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Clinical decision-making

1. When assessing a pregnant client who presents with a problem, providers decide there is a problem by:
2. Targeting history questions based on the client’s concerns.
3. Targeting physical examination based on the client’s concerns.
4. **Comparing findings to alert values.**
5. Reviewing records.
6. Priorities for care are determined by the client’s:
7. Questions and concerns
8. Non Emergent, non-life threatening needs
9. Future well-being
10. **Urgency of problems**
11. When a pregnant client first presents with a problem, you will develop a list of possible medical causes (differential diagnosis) for the woman’s symptoms or signs which helps you decide:
12. **What history questions, physical examination, and laboratory tests to perform.**
13. Where she should receive care.
14. What care she should receive.
15. If she needs urgent care.
16. A care plan will be developed based on findings by:
17. The assessing provider.
18. The client.
19. **The provider and client.**
20. The senior provider at the facility.
21. To participate in decisions about her care, a pregnant client should be:
22. **Alert and able to communicate.**
23. Literate.
24. Mobile.
25. Educated to at least the 8th grade level.

Quick check

1. The primary purpose of performing a Quick Check on a pregnant woman experiencing a complication is to:
   1. Make the woman feel welcome and cared for.
   2. **Identify women that need immediate care.**
   3. Get a baseline for the woman when you start caring for her.
   4. Decide where the woman should receive care.
2. Which of the following women is in shock, based on her vital signs?
3. Ms. A.: T 37.8°C, P 102 beats per minute, R 24 breaths per minute, BP 96/62 mmHg
4. **Ms. B.: T 36.8°C, P 112 beats per minute, R 32 breaths per minute, BP 86/42 mmHg**
5. Ms. C.: T 39.8°C, P 92 beats per minute, R 26 breaths per minute, BP 92/62 mmHg
6. Ms. D.: T 37°C, P 86 beats per minute, R 18 breaths per minute, BP 102/82 mmHg
7. Which of the following assessments are not part of the Quick Check:
   1. **Checking FHR.**
   2. Checking for signs of dehydration.
   3. Checking for signs of anemia.
   4. Asking the woman if she has concerns or problems.
8. Which of the following statements about Quick Checks is ***TRUE***:
9. A Quick Check should only be performed on women who present at the facility and are grunting and about to give birth.
10. A Quick Check should only be performed on women who present at the facility with a problem.
11. **A Quick Check should be performed on all pregnant women who present for care.**
12. Providers should decide which women need a Quick Check when they come to the facility in labor.
13. Which of the following findings on a Quick Check would alert you that the woman might have an urgent medical problem:
14. Temperature is 38°C.
15. Acetone 1+ in the urine.
16. Woman is grunting and wanting to push.
17. **Complaint of severe headache.**

Confirming intrauterine fetal demise

1. When your facility does not have a Doppler stethoscope or an ultrasound, you will confirm fetal death when you cannot hear a fetal heart rate by:
2. Listening again in 5 minutes.
3. Confirming that the pregnant woman does not currently feel fetal movement.
4. Palpating the woman’s abdomen to confirm that there is no fetal movement.
5. **Asking another provider or providers to listen to confirm the absence of a fetal heart rate.**
6. When should you provide information on the cause of fetal death?
7. As soon as you diagnose there is no fetal heart rate.
8. **Only when you have a clear cause of death.**
9. After the baby is born and the woman is stable.
10. When providing counseling to the woman on when to return for postpartum visits.
11. Which of the following is the most reliable way to confirm fetal death?
12. Having another provider confirm the absence of a fetal heart rate.
13. Confirming fetal death using a Doppler stethoscope.
14. **Confirming fetal death by ultrasound.**
15. Confirming fetal death by X-Ray.
16. What is perhaps the most important information about fetal death you can share with the woman?
17. **That there is nothing the woman ate, did, or did not do that caused the fetal death.**
18. That this will most likely not happen again in her next pregnancy.
19. That this occurs in many pregnancies and to many women.
20. That you can advise her on how to prevent a fetal death in the next pregnancy once you know what caused the baby’s death.
21. What is the best advice you can give to a mother / parents about seeing and holding a stillborn baby?
22. They should overcome any personal or cultural constraints and hold their baby to help in the grieving process.
23. If the baby has major malformations, they should avoid holding the baby so that their grieving is easier.
24. It is better not to hold the baby even when there are no malformations, as this may make the grieving harder.
25. **Holding the baby may help in the grieving process, but they are free to make a choice about whether they want to hold their baby.**

