Medical OB Emergencies Care & Newborn Care

OB  OY... is this going to be fun!

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NWCEMSS Continuing Education

Goals for Today
Childbirth
When things go right...
...and when they don’t
Emergencies in pregnancy
Documentation

Documentation Pearls
On slides when you see this scroll, it will offer a tip for documentation in the EMS pt care report.

First things first...

On a scale from 0 to 10, how would you rate your knowledge & skill set regarding the normal physiologic changes during pregnancy?

On a scale from 0 to 10
Rate your knowledge & skill set regarding the management of delivery complications

Uh oh....famous last words of an EMS Provider!
Anyone feel inadequately prepared, tremendously anxious and downright uncomfortable at the thought of delivering a baby prehospital?

3 key things to relieve stress in these situations:
1. Available equipment
2. Train for the situation
3. Know how to document correctly
On a scale from 0 to 10

Rate your knowledge & skill set regarding the initial resuscitation of a newly born infant in distress.

The Pregnancy Challenge

1. Why are females said to be “glowing” when pregnant?
2. Why do they often complain of ↑ SOB?
3. Why do they “appear” to be waddling when ambulatory?
4. Why is heartburn a common complaint especially in later pregnancy?
5. Identify three different positions in which a baby can present during birth

We will check answers at the end

The Pregnancy Challenge

6. Identify 3 imminent signs of delivery.
7. In which stage of labor is the baby delivered?
8. What 5 areas are evaluated in an APGAR score?
9. Identify two things found in an OB kit.
10. Identify 3 complications of pregnancy.

Why are we talking about this?

System Stats: 2014

Total: 600
Pts w/ either OB complaints or noted to be pregnant upon evaluation for other complaint

Total deliveries prehospital = 12
Prior to EMS arrival = 7
Either in ambulance, house or station = 5
Prehospital Impression

1. OB/pregnancy complications 89
2. OB / Childbirth 67
3. Other OB/Gyne 67
4. Traumatic Injury 64
5. Vaginal Hemorrhage 50
6. Abdominal Pain / Problems 48

Prehospital Impression

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<td>Pain</td>
<td>41</td>
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<td>No apparent illness / injury</td>
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<tr>
<td>Behavior / Psychiatric Disorder</td>
<td>22</td>
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<td>Syncope / Fainting</td>
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Pregnancy Documented

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Of the 12 deliveries we had in 2014

9/12 had reports on both mother & newborn
(1 mutual-aid to non-system EMS, 1 delivered on ED ramp w/NICU waiting, 1 NO excuse!)
(2/2) When the SBP was either < 90, an IV was established & a fluid bolus was appropriately given
4 documented the use of a car seat
7 females and 5 males!

NO multiples, what else would you like to know?

Knowing the physiologic changes of pregnancy helps to identify key assessment findings that may lead you to suspect complications.
Gynecologic Changes

Uterus
- Hollow, thick walled, muscular organ
- Lies in center of pelvis
- Provides a house for fetal development
- When empty measures 3 x 2 inches (7.5 x 5 cm)
- When full term (with one baby) measures 16 inches (40cm) long
- Muscle structure allows for significant stretch and growth

Cervix
- Lower portion of the uterus
- Canal ~ 1 inch long (2.5 cm)
- During labor, thins down & dilates open to about 4 inches (10 cm)
- Muscle elasticity allows for it
- While internal inspection is not a function performed by EMS, understand that the change must occur for birth to be completed

Fallopian tubes
- Thin flexible pair of tubes ~ 4 inches (10 cm) x <1/2 inch (1 cm)
- Pathway for eggs from ovary to uterine cavity
- Fertilization generally occurs in distal third of fallopian tube
- Often the site of ectopic pregnancies (complications seen early in pregnancy ~8-12 weeks, when embryo large enough to rupture tube.)

