

Fetal Monitoring Basics

Baseline, variability, accelerations, and early decelerations — the four findings that decide whether the fetus is well-oxygenated, or whether the nurse must act now.

FRAMEWORK: 2026 NCLEX-RN TEST PLAN **MODEL:** NCSBN CLINICAL JUDGMENT (NCJMM)

FOCUS: CATEGORY I TRACINGS & REASSURANCE **DIFFICULTY:** APPLICATION / ANALYSIS

TODAY'S LESSON MAP

- | | |
|--------------------------------|--------------------------------------|
| 01 High-Yield Overview | 08 Unfolding NGN Case Study |
| 02 10 Must-Know Rules | 09 "What Should the Nurse Do First?" |
| 03 Maternal-Fetal Safety Table | 10 Stop, Hold, or Escalate |
| 04 Red-Flag Cues | 11 Common NCLEX Traps |
| 05 Medication Safety | 12 End-of-Day Quick Review |
| 06 Fetal Monitoring Deep Dive | 13 Infographic Summary |
| 07 Advanced NGN Practice (×11) | |

§ 01

High-Yield *Overview*

Electronic fetal monitoring (EFM) is the nurse's window into how the fetus is tolerating labor. You are not just "watching a strip" — you are continuously asking one question: *is the placenta delivering enough oxygen?*

The fetal heart rate (FHR) tracing is read along two simultaneous channels. The **top channel** shows the fetal heart rate over time. The **bottom channel** shows uterine activity — contractions. Reading EFM is the act of interpreting the top channel *in relationship* to the bottom channel. A decel that occurs at a particular moment in the contraction cycle means something completely different than the same decel occurring at a different moment.

There are four findings that define a Category I (reassuring) tracing and that you must be able to identify on sight:

THE FOUR CORE FINDINGS — DAY 3

- 1. Baseline FHR:** 110–160 bpm, averaged over a 10-minute segment, excluding accelerations, decelerations, and periods of marked variability.
- 2. Variability:** Beat-to-beat fluctuation in the baseline. Moderate variability (6–25 bpm) is the single best

indicator of an intact fetal autonomic nervous system and adequate oxygenation.

3. Accelerations: Abrupt increases ≥ 15 bpm above baseline, ≥ 15 seconds in duration (less than 2 minutes total).

Accelerations = the fetus is okay.

4. Early decelerations: Symmetric, gradual decreases that *mirror* the contraction. Onset, nadir, and recovery coincide with onset, peak, and end of the contraction. Caused by head compression. *Benign — no intervention required.*

The clinical judgment skill being tested here is not memorization of definitions. It is the ability to look at a strip — or read a description of one — and decide: **does the fetus need me to act, or do I document and continue?** A Category I tracing means continue. A Category III tracing means act now. Most of what you will see on NGN exams sits in the gray middle — Category II — where the nurse must trend the strip and decide whether to escalate.

WHY THIS MATTERS FOR THE NCLEX

The 2026 test plan lists "perform testing within scope of practice (e.g., fetal monitoring)" and "recognize trends and changes in client condition and intervene as needed" under Reduction of Risk Potential. EFM interpretation is on every L&D NGN case study. Expect to be asked to recognize cues from a tracing, analyze whether the pattern is reassuring or concerning, and take action.

§ 02

10 Must-Know *Rules*

Burn these into memory. NGN questions reward the nurse who knows the numbers, the windows, and the patterns cold.

01 Normal baseline FHR is **110–160 bpm**. Anything below 110 for ≥ 10 minutes is bradycardia; anything above 160 for ≥ 10 minutes is tachycardia.

02 Baseline is established over a **10-minute window**, rounded to increments of 5, and *excludes* accelerations, decelerations, and periods of marked variability.

03 **Moderate variability (6–25 bpm)** is the single most reassuring finding on a strip. It means the fetal central nervous system is intact and oxygenated.

04 **Absent or minimal variability** + any abnormal pattern = Category III until proven otherwise. Always take this seriously.

05 An **acceleration** in a term fetus = ≥ 15 bpm above baseline lasting ≥ 15 sec. In a preterm fetus (< 32 weeks), the threshold drops to ≥ 10 bpm $\times \geq 10$ sec.

06 Accelerations — spontaneous or stimulated — **rule in fetal well-being**. You cannot have a Category III tracing with present accelerations.