Providing information using SBAR

1. Which of the following statements about using a communication tool like SBAR is ***FALSE***?
2. **It can help patients feel safer.**
3. It will ensure that critical information is shared.
4. It will ensure that changes in the patient’s status are not missed.
5. It will ensure that clear, concise information is shared.
6. What information will you ***NOT*** include when describing the Situation (S)?
7. Your name and unit
8. The patient’s name
9. **Medical history**
10. A short description of the problem
11. What information will you ***NOT*** include when describing the Background (B)?
12. **The most likely diagnosis.**
13. Vital signs.
14. Medical history.
15. Care provided.
16. What information will you include when describing the Assessment (A)?
17. Vital signs.
18. Results from laboratory tests.
19. **What you think is the diagnosis.**
20. Summary of the clinical course.
21. Which of the following statements about the Recommendation (R) section of the SBAR tool is ***FALSE***?
22. **Only senior providers should make recommendations for care.**
23. Recommendations can include what the provider thinks should be done for the woman.
24. Recommendations can include asking the referral provider what should be done until the senior provider arrives or the woman arrives at the referral facility.
25. Recommendations can include requesting that a senior provider come to examine the woman.

Assessing the 4 Ps

1. Labor is a series of events affected by the coordination of the four essential factors. One of these is the passenger (fetus). Which are the other three factors?
2. Power (contractions), passageway, placental position and function
3. Power (contractions), maternal response, placental position
4. **Passageway, power (contractions), patient**
5. Passageway, placental position and function, psychological response
6. Which of the following statements is ***FALSE***?
7. **A Bandl’s ring that disappears after she empties her bladder is a sign of obstructed labor.**
8. Anxiety can be a cause of prolonged labor.
9. Dehydration can be a cause of prolonged labor.
10. Telling a woman to push before she has the urge to do so can result in prolonged second stage.

# Patient

1. A woman is gravida 1 para 0 and has gone from 5-6 cm in 4 hours. All findings from the Quick Check and assessment of FHR and the four Ps are within normal limits. Membranes are intact. She says she is tired and has been lying down most of the time except to go to the bathroom. How will you care for her?
2. Augment labor with oxytocin.
3. Rupture membranes.
4. **Encourage mobility.**
5. Seek advanced care.
6. A woman is gravida 2 para 1 and has been at 7 cm for 4 hours. During a Quick Check, you note that her mouth and tongue are dry. She has sunken eyes and acetone 2+ in the urine. How will you care for her?
7. Seek advanced care.
8. Treat for dehydration and continue to monitor.
9. Treat for dehydration and evaluate the woman, the fetus, and the woman’s pelvis.
10. **Treat for dehydration and evaluate the 4 “P”s.**
11. A woman is gravida 1 para 0 and has been at 5 cm for 4 hours. All findings from the Quick Check and assessment of the FHR, woman’s condition, contractions, fetal position and presentation, and pelvis are within normal limits. Membranes are intact. She is very anxious and not tolerating contractions. How will you care for her?
12. Augment labor with oxytocin.
13. Rupture membranes.
14. **Offer pharmaceutical and non-pharmaceutical options to manage her pain.**
15. Seek advanced care.
16. Which of the following statements is ***FALSE***?
17. **It is a best practice to catheterize women in labor to prevent damage to the bladder.**
18. A full bladder in labor can become distended and cause the baby to have trouble moving down into the pelvis.
19. A full bladder in labor can become distended and may prevent a baby from being able to rotate into a good position for birth.
20. A full bladder in the postpartum period prevents the uterus from contracting well.
21. A woman is gravida 2 para 1 and her cervix dilated from 6 to 7 cm over the last 4 hours. She is complaining of a headache and dizziness. You note that she has a dry mouth and tongue and acetone 2+ in her urine, which is dark orange. Vital signs: Temperature - 38.0°C, Pulse – 98 bpm, Respirations – 26 breaths per minute, BP – 102/63 mmHg, FHR – 156 bpm. All other findings are within normal limits. What is the most likely diagnosis?
22. Shock.
23. **Dehydration.**
24. Prolonged labor.
25. Fetal distress.

