NCLEX 2026 · CLINICAL JUDGMENT SERIES

MATERNAL-NEWBORN · HIGH-YIELD

Obstetric *Emergencies*

Cord Prolapse · Uterine Rupture · Placental Abruption

System: Maternal-Newborn / OB

Focus: Prioritization · Safety · ABCs

Format: NGN Clinical Judgment

01

Umbilical Cord Prolapse

CORD BELOW · FETAL HYPOXIA

02

Uterine Rupture

VBAC RISK · SHOCK

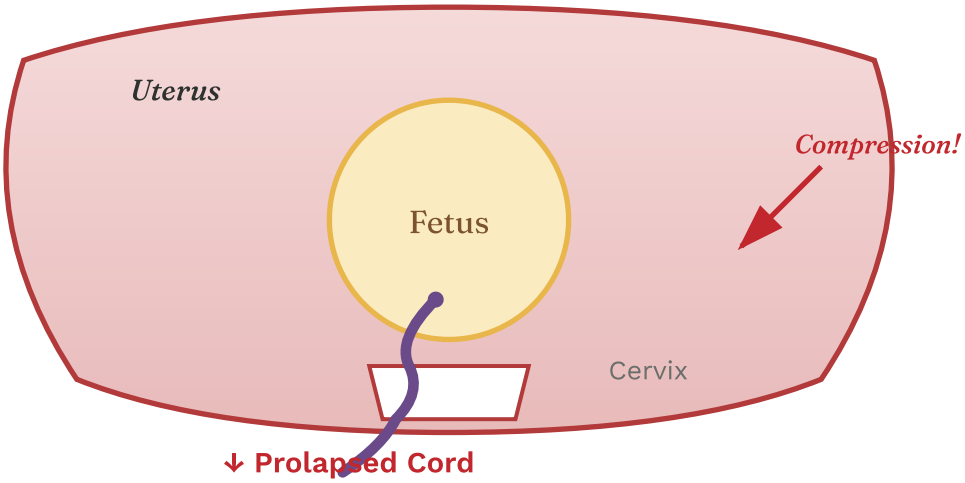
03

Placental Abruption

PREMATURE SEPARATION · BLEED

01 Umbilical Cord Prolapse

LIFE-THREATENING · FETAL



01 Definition / Overview

WHAT & WHY

- The **umbilical cord slips past or alongside the presenting fetal part** through the cervix *before* the baby is delivered.
- The presenting part compresses the cord against the maternal pelvis → **cord blood flow is cut off** → rapid fetal hypoxia.
- **True emergency**: minutes matter. Without intervention → fetal death within minutes.

02 Pathophysiology (Simplified)

MECHANISM

ROM (membranes rupture) with high / unengaged presenting part → Cord slips past presenting part into vagina →

Presenting part compresses cord against pelvis → ↓ Fetal O_2 → Bradycardia / Variable decels →

Fetal hypoxia / death if not relieved

Risk factors: breech / transverse lie, polyhydramnios, preterm or small fetus, multiple gestation, long cord, AROM with unengaged head.

03 Signs & Symptoms

WHAT YOU'LL SEE

EARLY / SUBTLE

- Variable decelerations after ROM
- Sudden change in FHR pattern
- Mother feels “something between her legs”

SEVERE / RED FLAG

- **Visible or palpable cord** in vagina
- **Sudden, prolonged fetal bradycardia** (<110 bpm)
- Severe variable decels unresponsive to position change

IMMEDIATE RED FLAGS

- Cord seen or felt at the perineum / in the vagina
- Fetal bradycardia immediately after ROM
- Deep variable decels that will not correct with position change