Ovaries
- Female sex organs
- Lies on either side of uterus in upper portion of pelvic cavity
- 2 functions:
  - Secrete hormones (Estrogen, progesterone, luteinizing hormone)
  - Develops & secretes eggs for reproduction

Uterine blood flow
- In non-pregnant state, uterus receives ~ 2% of blood flow
- During pregnancy, uterus receives ~ 20% of blood flow
- Massive ↑ in blood & blood vessels in uterus & related structures in pregnancy
- ↑ risk to miss blood loss potential prior to development of s & s

Ovaries
- Secrete hormones (Estrogen, progesterone, luteinizing hormone)
- Develops & secretes eggs for reproduction

Placenta / umbilical cord / amniotic sac
- Uterus
  - Hollow, thick walled, muscular organ
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**Placenta - never had one of those before!**

- Temporary structure
- An endocrine gland
- Secretes hormones during pregnancy
- Blood-rich
- Transfers heat
- Exchanges O2, CO2, nutrients, waste products
- Serves as protective barrier against some harmful substances for the baby

**Amniotic Sac**

- Inner - amnion, outer - chorion, gives sac support
- Contains fluid produced by cell walls or placenta, majority comes from mom’s blood supply
- Later fetal urine: 500 mL/day
- By 37 wks: 1000 mL
- Excessive amount: polyhydramnios

**Umbilical Cord**

- Connects fetus to placenta
- Formed at week 5 from thick embryonic stalk

**Umbilical Cord**

- 2 arteries (unoxygenated blood)
- 1 vein (oxygenated blood)
- Connective tissue providing substance & protection: Wharton's jelly

**Maternal-Fetal Blood Flow**

- Blood flows from placenta in through umbilical vein which connects to inferior vena cava then to heart
- Routed around the lungs through the ductus arteriosus, into aorta & then throughout baby.
- Deoxygenated blood is filtered by the liver and then transported to the mother

**Cardiovascular**

- A growing uterus & a baby with ↑ O2 demands
- ...therefore cardiac output (CO) ↑ 30%-50% to support the woman, uterus, & baby
- How does the body ↑ cardiac output?
During Pregnancy:
- HR increases ~20 bpm over baseline
- Plasma volume increases
- Dilutional anemia
- Decreased O2 carrying capacity
- BP fluctuates throughout trimesters

**Implications for EMS**

Hemodynamics depend on position:
- VS w/ pt on side > 20 weeks
- Orthostatics indicated? 1: on side, repeat sitting
- ↓ SBP >15 mmHg or ↑ HR >20 BPM significant

**By the third trimester...**

The weight of uterus, infant, placenta & amniotic fluid totals ~ 24 lbs.
Laying flat on back is NOT a good idea!

**Neurological changes**

Most experience headaches - migraine, stress, d/t hormonal changes
For change in LOC, personality, cognition
VS – HTN?
PMH (change in pattern of chronic HA) metabolic disorders; recent trauma (head/neck)
Meds (withdrawal)
Change in vision, photophobia, sound sensitivity, seizures

**Remember those hormones?**

**Progesterone**
- Hormone: smooth muscle relaxant
- Prevents premature uterine contractions
- Vasodilation: Causing blood pressure changes throughout trimesters

1st trimester - BP slightly lowered
2nd trimester - BP much lower
3rd trimester - BP normalizes

**Cardiovascular changes**

- SV ↑ 30%
- HR ↑ 15-20 bpm
- CO ↑ 30-40%
- SVR ↓ 5 to 15% (peripheral vasodilation d/t progesterone)
- SBP ↓ 10 mmHg (2nd trimester)
- DBP ↓ 15 mmHg
- MAP ↓ 15 mmHg
- (Return to normal wk 36)

**Implications?**

**Supine Hypotensive Syndrome**

Laying flat on back is NOT a good idea!
**Pulmonary Changes**
Upper airway congestion
Diaphragm up 4 cm
↓ oxygen reserve
↓ residual volume
↑ risk for hypoxia & SOB
↑ RR minimal (15%)
↑ pO2/↓ pCO2
↑ O2 requirements (10-20%)

**Hematological**
Blood volume ↑ 35-50% to 7-9 L
Needs to fill utero-placental vasculature
Can mask a 30% gradual blood loss

Plasma volume increases by 40-45%
RBC volume increases by 20%
Physiologic anemia implications?
Increased coagulability

**Gastrointestinal**
Laxity & stretching of abdominal wall
Compartmentalization of abdominal contents; upward displacement

**Genitourinary**
↑ vascular supply to kidneys and uterus

**Musculoskeletal**
Realignment of spinal curvatures maintain balance
Produces shift in posture
Leads to typical gait of pregnancy