# Power

1. The cervical dilatation of client who is gravida 3 para 2 has and cervical dilatation gone from 5-7 cm in four hours. She and her baby are doing well and tolerating labor, and all other findings are normal and membranes are intact. She is having 2-3 contractions every 10 minutes, each lasting 30-40 seconds. What will you do?
2. Augment labor with oxytocin.
3. **Provide general labor support.**
4. Rupture membranes.
5. Plan to begin assessing cervical dilatation every 1-2 hours to see if labor is progressing.
6. You are caring for a client in active labor who is gravida 2 para 1. She is having two contractions in 10 minutes, each lasting 40 seconds. Her membranes have not ruptured and her cervix dilated from 6 to 8 cm over the last 4 hours. She and her baby are doing well and tolerating labor. Based on these findings, what will you do?
7. Augment labor with oxytocin because there are less than three contractions in 10 minutes.
8. Rupture membranes to speed up labor and improve contractions.
9. **Continue to monitor the woman, fetus, and labor progress.**
10. Alert the theater team that your client might imminently need a cesarean operation.
11. A client who is gravida 8 para 6 had a cervical dilatation of 7 cm when contractions ceased. You and another provider could not auscultate a fetal heart rate. She is in shock. What is the most likely diagnosis?
12. Placental abruption.
13. Placenta praevia.
14. False labor.
15. **Ruptured uterus.**
16. Which of the following statements is ***TRUE***?
17. Any time cervical dilatation is slower than 1 cm/hour in active phase of labor, the woman needs an infusion of oxytocin to speed up labor.
18. Any time a woman in active phase of labor has two contractions or less in 10 minutes, each lasting less than 40 seconds, she needs an infusion of oxytocin to improve contractions.
19. **Cervical dilatation slower than normal when there are at least 3 contractions in 10 minutes, each lasting at least 40 seconds is a sign that labor may be obstructed or there is CPD/FPD.**
20. If cervical dilatation is slower than 1 cm/hour in active phase of labor and membranes are not ruptured, an amniotomy alone will speed up labor without risking the dangers of an oxytocin infusion.
21. A client who is gravida 1, para 0 is admitted in labor. Her cervix is 100% effaced, and she is dilated to 5 cm. Her fetus is at +1 station. The fetal head is:
22. **Not yet engaged**
23. Entering the pelvic inlet
24. Below the ischial spines
25. Visible at the vaginal opening

# Passenger

1. During a vaginal examination, you find that the cervix is thicker on one side and thinner on the other side when the cervix is 7 cm dilated. What fetal position will you diagnose?
2. Occiput posterior.
3. Occiput anterior.
4. **Asynclitic.**
5. Chin posterior.
6. After doing Leopold’s maneuvers, you determine that the fetus is in the LOA position. To best auscultate the fetal heart, the fetoscope is placed:
7. Above the umbilicus at the midline
8. **Below the umbilicus on the woman’s left side**
9. Below the umbilicus on the woman’s right side
10. Below the umbilicus near the left groin
11. A laboring client complains of low back pain; this pain occurs most when the position of the fetus is:
12. Breech
13. Transverse
14. Occiput anterior
15. **Occiput posterior**
16. If the fetal head is well flexed, what will you note on vaginal examination?
17. **The fetal occiput is lower in the vagina than the sinciput.**
18. The fetal sinciput is lower in the vagina than the occiput.
19. The fetal sinciput and occiput are at the same level in the vagina.
20. You cannot identify if the fetal head is well flexed on vaginal examination.
21. In vertex presentations, when the fetal head is poorly flexed:
22. The smallest diameter of the head will present.
23. **The largest diameter of the head will present.**
24. The face will present.
25. The position is asynclitic.