04 Priority Nursing Interventions

ABC · SAFETY · ACT NOW

- **1. CALL for help** — notify provider STAT, activate emergency response.
- **2. RELIEVE cord pressure** — insert sterile gloved hand into vagina and **elevate presenting part off the cord**. Do NOT remove hand until delivery.
- **3. POSITION** the mother in **knee-chest** or **Trendelenburg** (or exaggerated Sims / hips elevated) to shift fetus off cord.
- **4. OXYGEN** — apply **10 L/min via non-rebreather mask**.
- **5. DISCONTINUE oxytocin** if infusing; start / increase IV fluids.
- **6. MONITOR FHR** continuously; **do NOT attempt to push cord back inside**.
- **7. PROTECT cord** — if cord is outside, cover with **warm sterile saline gauze** to prevent drying / vasospasm.
- **8. PREPARE for emergency C-section** — quickest route to delivery if cervix is not fully dilated.

05 Pharmacology

KEY DRUGS

Terbutaline

TOCOLYTIC · B_2-ADRENERGIC AGONIST

MECHANISM	Relaxes uterine smooth muscle → stops contractions → buys time for delivery.
SIDE EFFECTS	Maternal tachycardia, tremor, hyperglycemia, pulmonary edema.
NURSING	Monitor maternal HR (hold if >120), FHR, lung sounds, blood glucose.

IV Isotonic Fluids (LR or NS)

VOLUME EXPANSION

PURPOSE	Improve maternal perfusion → improve placental / fetal perfusion.
NURSING	Large-bore IV (18 g), bolus per order, monitor I&O.

06 NCLEX Test Traps

DON'T FALL FOR IT

- **Trap:** Choosing “push the cord back in.” **Never.** You lift the *presenting part* off the cord — not the cord itself.
- **Trap:** Picking “notify the provider” as the FIRST action. Lifting the presenting part OFF the cord (relieving pressure) is often prioritized with calling for help simultaneously.
- **Trap:** Positioning supine. **Knee-chest** or **Trendelenburg** is correct.
- **Trap:** Wrapping a protruding cord in dry gauze. Use **WARM STERILE SALINE** gauze — dry gauze causes vasospasm.
- **Trap:** Continuing oxytocin. **Stop it** — contractions worsen compression.

07 Patient Education

TEACH-BACK

- **Report ROM immediately** — time and color of fluid matter.
- If water breaks at home **before labor** or baby is not engaged: **lie down** and come to the hospital right away.
- If a cord is seen or felt: **get on hands & knees (knee-chest)** and call 911.
- Understand why **emergency C-section** may be needed — safest route when cord is compressed.

08 Memory Boosters

LOCK IT IN

🧠 Mnemonic: "CORD" — priority actions

C | **Call** for help · Cover cord with warm saline gauze

O | **Oxygen** 10 L non-rebreather

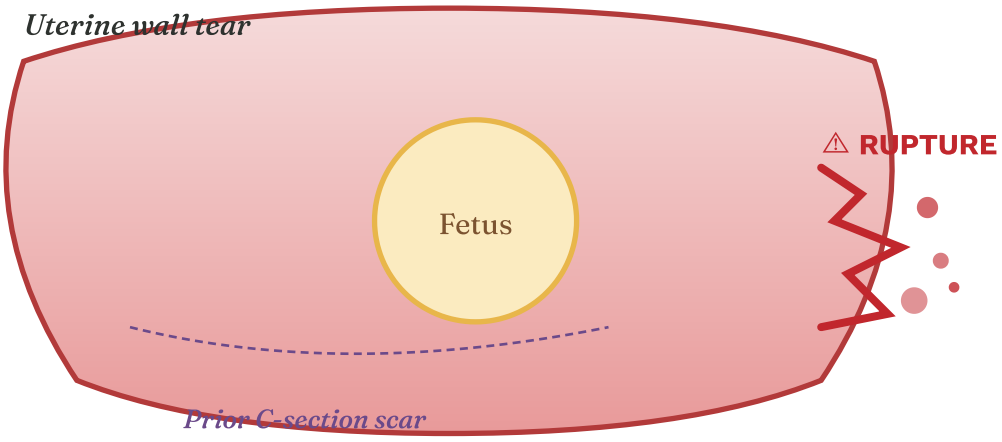
R | **Relieve** pressure — knee-chest / Trendelenburg + lift presenting part

D | **Deliver** — prep for emergency C-section

Pattern recognition: ROM + sudden fetal bradycardia / severe variables = **think cord prolapse FIRST**.

