

# LABOR & DELIVERY CLINICAL CHEAT SHEET



## MOM'S VITAL SIGNS

<b>BLOOD PRESSURE (BP)</b>	<b>SYSTOLIC</b> 120 mmHg <b>DIASTOLIC</b> 80 mmHg
<b>HEART RATE (HR)</b>	60 - 100 bpm
<b>* RESPIRATORY RATE (RR)</b>	12 - 20 breaths/min
<b>TEMPERATURE (T)</b>	97.8 - 99°F (36.5 - 37.2°C)
<b>OXYGEN (O<sub>2</sub>)</b>	95 - 100% <small>COPD pts are expected to have lower O<sub>2</sub> levels</small>
<b>*NAD TIP:</b> After you are done taking the patient's RR, keep your finger on their pulse while assessing respiratory rate. (Often the patient knows you are taking their respiratory rate, they may breathe differently.)	

## STAGES OF LABOR

- 1<sup>ST</sup> STAGE** Regular contractions → Complete dilation (10 cm)
- 2<sup>ND</sup> STAGE** Complete dilation (10 cm) → Baby is delivered
- 3<sup>RD</sup> STAGE** Baby is delivered → Placenta is delivered
- 4<sup>TH</sup> STAGE** Placenta is delivered → Recovery (8 hours postpartum)

## BABY'S VITAL SIGNS

<b>BLOOD PRESSURE (BP)</b> (Not done routinely)	<b>SYSTOLIC</b> 60 - 80 mmHg <b>DIASTOLIC</b> 40 - 50 mmHg
<b>HEART RATE (HR)</b>	110 - 160 bpm can be 180 if crying can be 100 if sleeping
<b>RESPIRATORY RATE (RR)</b>	30 - 60 breaths/min
<b>TEMPERATURE (T) (Axillary)</b>	97.7 - 99.5°F (36.5 - 37.5°C)
<b>HAP</b>	Equal to the # of weeks gestation or higher



Breathing pattern is **IRREGULAR**.  
Newborns are **ABDOMINAL** breathers.

To count breaths, place your hand on their abdomen.

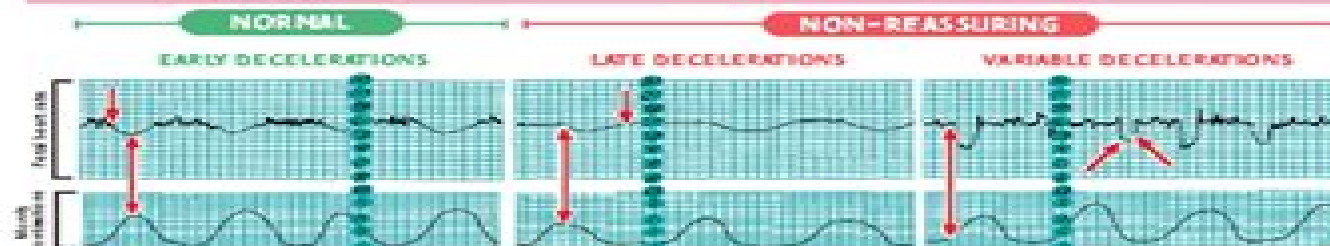
Count for a full minute!



**⚠️ SIGNS OF RESPIRATORY DISTRESS**

- Retractions
- Nasal flaring
- Grunting

## FETAL MONITORING



### A TOOL TO HELP INTERPRET FETAL STRIPS

<b>V</b> Variable Decelerations →	<b>C</b> Cord Compression
<b>E</b> Early Decelerations →	<b>H</b> Head Compression
<b>A</b> Accelerations →	<b>O</b> OK (normal fetal response)
<b>L</b> Late Decelerations →	<b>P</b> Placental Insufficiency

## OBSTETRICAL EMERGENCIES

	DESCRIPTION	TREATMENT
<b>Pre-eclampsia / Eclampsia</b>	Eclampsia is when a woman with pre-eclampsia has seizures	BP control, MgSO <sub>4</sub> , delivery of the baby
<b>Postpartum Hemorrhage (PPH)</b>	Major blood loss (vaginal birth: >500 mL in 24 hours) (cesarean birth: >1000 mL in 24 hours)	Surgical ligation, hysterectomy, removal of leftover placenta, uterine tamponade & misoprostol
<b>Uterine Rupture</b>	When the uterus ruptures (wall of the uterus breaks open, commonly caused by pressure)	STAT delivery, blood transfusions, possible hysterectomy

## MEDICATIONS

<b>OXYTOCIN (Pitocin)</b>	Stimulates uterine contractions
<b>MISOPROSTOL (Cytotec)</b>	Cervical ripening agent
<b>TERBUTALINE (Dybeline)</b>	HALTS uterine contractions
<b>NIFEDIPINE (Procardia)</b>	HALTS uterine contractions
<b>MAGNESIUM SULFATE</b>	Preventing & controlling seizures in mothers with <b>pre-eclampsia/eclampsia</b>



## APGAR

	0 POINTS	1 POINT	2 POINTS
<b>A</b> <b>ACTIVITY</b> (Muscle tone)	Absent	Flexed arms & legs	Active
<b>P</b> <b>PULSE</b>	0	< 100	> 100
<b>G</b> <b>GRINACE</b> (Reflex irritability)	Flaccid	Minimal response to stimulation	Prevents response to stimulation
<b>A</b> <b>APPEARANCE</b> (Skin color)	Blue / pale all over	Pink body Blue extremities (acrocyanosis)	Pink
<b>R</b> <b>RESPIRATION</b> (Effort)	No breathing	Slow & irregular	Vigorous cry

**ASSESSMENT OF APGAR**  
1 MINUTE  
and  
5 MINUTES  
after birth.

### SCORING & INTERVENTIONS

<b>7-10</b> The newborn is doing well. Only routine post-delivery care needed.	<b>4-6</b> Some resuscitation assistance needed: oxygen, suction, stimulate the baby, rub baby's back.	<b>0-3</b> Newborn full resuscitation.
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# Labor Study Guide Arco

**Michael Hoelscher**



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