07 **Early decelerations mirror contractions**. Onset, nadir, and return are gradual. Caused by head compression. *Benign — document only.*

08 If you cannot tell early from late, **look at the timing of the nadir**. Early = nadir at the peak of contraction. Late = nadir after the peak.

09 VEAL CHOP MINE: Variable = Cord compression = Move (reposition). Early = Head compression = Identify/document. Accelerations = Okay = No action. Late = Placental insufficiency = Execute interventions.

10 Document FHR every **30 minutes in active first stage**, every **15 minutes in second stage** for low-risk; every 15/5 for high-risk. After any procedure (AROM, epidural, position change), *re-assess FHR immediately*.

§ 03

Maternal-Fetal *Safety Table*

Each finding tells you something different about the mother, the fetus, and what to do next.

Finding	What it means	Mother risk	Fetal/newborn risk	Priority nursing action	Notify / Escalate
Baseline 110–160 bpm	Normal — expected oxygenation	None	None	Continue routine monitoring; document at intervals.	No.
FHR > 160 × ≥10 min (tachycardia)	Possible maternal fever, infection (chorioamnionitis), dehydration, maternal anxiety, beta-agonist drugs (terbutaline), early fetal hypoxia	Infection, dehydration, sepsis	Early hypoxia, infection, anemia	Check maternal temperature & BP, hydrate IV per orders, reposition, evaluate medication history, assess variability.	Yes if persistent, temp ≥100.4°F, foul fluid, or variability is lost.
FHR < 110 × ≥10 min (bradycardia)	Possible cord compression, maternal hypotension, rapid descent, late hypoxia, congenital heart block, anesthesia effect	Hypotension (post-epidural), uterine rupture	Hypoxia, acidosis	Reposition (L lateral first), IV bolus, O ₂ 10 L NRB, stop oxytocin, sterile vaginal exam to rule out prolapse.	Yes — immediately. Rapid response if < 100 for > 3 min.
Moderate variability (6–25 bpm)	Intact fetal CNS, adequate oxygenation	None	None — reassuring	Document; continue plan.	No.
Minimal variability (≤5 bpm)	Fetal sleep cycle (up to 40 min), opioids, magnesium, hypoxia, acidosis	Medication effect	Possible hypoxia if persistent > 40–60 min	Reposition, stimulate fetus (scalp/vibroacoustic), review meds, evaluate trend.	Yes if persistent > 60 min or paired with decels.

Finding	What it means	Mother risk	Fetal/newborn risk	Priority nursing action	Notify / Escalate
Absent variability	Severe hypoxia, acidosis, fetal compromise — until proven otherwise	Possible abruption, rupture	Acidosis, neurologic injury, demise	Intrauterine resuscitation (LION): Lateral position, IV fluid bolus, O ₂ 10 L NRB, stop oxytocin, Notify provider; prepare for delivery.	Yes — emergency. Activate rapid response/OB emergency team.
Marked variability (>25 bpm)	Acute hypoxia, cord compression, fetal stimulation, early acidosis	Possible abruption	Acute hypoxia trend	Reposition, IV bolus, stop oxytocin, evaluate context, continue close monitoring.	Yes if persistent or with decels.
Accelerations present	Confirms fetal well-being and intact pH	None	None — reassuring	Document; continue plan.	No.
Early decelerations	Head compression — most common in active labor / second stage	None directly	None — benign	Document; continue monitoring; reassure client.	No.
Sinusoidal pattern	Severe fetal anemia, hemorrhage (fetal-maternal), Rh isoimmunization	Possible abruption, vasa previa	Hemorrhage, severe anemia, demise	Category III — full intrauterine resuscitation, prepare for emergency cesarean.	Yes — emergency.

§ 04

Red-Flag *Cues*

When you see any of these on a strip or in nurse's notes, your hands should already be moving.

IMMEDIATE ASSESSMENT

Sudden drop in FHR below 110 bpm • Loss of variability paired with decels of any type • Tachycardia > 160 with maternal fever • Sinusoidal pattern • Any abrupt change after AROM, epidural, oxytocin titration, or position change.

REPOSITION FIRST (LEFT LATERAL)

Variable decelerations (suggest cord compression) • New-onset bradycardia in a client lying supine • Bradycardia after epidural placement (positional + hypotension) • Maternal complaint of dizziness with FHR change.