02 Uterine Rupture

LIFE-THREATENING · MOM + FETUS



01 Definition / Overview

WHAT & WHY

- A **tear through the uterine wall**, often along a previous cesarean or uterine surgery scar.
- Can be **partial** (dehiscence) or **complete** (through all layers → fetus and/or placenta extrude into abdomen).
- **True emergency for mom AND baby**: maternal hemorrhage + fetal hypoxia → death if not delivered within minutes.

02 Pathophysiology (Simplified)

MECHANISM

Weakened uterine wall (prior C-section, trauma, overdistention, hyperstim) → Strong / tetanic contractions stress the wall →

Wall tears — partial or complete → Fetus/placenta may extrude into abdomen + massive bleeding →

Maternal shock + fetal hypoxia

Top risk factors: prior classical C-section, prior uterine surgery, **TOLAC / VBAC**, oxytocin / misoprostol hyperstimulation, grand multiparity, trauma, overdistended uterus.

03 Signs & Symptoms

CLASSIC TRIAD + MORE

EARLY / WARNING

- Hyperstimulation / tetanic contractions
- Rising maternal HR, mild restlessness
- Slight non-reassuring FHR changes (late decels)
- Pain **between** contractions, not relieved by epidural

SEVERE / RED FLAG

- **Sudden, sharp, “tearing / ripping” abdominal pain**
- **Loss of fetal station** (presenting part recedes / no longer palpable at cervix)
- **Contractions suddenly stop**
- **Fetal parts palpable through maternal abdomen**
- Fetal bradycardia / loss of FHR
- Signs of **hypovolemic shock**: ↓BP, ↑HR, pallor, cool/clammy
- Vaginal bleeding (may be minimal if bleeding is intra-abdominal)

CLASSIC TRIAD — DON'T MISS IT

- Sudden, severe abdominal pain (often with a “pop” sensation)
- Abrupt cessation of contractions
- Abnormal / absent FHR + loss of fetal station

04 Priority Nursing Interventions

ABC · TREAT MOM AND BABY

- **1. STOP oxytocin immediately** if infusing.
- **2. CALL provider STAT**; activate obstetric emergency / rapid response.
- **3. ADMINISTER O_2** 10 L via non-rebreather.
- **4. IV ACCESS** — **two large-bore IVs (16–18 g)**, bolus isotonic crystalloid.
- **5. PREPARE for emergency C-section / laparotomy** — definitive treatment.
- **6. TYPE & CROSSMATCH**; prepare to transfuse **PRBCs**; have blood products at bedside.
- **7. MONITOR** maternal VS q 5 min, continuous FHR, LOC, urine output (Foley).
- **8. POSITION** left lateral to improve placental perfusion; elevate legs if shock.
- **9. ANTICIPATE hysterectomy** if bleeding cannot be controlled; **obtain informed consent**.
- **10. PROVIDE emotional support** — this is sudden, terrifying, and often traumatic.

05 Pharmacology

KEY DRUGS

Oxytocin (Pitocin) — DISCONTINUE

UTEROTONIC · NOT GIVEN NOW

KEY POINT If rupture is suspected, **stop the infusion immediately** — it drove the hyperstimulation that tore the uterus.

IV Crystalloids (LR / 0.9 % NS)

VOLUME RESUSCITATION

PURPOSE Restore circulating volume in hypovolemic shock.

NURSING Bolus per order, monitor BP, MAP, UOP > 30 mL/hr.

Blood Products (PRBCs, FFP, Platelets)

MASSIVE TRANSFUSION PROTOCOL

PURPOSE Replace blood loss; correct coagulopathy / DIC.