# Passage

1. Which of the following statements is ***TRUE***?
2. All women should have clinical pelvimetry during prenatal care to make a decision about mode of birth.
3. All women should have clinical pelvimetry when they arrive in labor to make a decision about mode of birth.
4. **If labor is not progressing normally, clinical pelvimetry may help make a decision about mode of birth.**
5. Any woman with abnormal findings on clinical pelvimetry should have a cesarean operation.
6. A diagnosis of CPD/FPD is made when:
7. The estimated fetal weight is greater than 4.0 kg.
8. Pelvic measurements are abnormal.
9. There is slow fetal descent during the first stage of labor.
10. **There is failure of labor to progress with good contractions.**
11. A client is gravida 1 para 0 and her fetus is in occiput posterior position with a poorly flexed head. How will you manage her?
12. Plan for a cesarean birth because it is not likely she will give birth vaginally.
13. **Encourage a hands and knees position to help rotate the baby and monitor labor progress closely.**
14. Provide routine care as the smallest diameter of the head will present in this position.
15. Perform clinical pelvimetry and perform a cesarean if the measurements are abnormal.
16. A client is gravida 1 para 0 and the estimated fetal weight is 4.2 kg. How will you manage her?
17. Plan for a cesarean birth because it is not likely she will give birth vaginally.
18. Perform clinical pelvimetry and plan for a cesarean birth if the measurements are abnormal.
19. Plan for a cesarean birth if the head is not well flexed.
20. **Plan for a trial of labor but monitor labor progress closely.**
21. Suspect CPD/FPD when:
22. **The head is floating and the cervix is 7 cm dilated.**
23. The cervix dilated from 4-6 cm in four hours and the woman is having two contractions every 10 minutes, each lasting 30 seconds.
24. The baby is in occiput anterior position and the head is poorly flexed.
25. The head is at -3 station and the cervix is 5 cm dilated.

Diagnosing obstructed labor or CPD/FPD

1. Which of the following women may have obstructed labor or cephalopelvic disproportion (CPD) / fetal pelvic disproportion (FPD)?
2. Ms. A. is gravida 5 para 3 and has remained at 7 cm for 4 hours. There is no Band’s ring, the cervix is soft and 100% effaced and the presenting part is at 2/5 and well applied to the cervix. There is 1+ molding and 0+ caput. Ms. A. has 2 contractions in 10 minutes, each lasting 30-40 seconds.
3. **Ms. B. is gravida 1 para 0 and has remained at 5 cm for 6 hours. There is no Band’s ring, the cervix is edematous and the presenting part is at -3 station and not well applied to the cervix. There is 3+ molding and 3+ caput. Ms. B. has 4 contractions in 10 minutes, each lasting 50-60 seconds.**
4. Ms. C. is gravida 2 para 1 and has remained at 6 cm for 4 hours. There is no Band’s ring, the cervix is soft and 100% effaced and the presenting part is at -2 station (1/5). There is 2+ molding and 1+ caput. Ms. C. has 2 contractions in 10 minutes, each lasting 50-60 seconds.
5. Ms. D. is gravida 6 para 4 and has gone from 5-6 cm in 4 hours. She had a suspected Bandl’s ring that disappeared after she passed urine. The cervix is soft and 100% effaced and the presenting part is at 0 station (2/5). There is 0+ molding and 0+ caput. Ms. D. has 4 contractions in 10 minutes, each lasting 40-50 seconds.
6. What finding may be present in both prolonged labor and obstructed labor or CPD/FPD during the active phase of first stage?
7. Edematous cervix.
8. 3+ molding and/or caput.
9. **Cervix dilating less than 1 cm/hour.**
10. Fetal presenting part not well applied to the cervix.
11. Ms. Y. is gravida 4 para 3 and her cervix has dilated from 6 to 8 cm over the last 4 hours. You notice what you think is a Bandl’s ring but this goes away after she passes urine. She is having four contractions in 10 minutes, each lasting 40-50 seconds. Her membranes are intact. FHR is 136 bpm. Ms. Y’s vital signs are within normal limits. What will you do?
12. Immediately seek advanced care.
13. Augment labor with oxytocin.
14. Rupture membranes.
15. **Continue to monitor the woman, fetus, and labor progress closely.**
16. What are some things you will assess to help you rule-out obstructed labor or CPD/FPD during the active phase of first stage?
17. Presence of Bandl’s ring, signs of dehydration, placental position, condition of the cervix.
18. **Presence of Bandl’s ring, progress of labor, condition of the cervix, presence of molding.**
19. Maternal condition, signs of anemia, placental position, contractions.
20. Fetal presentation, contractions, presence of molding, placental position.
21. Which of the following is ***NOT*** a potential cause of obstructed labor or CPD/ FPD?
22. **Dehydration.**
23. Abnormal fetal position.
24. Large baby.
25. Tumors in the birth canal.