**Vaginal Bleeding**
Numerous reasons **WHY**
Possible pregnancy?
Obtain good history
Give supplemental oxygen!
Warm IVF challenges
IF > 20 weeks gestation, position pt side lying
Obtain BP while pt in on their side
Documentation

Note type, color, amount, & nature of vag. bleeding. If tissue passes, collect for submission to hospital.
A pregnant female is c/o midline lower abdominal cramping. LMP: 12 wks ago. She is experiencing moderate vaginal bleeding but has not passed any tissue. The abdomen is soft. VS are WNL. Which of these is likely?

A. Placenta previa  
B. Abruptio placenta  
C. Ectopic pregnancy  
D. Spontaneous miscarriage

**Abortion - Miscarriage**

Loss of a pregnancy before 20 wks (period of viability); most often between 12-14th wks

Incidence: ~21-27% experience vaginal bleeding in their 1st trimester

Bleeding or pain may be 1st sign of miscarriage or ectopic preg.

12-25% of all clinically recognized pregnancies end in miscarriage

**Management**

Assess / manage ABCs

Position supine if impending shock

Careful monitoring:

VS; SpO2, & rhythm

IV NS in 200 mL increments if hypoperfusing – (hypovolemic shock SOP)

Save all vaginal discharge containing passed tissue or clots & bring to hospital

Provide psychological support & reassurance

**Ectopic Pregnancy**

Implantation of fertilized egg in any location other than uterine endometrium

Egg can implant in fallopian tubes or in abdominal tissue

Occurs ~ 2% in U.S. (1:50 pregnancies)

**History**

- Gravidity—number of pregnancies
- Para—number of viable fetus delivered
- Length of gestation
- Estimated date of confinement
- Previous complications with pregnancies

When did pain start?

Onset, strength, duration, location, frequency

Regularity

Time: beginning of one to beginning of next

Proper prenatal care?

(assess for high risk)
**Ectopic Assessment**

At risk for rapid development of shock
- Take VS frequently
- Abdominal—significant lower quadrant tenderness
- Bleeding can range from spotting to profuse

**Pre-Eclampsia**

Multi-system disorder, neither primarily a seizure disorder nor a HTN condition
- Disease of healthy young women and those w/ existing underlying dx

Challenges
- No definitive diagnostic test
- Onset and course unpredictable

**Emergency Management**

Position supine
- O2 per mask as indicated (SpO2 must be >94% for adequate fetal oxygenation)
- Careful monitoring of VS & rhythm
- IV NS titrated to pt response (hypovolemic shock SOP)
- Psychological support
- Reassure pt

**Which of these is indicated to treat a pt w/ suspected ruptured ectopic pregnancy?**

A. Dopamine drip for SBP < 90
B. NS IVF challenges in 200 mL increments
C. Position on side & manually displace uterus
D. Vasopressin 40 u IVP to tamponade bleeding

**Associated w/ 5-10% of pregnancies**
- Responsible for 15% of all maternal deaths
- Cause of fetal growth retardation & morbidity
- Many theories regarding cause

**What prehospital care is indicated for a pt with pre-eclampsia?**

SOP p. 59
Management

*Time sensitive patient*
- Gentle handling; quiet environment
- Minimize CNS stimulation
- (No lights & sirens)
- Position on side
- Monitor FHTs if able
- Monitor ECG, maternal VS
- O₂, IV NS TKO
- MgSO₄ 2 Gm in 16 mL NS, slow IVP over 5 min

Placenta Previa

- Implantation of embryo low in the uterus near or over the cervix
- Placenta usually migrates up and away from cervix in late pregnancy
- In small percentage, migration does not occur

Placenta Previa

- Bright red vaginal spotting or bleeding
- Starts suddenly; described as painless
- With greater separation, often profuse

Uterine tone generally soft & non-tender or pt may experience preterm labor

May present in shock

Pre-term Labor Assessment

- Status of membranes
- If ruptured BOW, assess for prolapsed cord
- Presence/absence of fetal movements
- Inspect for bulging or crowning

Which of these is indicated for the prehospital management of a prolapsed cord per SOP?