NURSING Two-RN verification, monitor for transfusion reaction, labs (CBC, coags, fibrinogen).

06 NCLEX Test Traps

DON'T FALL FOR IT

- **Trap:** Assuming heavy vaginal bleeding will be present. In complete rupture, bleeding is often **intra-abdominal** — vaginal bleeding may be minimal.
- **Trap:** Continuing oxytocin until the provider arrives. **Stop it first.**
- **Trap:** Missing **loss of fetal station** as a hallmark sign — the baby literally moves back up.
- **Trap:** Confusing “tetanic contraction pain” (pre-rupture) with normal labor pain — a contraction that **never relaxes** is a red flag.
- **Trap:** Choosing tocolytics as first action — the priority is **immediate delivery** (surgical), not stopping labor.

07 Patient Education

TEACH-BACK

- **TOLAC / VBAC counseling**: discuss risk of rupture (~0.5–1 %) vs benefits of vaginal birth; deliver at facility able to do emergency C-section.
- Report any **sharp abdominal pain**, **contractions that won't relax**, or **change in fetal movement** immediately.
- Understand signs of shock (dizziness, pallor, fast heartbeat) and when to call 911.
- After rupture: discuss future pregnancies — usually requires **repeat C-section**; hysterectomy may end fertility.
- Address **emotional recovery** — trauma counseling, grief if fetal loss.

08 Memory Boosters

LOCK IT IN

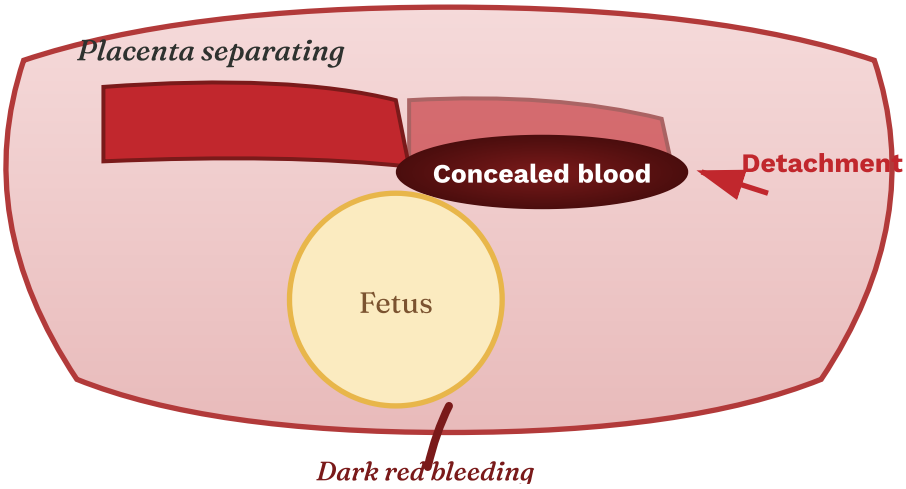
🧠 Mnemonic: "RUPTURE" — know it cold

R	**Ripping** / tearing sudden pain
U	**Uterine** contractions cease abruptly
P	**Presenting part** recedes — loss of station
T	**Tachycardia** (maternal) + hypotension = shock
U	**Unusual** fetal parts palpable through abdomen
R	**Rapid** fetal bradycardia or loss of FHR
E	**Emergency** C-section / laparotomy NOW

Pattern recognition: VBAC + sudden pain + "the contraction pattern went flat" = **think rupture until proven otherwise**.

03 Placental Abruption

LIFE-THREATENING · HEMORRHAGE



01 Definition / Overview

WHAT & WHY

- **Premature separation** of a *normally implanted* placenta from the uterine wall **after 20 weeks gestation** and before delivery.
- Bleeding may be **revealed** (visible vaginal bleeding) or **concealed** (blood trapped behind placenta) — concealed is more dangerous because loss is underestimated.
- Leading cause of **3rd-trimester bleeding + maternal / fetal morbidity**; risk of DIC, hemorrhagic shock, fetal demise.