IV FLUID BOLUS (IF ORDERED/POLICY)

Maternal hypotension after epidural with FHR change • Maternal tachycardia from dehydration • Category II tracing with decreased variability — bolus is part of standard intrauterine resuscitation.

STOP OXYTOCIN

Tachysystole (> 5 contractions in 10 min averaged over 30 min) • Recurrent late decelerations • Recurrent severe variable decelerations • Prolonged deceleration > 2 min • Any Category III tracing.

OXYGEN — ONLY WHEN INDICATED BY POLICY/FETAL STATUS

Recurrent late or prolonged decelerations with Category II/III tracing • Persistent absent/minimal variability with concerning pattern. Routine O₂ for "reassurance" is no longer evidence-based — use it for fetal indication, not maternal anxiety.

PROVIDER NOTIFICATION / RAPID RESPONSE

Category III tracing • Sinusoidal pattern • Prolonged decel > 2 min not resolving with resuscitation • Suspected cord prolapse • Maternal hemodynamic instability paired with FHR change • Tachysystole not resolving with oxytocin off.

§ 05

Medication *Safety*

Even on a "monitoring" day, three drug classes intersect with what you see on the strip. Know them.

Oxytocin (Pitocin)

Domain	Detail
Why given	Induction or augmentation of labor — produces uterine contractions.
Assess before	Baseline FHR, contraction pattern, cervical exam, maternal vitals, fluid status, Bishop score.
Most dangerous adverse effect	Tachysystole leading to uteroplacental insufficiency, fetal hypoxia, uterine rupture. Water intoxication possible with high-dose long infusions.
Hold / notify parameters	Stop infusion for: tachysystole (>5 contractions/10 min), recurrent late decels, prolonged decels, FHR <110, absent variability with decels, abnormal pattern.
Antidote / reversal	No direct antidote. Reversal = stop infusion (short half-life ~3–5 min), reposition, IV fluids, O ₂ if indicated. Terbutaline 0.25 mg SC may be ordered for refractory tachysystole.

Nursing monitoring	Continuous EFM, contraction frequency/duration/intensity, resting tone, maternal vitals, I&O, fundal palpation.
Client teaching	Expect stronger, more regular contractions; report increased pain or no rest between contractions.
Common NCLEX trap	Increasing oxytocin during a Category II tracing because contractions seem inadequate. <i>Strip first, dose second.</i>

Terbutaline (Brethine)

Domain	Detail
Why given	Beta-2 agonist — used for <i>uterine relaxation</i> in tachysystole or as a short-term tocolytic for fetal resuscitation.
Assess before	Maternal heart rate, BP, blood glucose, FHR.
Most dangerous adverse effect	Maternal tachycardia (>120), arrhythmias, pulmonary edema, hyperglycemia. <i>Fetal tachycardia is expected.</i>
Hold / notify	Hold if maternal HR >120, BP unstable, chest pain, SOB. Notify provider for any cardiac symptom.
Antidote / reversal	Beta-blocker (propranolol) for severe tachycardia per provider; supportive care.
Monitoring	Maternal HR, BP, lungs, glucose; FHR.
NCLEX trap	Confusing terbutaline tachycardia in the fetus with hypoxia. The drug crosses the placenta — expect a brief rise in baseline.

IV Lactated Ringer's / Normal Saline (Maternal Fluid Bolus)

Domain	Detail
Why given	Increase maternal intravascular volume → improve uteroplacental perfusion → improve fetal oxygenation. Standard part of intrauterine resuscitation.
Assess before	IV patency, breath sounds, BP, edema, history of cardiac/renal disease, preeclampsia (fluid restriction risk).
Most dangerous adverse effect	Pulmonary edema (especially in preeclampsia, cardiac disease, after magnesium sulfate).
Hold / notify	Crackles in lungs, SpO ₂ drop, dyspnea, severe-range BP, oliguria worsening.
Antidote / reversal	Slow/stop infusion; furosemide if pulmonary edema (per provider).