A. Clamp & cut the cord immediately
B. Instruct mom to pant during contractions
C. Continuously palpate the cord for fetal HR
D. Insert gloved fingers b/t pubic bone & presenting part

CE Credit Questions
Prolapsed Cord

Incidence: 1:200-500 all births
Predisposing factors: preterm labor, abnormal fetal positions (7.5% of breech), multiple births
Danger to fetus: cord compression
Time to dead baby: 4-6 min if all blood has been cut off

Management

Do not push cord back into vagina
Keep exposed cord warm and moist
Time sensitive patient
Transport w/ hand in place
Do not manipulate cord

Ready or Not...

Between 30-36 weeks the baby moves into the cephalic position or head down position.

Braxton-Hicks Contractions

Irregular
Not sustained
Body's preparation
Not an indication of impending labor

LABOR

3 Phases
First phase
Regular contractions, thinning & gradual dilation of cervix; ends when cervix is fully dilated

Dilation Period

Something’s got to give!
Which of these should be done by a paramedic to determine if delivery is imminent?

A. A vaginal exam to check cervical dilation (cm)
B. Quantify the severity of labor pains (0-10)
C. Determine the amount of bloody show
D. Check for crowning with contractions

Get Ready...GO!

The first phase of labor is completed when the contractions last between 30 seconds and 1 minute and are 2-3 minutes apart.

This is an indication that delivery of the baby is imminent.

In accordance with SOP, what should be done to assist the mother during a contraction?

If the mother becomes either hypotensive or lightheaded, what should be done?

Dear God, What’s going on in there?

What’s in all this stuff I carry anyway?
The time from when baby enters birth canal until one is born

Delivering the head
While the head is to deliver passively, remember that controlling the rate of descent is needed, but how?

After the head is delivered

As soon as head delivers...
Have mother stop pushing
If no meconium: Do NOT suction yet as bulb syringe may trigger a vagal reflex

Thick meconium ONLY
Gently suction mouth then nose w/ bulb syringe
Anticipate need for newborn resuscitation of a nonvigorous infant using tracheal suction after delivery

If no meconium, just wait until baby delivers to bulb syringe suction
Which is indicated *first* after head delivery if there is no evidence of meconium in the amniotic fluid?

A. Suction nose & mouth with an 8 Fr catheter.
B. Guide head upwards to deliver posterior shoulder.
C. Rotate infant’s head so it faces downward.
D. Feel around the neck for nuchal cord.

**Gestational Diabetes**

While we do not have time to discuss in class, it is discussed in the handout. The mention here is to remind EMS that if a mother should mention that she has gestational diabetes, the baby is prone to be larger than normal and that creates the potential for other complications.

...such as?

**Nuchal Cord**

Feel deep in neck folds for cord. Gently slip cord over infant’s head.

**En Caul**

“With a veil”

Rare events

No risk to baby as they are still receiving nutrients through placenta.

**McRobert’s Maneuver**

**SHOULDER DYSTOCHIA**

Rare events

No risk to baby as they are still receiving nutrients through placenta.
Remember, they are slippery!

Placental delivery
- Do NOT delay transport for placenta
- Can take up to 30 min to deliver
- Do NOT pull on the cord to facilitate delivery

Post-Partum Care
- Mother may be cold-cover with blankets
- If perineum torn/bleeding, apply direct pressure w sanitary pad (apply ice pack)
- Fundal massage

Delivery
There's more?

Newborn Care

APGAR
The APGAR score is a widely used, standard method to assess a newborn infant
- Easy, quick, & is consistent between health care providers to trend newborn's condition at critical times of 1 & 5 min after delivery

After delivery, umbilical cord is clamped & cut, the infant is dried...

A bulb syringe works well if suctioning is needed
- Compress the bulb prior to suctioning secretions
- Suctioning: 1 mouth/2 nares
- First mouth, then nose: this prevents aspirating secretions
- Dry & suction: effective at stimulating respirations
Appearance & Color

Newborn infants who are uncompromised will maintain a pink color of mucous membranes without the need of supplemental oxygen.

A normal newborn:
- Entirely pink – 2
- Blue hands or feet – 1
- Blue or pale – 0

Breathing with good effort, but hands & feet a little blue yet?