02 Pathophysiology (Simplified)

MECHANISM

Vascular insult (HTN, trauma, cocaine, smoking, PPROM) → Decidual vessels rupture →

Blood collects behind placenta — shears it off uterine wall → ↓ Gas exchange → fetal hypoxia →

Maternal hemorrhage ± DIC

Top risk factors: maternal HTN / preeclampsia (#1), abdominal **trauma** (MVC, IPV), **cocaine** / methamphetamine use, smoking, prior abruption, multiparity, PPROM, advanced maternal age.

03 Signs & Symptoms

DARK RED + PAINFUL

MILD / PARTIAL

- Scant to moderate **dark red** vaginal bleeding
- Mild abdominal / back pain, uterine tenderness
- Uterus slightly firm between contractions
- Stable VS, reassuring FHR

SEVERE / RED FLAG

- **Sudden, sharp, severe abdominal / back pain**
- **Rigid, “board-like” uterus** that does not relax
- **Dark red vaginal bleeding** (or NO bleeding = concealed!)
- **Rising fundal height** (concealed bleed filling uterus)
- Fetal distress → late decels, bradycardia, demise
- Maternal hypovolemic shock ± **DIC** (oozing from IV sites, gums)

HALLMARK

- **Painful** dark red vaginal bleeding + **rigid** uterus = abruption until proven otherwise.
- Remember: **vital signs may look “OK” at first** because healthy pregnant patients compensate — don't be fooled.

04 Priority Nursing Interventions

ABC · CONTROL HEMORRHAGE

- **1. ASSESS ABCs** and VS q 5–15 min; continuous FHR monitoring.
- **2. POSITION** left lateral (improves placental perfusion); **never perform vaginal exam** until placenta previa is ruled out.
- **3. OXYGEN** — 10 L via non-rebreather.
- **4. IV ACCESS** — **two large-bore IVs (16–18 g)**; bolus isotonic fluids per order.
- **5. LABS** — CBC, type & crossmatch (2+ units PRBCs), coags (PT/PTT, fibrinogen, D-dimer — watch for DIC), Kleihauer-Betke if mom is Rh-negative.
- **6. MEASURE fundal height** (mark with pen) — an **increasing** fundal height = concealed bleeding.
- **7. QUANTIFY blood loss** — weigh pads (1 g = 1 mL).
- **8. FOLEY** — strict I&O, UOP > 30 mL/hr indicates adequate perfusion.
- **9. PREPARE for delivery** — usually **emergency C-section** if severe or fetal distress.
- **10. EMOTIONAL support** — keep patient and family informed; address fetal loss grief if needed.

05 Pharmacology

KEY DRUGS

IV Crystalloids (LR / 0.9 % NS)

VOLUME RESUSCITATION

PURPOSE Restore circulating volume, maintain MAP and placental perfusion.

NURSING Two large-bore IVs; titrate to BP and UOP.

Blood Products (PRBCs, FFP, Platelets, Cryo)

TRANSFUSION / DIC CORRECTION

PURPOSE Replace blood loss; FFP/cryo correct DIC coagulopathy.

NURSING Two-RN verification; monitor for reactions; recheck coags.

Rho(D) Immune Globulin (RhoGAM)

RH ISOIMMUNIZATION PROPHYLAXIS

PURPOSE Given to **Rh-negative** mothers after bleed to prevent antibody formation.

NURSING Check Rh status; IM injection; dose based on Kleihauer-Betke.

Betamethasone

ANTENATAL CORTICOSTEROID (IF PRETERM & STABLE)

PURPOSE Accelerates fetal lung maturity if delivery is anticipated 24–34 weeks.

NURSING IM; monitor maternal glucose; only if mom/fetus can wait.