Diagnosing malposition and malpresentation

1. Which of the following malpositions will most likely require a cesarean birth?
2. Chin anterior position.
3. **Chin posterior position.**
4. Asynclitic position.
5. Occiput posterior position.
6. Which of the following malpresentations will most likely result in a vaginal birth?
7. **Complete breech with a flexed fetal head.**
8. Frank breech with a poorly flexed fetal head.
9. Footling breech.
10. Brow.
11. On abdominal examination, neither the head nor the buttocks is felt at the symphysis pubis and the head is felt in the left flank. What is the most likely malposition / malpresentation?
12. Face presentation.
13. Breech presentation.
14. **Shoulder presentation.**
15. Occiput anterior position.
16. On vaginal examination, the posterior fontanelle is felt to the left of the woman’s sacrum and the anterior fontanelle is felt to the right of woman’s pubic bone. What is the most likely malposition / malpresentation?
17. Chin anterior position.
18. Brow presentation.
19. Complete breech.
20. **Left occiput posterior position.**
21. What is the ***first thing*** you will do if you note that the FHR is 112 bpm after a contraction?
22. Stop oxytocin if it is being given.
23. **Prop up the woman or place her on her left side.**
24. Give oxygen 4–6 L.
25. Give fluids to the woman (by mouth or IV).

Pre-referral / Pre-operative care

1. Which of the following woman does ***NOT*** need pre-referral / pre-operative care?
2. Woman with the fetus in chin posterior position.
3. **Woman with the fetus in complete breech and a well flexed head.**
4. Woman with the fetus in frank breech and a poorly flexed head.
5. Woman with suspected obstructed labor.
6. What interventions will you provide for ***ALL*** women prior to referral?
7. **IV and indwelling catheter.**
8. IV, indwelling catheter, and oxygen.
9. IV, indwelling catheter, and antibiotics.
10. IV, indwelling catheter, and MgSO4.
11. How will you manage pain for women who are receiving pre-referral / pre-operative care?
12. Tell women that it is dangerous to provide any pharmaceutic pain options at this time.
13. Give pharmaceutic pain options if the woman’s BP is within normal limits.
14. Tell women to be patient until they reach the referral facility or the senior provider arrives.
15. **Provide pain management based on the woman’s preferences and what is available.**
16. How will you monitor the woman while waiting to reach the referral facility?
17. Intake and output hourly; progress of labor, contractions, and the condition of the woman and her fetus every 30 minutes.
18. Intake and output, progress of labor, contractions, and the condition of the woman and her fetus every 30 minutes.
19. **Intake and output hourly; progress of labor every 4 hours; contractions, the condition of the woman and her fetus every 30 minutes.**
20. Intake and output every 30 minutes; progress of labor every 2 hours; contractions, the condition of the woman and her fetus every 30 minutes.
21. For which women will you provide antibiotics prior to referring them?
22. All women.
23. Only women with a temperature higher than 38°C.
24. **Only women with signs of an infection.**
25. Only women who have a temperature >38°C and a complete blood count that shows she has a bacterial infection.