Acrocyanosis

Blow by oxygen can help

With a newborn, pulse may best be determined by palpation at base of umbilical cord.

The rate should be:
- > 100 bpm – 2
- < 100 bpm – 1

(providers should be initiating oxygenation)
An absent pulse rate - 0
(providers should be initiating chest compressions)

Pulse

Grimace or reflex irritability

Normal newborns will cry, especially when stimulated by drying.

Vigorous cry: 2
Faces/grimacing: 1
No response: 0

Most newborns are active and have good muscle tone.

Active moving of all extremities 2
Limited movement / some flexion 1
Newborn is flaccid or limp 0

Activity
Respiratory effort

Most newborns normally breathe & begin to cry almost immediately after birth (& never stop!)

Crying 2
A slow or irregular rate of breathing 1
(Would necessitate need for assisted ventilation)

If breathing is slow or irregular, stimulation may be attempted with 100% O₂
An absent respiratory effort is a zero & requires provider to initiate ventilations

A newborn makes a face but no sounds when mouth & nose are suctioned w/bulb syringe. What APGAR rating for reflex irritability should be given?

A. Absent
B. Grimace
C. Cough or sneeze
D. Active motion

Newborn’s legs are pulled up to the body & baby mildly resists efforts to extend them w/weak muscle tone. What APGAR rating for activity should be given?

A. Limp
B. Some extremity flexion
C. Active motion
D. Absent

What are the implications if a crying newborn w/ a RR of 40 has dusky toes & fingers but a pink torso at the 1 min APGAR score?

A. Acrocyanosis is normal & the newborn may need blow-by O₂.
B. The infant likely has a congenital heart defect & needs full resuscitation.
C. The infant needs immediate intubation & ventilation w/ a neonatal BVM.
D. The infant likely has meconium aspiration & needs deep tracheal suctioning.

Identification banding for mother and infant
How is this accomplished?

How secure is that baby in mother’s arms?

SOP p. 56
Now that we successfully delivered a bouncing baby and mom got through that we are golden, right?

Not so quick...
How would you rate your knowledge and skill regarding management of delivery complications??
Yep...that’s a foot!

Could it get any worse? Remember, that’s what mom is saying.

Breech Presentations
Incidence of births: 25% occur before 28 wks 7% occur at 32 wks 1-3% occur at term

Frank breech (top) 50-70%

Footling breech (right) 5-10%

Communication with the hospital
This information is helpful...

- Patient's age
- Previous pregnancy history (gravida/para)
- Due date (gestational age)
- Onset of labor
- Status of membranes
- Presence or absence of abnormal bleeding
- Risk factors for complicated delivery: pre-eclampsia, breech, twins, etc.
- Vital signs; physical exam findings
- Treatment administered and ETA

Breech deliveries are usually slow, so you will often have time to transport to the hospital...but if the delivery is in progress you need to know what to do!

Leave fetal membranes intact as long as possible.

- *they act as a dilating wedge; prevent cord pressure*

- Thick meconium passage is common as baby is squeezed through the birth canal
- This is not usually associated with meconium aspiration because the meconium passes out of the vagina and does not mix with amniotic fluid

O2 NRM

- IV (anticipate hemorrhage)
- Do not tear membranes
- Allow legs/buttocks to deliver passively
- Support body wrapped in towel
- Loosen cord if possible

Trauma

- Severe pain
- Increased uterine irritability
- Hypotension, shock
- Abnormal uterine contour
- May feel fetal parts directly under skin
- Contractions cease
- Fetal death

Uterine rupture
Management

Time sensitive patient
O2 12-15 L/NRM
IVF to patient response
Monitor ECG
Monitor fetal movements as able
Transport on side or tilted
Requires surgical intervention

Abruptio Placenta (Pain)

Premature separation of placenta from uterine wall
Occurs in 1:50-100 deliveries; up to 50% in severe blunt abdominal trauma
Causes hemorrhage in mom; hypoxia in fetus
Maternal mortality < 1%; fetal mortality up to 100%
Leading cause of fetal trauma
Increased risk up to 5 days post-trauma

Predisposing Factors

Multiparity
Diabetes
Hypertension
Blunt uterine trauma
Short umbilical cord

Sudden onset sharp uterine pain that is unrelenting, constant & severe
Hx of precipitating event/disease or previous abruption

TIME SENSITIVE PATIENT
Position on side or tilt backboard
O₂ 12-15 L/NRM
IVF challenges titrated to pt & fetal response
Psychological support

Alright, so now how do we document this little miracle?