06 NCLEX Test Traps

DON'T FALL FOR IT

- **Trap:** Performing a **vaginal exam** on 3rd-trimester bleeding. **NEVER** until placenta previa is ruled out by ultrasound — could cause catastrophic hemorrhage.
- **Trap:** Judging severity by visible bleeding. In **concealed abruption**, little/no external bleeding can hide massive loss. Watch **rising fundal height** and VS.
- **Trap:** Confusing abruption with **previa**. Abruption = **painful, dark red, rigid**. Previa = **painless, bright red, soft**.
- **Trap:** Missing **DIC**. Oozing from IVs, gums, hematuria → check PT/PTT, fibrinogen, platelets.
- **Trap:** Supine position. Use **left lateral** to offload the vena cava and improve placental perfusion.
- **Trap:** Forgetting RhoGAM in Rh-negative mothers.

07 Patient Education

PREVENTION + REPORTING

- **Control blood pressure** — take antihypertensives as prescribed, attend all prenatal visits.
- **No smoking, no cocaine / methamphetamine**, no alcohol.
- **Wear seatbelt properly** — lap belt *under* the belly, shoulder belt between breasts.
- Report **any vaginal bleeding, abdominal pain, decreased fetal movement, or trauma** IMMEDIATELY.
- Know warning signs of **preeclampsia**: severe headache, visual changes, RUQ pain, swelling.
- Screen for **intimate partner violence** — trauma is a leading cause; provide safety resources privately.

08 Memory Boosters

LOCK IT IN

🧠 Mnemonic: "DETACH" — it detached!

D	**Dark** red vaginal bleeding (or concealed)
E	**Extreme** abdominal / back pain — sudden
T	**Tender**, rigid, board-like uterus
A	**Abnormal** FHR — late decels, bradycardia
C	**Clotting** issues / DIC risk
H	**Hypovolemic** shock — watch for concealed loss

Pattern recognition: 3rd-trimester bleed + **pain + rigid uterus** → **abruption**. 3rd-trimester bleed + **painless + soft uterus** → **previa**.

Side-by-Side *Comparison*

When the stem gives you the clue, recognize the pattern fast.

	Cord Prolapse	Uterine Rupture	Placental Abruption
Key trigger	ROM with unengaged presenting part	VBAC / prior C-section · oxytocin hyperstim	HTN / preeclampsia · trauma · cocaine
Pain	None (maternal) — fetal distress is the clue	Sudden, sharp, “ripping” — often between contractions	Sudden, severe abdominal / back pain
Bleeding	Usually none	Variable; often intra-abdominal (not vaginal)	**Dark red** vaginal bleed — or concealed
Uterus	Normal tone	Contractions stop abruptly; loss of fetal station	**Rigid, board-like**, tender
FHR	Sudden bradycardia / severe variable decels	Late decels → bradycardia → loss of FHR	Late decels, bradycardia, fetal distress
First action	**Relieve cord pressure** — knee-chest + lift presenting part + call for help	**Stop oxytocin**, call provider, prep for stat C-section	**Left lateral + O_2 + 2 large-bore IVs**, notify provider, **no vag exam**
Definitive Tx	Emergency C-section	Emergency C-section / laparotomy ± hysterectomy	Emergency C-section (usually) + resuscitation
Memory	**CORD**: Call · O_2 · Relieve · Deliver	**RUPTURE** triad: pain + stop + loss of station	**DETACH**: dark · painful · rigid

⚠ High-Yield: Abruption vs. Placenta Previa

Placenta Previa

- **PAINLESS** bleeding
- **Bright red** blood
- Soft, non-tender uterus
- Placenta covers / near cervix
- **NO vaginal exam**

vs

Placental Abruption

- **PAINFUL** bleeding (or concealed)
- **Dark red** blood
- Rigid, board-like uterus
- Placenta prematurely detaches
- Risk of DIC, shock

NCLEX 2026 · Clinical Judgment Model · Recognize cues → Analyze cues → Prioritize → Act