Diagnosing cause of fever

1. What is the best way to direct your physical examination and choice of laboratory examinations to identify the cause of fever?
2. Checking vital signs.
3. **Taking a thorough history of signs and symptoms.**
4. Reviewing the woman’s labor record.
5. Reviewing laboratory results from the prenatal card.
6. Which women in labor should receive antibiotics for a uterine infection if they have a temperature >38°C?
7. All women who have a temperature >38°C in labor should receive antibiotics for a possible uterine infection.
8. Only women with ruptured membranes longer than 18 hours.
9. **Only women with foul-smelling vaginal discharge and uterine tenderness.**
10. Only women with a complete blood count that shows she has a bacterial infection.
11. Which of the following lists possible causes of an intrapartum fever?
12. **UTI, dehydration, uterine infection, epidural in place for 4 or more hours.**
13. Pneumonia, placenta praevia, uterine infection, epidural in place for at least 2 hours.
14. Malaria, placental abruption, uterine infection, epidural in place for at least 4 hours.
15. Dehydration, prolonged labor, uterine infection, epidural in place for at least 2 hours.
16. Ms. B. has a temperature of 38.5°C. Vital signs: Respirations – 26 breaths/min, Pulse – 98 bpm, BP 102/78 mmHg, FHR – 168 bpm. Cervical dilatation: went from 5 to 6 cm in 4 hours. Contractions – 3 in 10 minutes, each lasting 40-50 seconds. Membranes are intact. Is complaining of wet cough and shortness of breath. You note rales in her lung bases. Other findings are within normal limits. What is the most likely diagnosis?
17. Urinary tract infection.
18. **Bronchitis.**
19. Uterine infection.
20. Dehydration.
21. How will you manage IV infusions if shock is suspected in a woman in labor with a temperature >38°C?
22. **Infuse 1L of IV fluids (normal saline or Ringer’s lactate) initially at the rate of 1 L in 15–20 minutes.**
23. Infuse plasma substitutes (e.g. dextran) initially at the rate of 1 L in 15–20 minutes.
24. Infuse IV fluids (normal saline or Ringer’s lactate) at the rate of 1 L in four hours.
25. Begin a blood transfusion, initially with one unit of blood.

Management of intrapartum uterine infection (labor through postpartum)

1. What antibiotic regimen will you provide women in labor with a uterine infection?
2. **Ampicillin 2gm IV every 6 hours and gentamycin 5mg/kg IV daily.**
3. Clindamycin 150 mg by mouth every 6-8 hours.
4. Ampicillin 2gm IV as a one-time dose.
5. Clindamycin 150 mg IV every 6-8 hours and gentamycin 5mg/kg IV daily.
6. For how long will you continue antibiotics for women diagnosed with a uterine infection during labor?
7. Stop antibiotics immediately after a vaginal birth.
8. Continue antibiotics for 48 hours if the woman has a cesarean birth.
9. Stop antibiotics as soon as her temperature is 38°C or less.
10. **Continue antibiotics after birth for 24-48 hours after the last clinical signs and symptoms of infection have ended.**
11. How will you treat the newborn if the woman was treated for a uterine infection during labor?
12. Observe the newborn for at least 48 hours and treat if the baby has signs of infection.
13. Delay breastfeeding until the woman’s antibiotic course is complete.
14. **Treat all newborns with prophylactic IV/IM antibiotics (ampicillin 50 mg per kg every 12 hours and gentamicin 4-5 mg per kg every 24 hours) for at least two days.**
15. Only treat premature newborns with prophylactic IV/IM antibiotics (ampicillin 50 mg per kg every 12 hours and gentamicin 4 mg per kg every 24 hours) for at least two days.
16. Ms. X.was started on antibiotics during labor but the infection is not getting better. What is the first thing will you do?
17. Continue with the same antibiotic regimen for at least 48 hours postpartum.
18. Seek advanced care.
19. **Make sure the dosages of antibiotics are adequate.**
20. Increase the dosage of paracetamol to manage the fever.
21. Ms. Y.was being treated for a uterine infection during labor and now needs a cesarean birth. How will you prepare her for the procedure?
22. Cleanse the vagina with chlorhexidine before the procedure.
23. **Cleanse the vagina with povidone-iodine before the procedure.**
24. Give an additional dose of antibiotics at least one hour before the incision.
25. If not already being used, start giving clindamycin 150 mg IV every 6-8 hours.