I know!
EACH PATIENT NEEDS THEIR OWN PATIENT CARE REPORT

With their own specific information documented

Mother’s PCR

Absolutely everything that you saw, were told, performed and witnessed should be completed on the run report

Care given to mother is specified on this report

This document is no different than any other pts report with detailed medical history

Infant’s PCR

1. Date and time of delivery
2. Presence/absence of nuchal cord (how many times)
3. Appearance of amniotic fluid, if known; esp if brown, green or blood tinged
4. APGAR scores at 1 min & 5 min post delivery
5. Time of placenta delivery & if it was intact
6. Any infant resuscitation initiated & response

Documentation

Narrative Summary of Events

responded for a woman in labor. X:O/V we found a 2.5’/y female pt conscious alert/awake laying on her side bed in the living room. She is in active labor and states her contractions began last evening around 11:30 last evening. She states she was seen at the and she was sent home because she was not dilated and her contractions were 14 minutes apart at that time. She states her contractions are near constant at this time. She states she has been pregnant once prior and delivered one vaginal birth prior. She states her expected due date is March 20th. She states her pregnancy thus far has been normal without any complications. EMS gathered vital and attempted to plac pt on chair. Pt instructed EMS she was ready to deliver after she was set up, pt was then assisted back into the bed. Pt was placed in a position of comfort with family member assisting her breathing. Pt delivered baby head first. Once head and top shoulders were delivered, pt was instructed to stop pushing. Baby was suctioned immediately and began to cry. Nurse then instructed to push once more and the rest of the baby was delivered and engulfed in a warm, clean blanket. Baby was suctioned further. Umbilical cord was clamped at 4” and cut. Baby was placed on mothers chest and umbilical cord was cut once it stopped pulsing. Mother was carried down the stairs in a blanket. Te established in NICU with warm fluids. Hospital was contacted and no further orders were given. Pt transferred in position of comfort, baby was eating on mother’s chest. Two paramedics were assisting to hold the baby as well as end. Pt and baby were transported without incident and pt care transferred to 30 Rs/24 Jr.

Documentation

Infant Report

Narrative Summary of Events

New call for status of predominance. X:O/V crew found mother ADM sitting on the floor of the bathroom with newborn baby pt. In last form. Crew noted APAGAR of 9 on arrival and 10 five minutes after arrival. Female baby was entirely pink, pale, greater than STG, actively crying and moving all extremities and moved when last was gently pocked. Crew took vital signs, chamfered and cut cord. Baby cleaned, washed and nose suctioned with no meconium present. Baby wrapped in blanket and cap applied to head. Mother was only Spanish speaking and crew gathered that baby was born approximately 15 minutes prior to EMS arrival. Crew moved pt. to ambulance no problem. Baby transported in child seat with mother. Crew applied child/mother ID tags. No change in pt. condition en route to hospital. NICU contacted for report with no orders given. Pt. care transferred and report given to RN in OB department.
The Pregnancy Challenge

Why are females said to be “glowing” when pregnant?
- ↑ blood volume

Why do they often complain of ↑ SOB?
- ↑ O2 demand with ↓ lung capacity
- ↑ pulse rate

Why do they “appear” to be waddling when ambulatory?
- Extra weight carried; ligaments stretched
- Sway back posture; more off balance

Why is heartburn a common complaint especially in later pregnancy?
- Enlarging fetus; displacement GI tract
- Enlarging belly, nausea, heartburn
Identify three different positions in which a baby can present?
  • Vertex, frank breach, footling breach

Identify 3 Imminent Signs of Delivery
  • Contractions 2 minutes or less apart, crowning / presenting parts, bulging perineum, involuntary pushing w/ contractions

In which stage of labor is the baby delivered?
  • Stage two

What 5 areas are evaluated in an APGAR score?
  • Heart beat, breathing, muscle tone, reflexes and skin color

Questions?

We would never leave you hanging...