Augmentation with oxytocin (labor through postpartum)

1. Which of the following is ***NOT*** a contraindication to augmentation of labor with oxytocin?
2. **Occiput posterior position with a poorly flexed head.**
3. Frank breech with a well flexed head.
4. Complete breech with a poorly flexed head.
5. Chin posterior position.
6. You are caring for a client in labor who is receiving oxytocin by IV infusion to stimulate uterine contractions. Which assessment finding would indicate that the infusion needs to be increased when the maternal and fetal conditions are reassuring?
7. **Two contractions occurring within a 10-minute period, each lasting 30-40 seconds.**
8. Three contractions occurring within a 10-minute period, each lasting 40-50 seconds.
9. Four contractions occurring within a 10-minute period, each lasting 50-60 seconds.
10. Five contractions occurring within a 10-minute period, each lasting 50-60 seconds.
11. You are caring for a client in labor who is receiving oxytocin by IV infusion to stimulate uterine contractions. Which assessment finding would indicate that the infusion needs to be discontinued?
12. Two contractions occurring within a 10-minute period, each lasting 30-40 seconds.
13. **A fetal heart rate of 90 beats per minute.**
14. Adequate resting tone of the uterus palpated between contractions.
15. Increased urinary output.
16. Ms. X. received an oxytocin infusion during labor for ineffective contractions. She has now given birth to the baby. How will you manage the third stage of labor?
17. Continue the IV infusion drip at the same and do not give an additional uterotonic drug.
18. Open the IV infusion and infuse the oxytocin solution rapidly.
19. **Continue the IV infusion drip but give an additional 10 IU of oxytocin by IM or IV injection.**
20. Continue the IV infusion drip but give misoprostol 600 mcg by mouth.
21. Ms. X. received an oxytocin infusion during labor for ineffective contractions. She has now given birth to the baby and delivered the placenta. When will you discontinue the oxytocin drip?
22. Stop the IV infusion drip as soon as the placenta is delivered.
23. Stop the IV infusion drip once you are sure that the uterus is well contracted.
24. Stop the IV infusion drip once breastfeeding is well established.
25. **Continue the IV infusion drip to give the equivalent of 10 IU of oxytocin over 3.5 hours.**

Management of hyperstimulation

1. Which of the following is NOT part of the diagnostic criteria for hyperstimulation of the uterus?
2. More than five contractions in 10 minutes.
3. Any contraction lasting longer than 60 seconds.
4. The uterus does not relax between contractions.
5. **A fetal heart rate of 90 beats per minute.**
6. You are caring for a client in labor who is receiving oxytocin by IV infusion to stimulate uterine contractions. You note there are six contractions in 10 minutes, each lasting 50-60 minutes. The FHR is 102 bpm. What is the order of priority of the actions that you will take?
7. 1. Stop the oxytocin infusion 2. Perform a vaginal examination 3. Reposition the client 4. Check the client’s blood pressure and heart rate 5. Administer oxygen at 4 to 6 L/min.
8. **1. Stop the oxytocin infusion 2. Position the woman on her left side. 3. Administer oxygen at 4 to 6 L/min. 4. Give betamimetics. 5. Give fluids by mouth or IV.**
9. 1. Position the woman on her left side. 2. Perform a vaginal examination. 3. Stop the oxytocin infusion if cervical dilatation has progressed. 4. Give betamimetics. 5. Give oral fluids.
10. 1. Stop the oxytocin infusion 2. Position the woman on her left side. 3. Administer oxygen at 4 to 6 L/min. 4. Give fluids by mouth or IV. 5. Conduct a vaginal examination.
11. You are caring for a client in labor who is receiving oxytocin by IV infusion to stimulate uterine contractions. You note there are five contractions in 10 minutes, each lasting 60-70 minutes. The FHR is 142 bpm when the woman is on her left side. What is the order of priority of the actions that you will take?
12. 1. Stop the oxytocin infusion 2. Perform a vaginal examination 3. Reposition the client 4. Check the client’s blood pressure and heart rate 5. Administer oxygen at 4 to 6 L/min.
13. 1. Stop the oxytocin infusion 2. Administer oxygen at 4 to 6 L/min. 3. Give betamimetics. 4. Observe for improvement in uterine activity and FHR.
14. 1. Perform a vaginal examination. 2. Stop the oxytocin infusion if cervical dilatation has progressed. 3. Give betamimetics. 4. Observe for improvement in uterine activity and FHR.
15. **1. Stop the oxytocin infusion 2. Observe for improvement in uterine activity and FHR. 3. If normal uterine activity is not established within 20 minutes, relax the uterus using betamimetics.**
16. You are working in an advanced care facility and stopped the oxytocin infusion on a woman you were caring for because she had hyperstimulation of the uterus. When would you consider restarting the oxytocin infusion?
17. Never. Augmentation has failed.
18. If the FHR becomes reassuring for at least 30 minutes regardless of uterine contractions.
19. If uterine contractions are normal for at least 30 minutes regardless of FHR.
20. **If the FHR becomes reassuring or normal and contractions are 3 in 10 minutes, each lasting 40-50 seconds for a period of at least 30 minutes.**
21. Which of the following in ***NOT*** a potential complication of oxytocin infusion during labor?
22. **Uterine infection**.
23. Uterine rupture.
24. Fetal distress.
25. Postpartum hemorrhage.

Management of shoulder dystocia

1. Which of the following statements about shoulder dystocia is ***TRUE***?
2. Cesarean birth should be routinely performed in the case of multiple risk factors for shoulder dystocia.
3. **Shoulder dystocia cannot be predicted*.***
4. Once shoulder dystocia is diagnosed, you will have about ten minutes to deliver the baby before asphyxia and permanent damage can occur.
5. Clinical pelvimetry will help predict shoulder dystocia.
6. Mme. V. is a 25-year-old G2P1 woman is giving birth at 42 weeks’ gestation. She is moderately obese, but the fetal weight clinically appears to be about 3700 g. After a 10-hour first stage of labor, and a 2-hour second stage of labor, the fetal head is born but is noted to be retracted back toward the patient’s introitus. The fetal shoulders do not deliver, even with maternal pushing. What is the most likely problem?
7. Tight nuchal cord.
8. Uterine rupture.
9. **Shoulder dystocia.**
10. Placenta accreta.
11. What is your first step in managing Mme. V. after calling for help?
12. Gaskin maneuver.
13. **McRoberts maneuver.**
14. Internal pressure on the anterior shoulder.
15. Grasp the humerus of the posterior arm.
16. If the baby is still not born after attempting all of the maneuvers for the first time, what will you do?
17. **Begin again with maneuver 1.**
18. Transport the woman to the theater for an emergency cesarean birth.
19. Use forceps to deliver the baby.
20. Perform a symphysiotomy.
21. You have just diagnosed shoulder dystocia and note there is a nuchal cord. How will you manage the cord?
22. Immediately cut the cord to facilitate delivery of the shoulder.
23. Cut the cord after the anterior shoulder is delivered.
24. Cut the cord 1-3 minutes after birth of the baby.
25. **Maintain an intact cord as long as possible.**

Management of frank / complete breech birth

1. Ms. D. is a gravida 2 para 1 client who has come to your facility in labor and her cervix is now 6 cm dilated. When you palpate her abdomen, you find that the fetus’ legs are extended toward the fetal shoulders. What presentation is this?
2. Complete breech.
3. Footling breech
4. **Frank breech**
5. Incomplete breech
6. What will you need to verify before reassuring Ms. D and her companion that she can most likely give birth vaginally?
7. **The fetal head is well flexed, fetal weight more than 2500 g but less than 4000 g, gestational age is at least 37 weeks.**
8. The fetal weight is less than 4000 g, gestational age is at least 40 weeks.
9. The fetal weight is more than 2500 g, gestational age is at least 34 weeks.
10. The fetal weight is more than 2500 g but less than 4000 g, gestational age is at least 37 weeks.
11. What position should Ms. D. adopt during second stage?
12. **Ms. D. should adopt the position of her choice during second stage.**
13. The safest position is for her to be on her back in stirrups.
14. The safest position is for her to be on hands and knees.
15. The safest position is for her to be on her left side.
16. You are caring for Ms. E. who has a frank breech presentation. Gestational age is 34 weeks. What is the risk for her baby if she gives birth vaginally?
17. Fetal distress.
18. Prolapsed cord.
19. Placental abruption.
20. **Entrapped head.**
21. While monitoring Ms. D. when her cervix is 7 cm dilated, you note that the FHR is 118 bpm during a contraction and 142 bpm after the contraction is over. The liquor is meconium-stained. What is the most likely problem?
22. Prolapsed cord.
23. Fetal distress.
24. Entrapped head.
25. **There is no problem.**