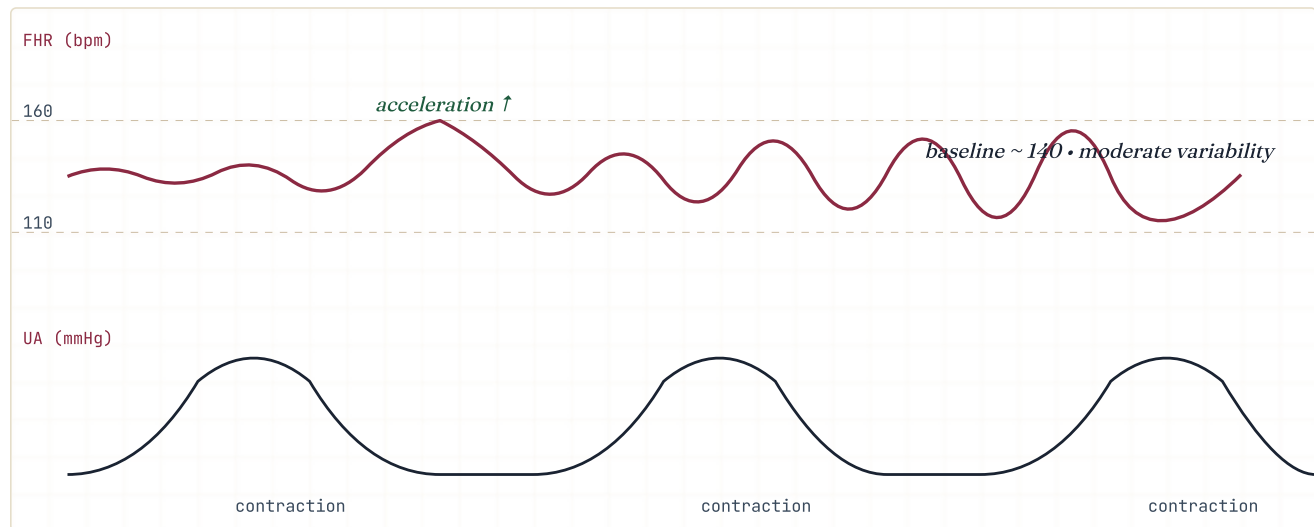
Monitoring	Lungs every 15–30 min during bolus; SpO ₂ ; urine output; FHR response.
NCLEX trap	Giving a full liter bolus to a client with severe preeclampsia "because the strip looks bad." Bolus carefully; lungs first.

§ 06

Fetal Monitoring *Deep Dive*

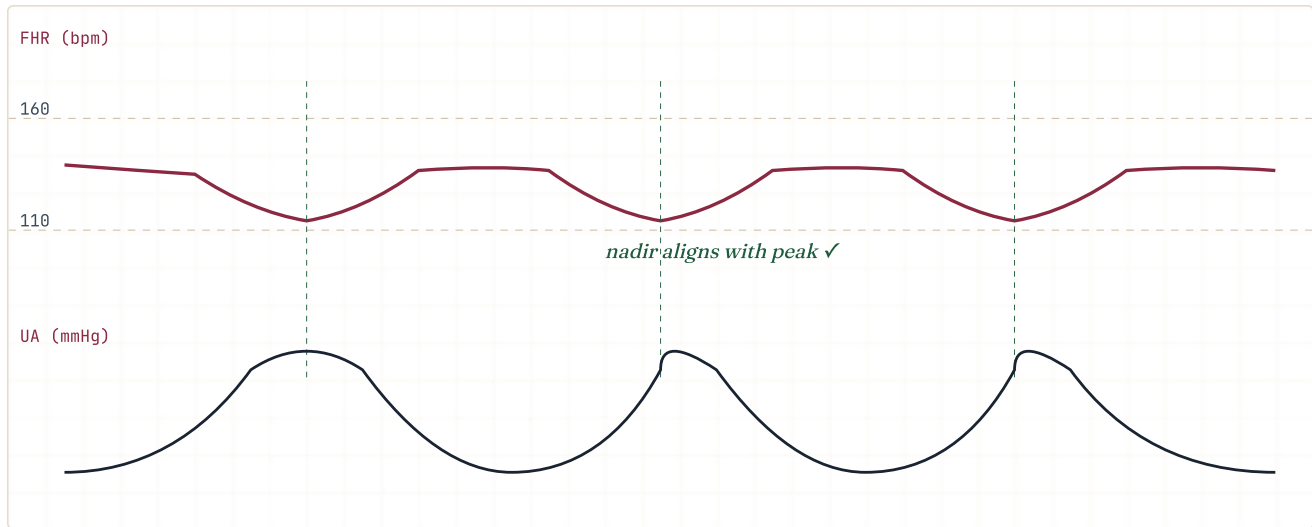
Read every strip in this order: baseline → variability → accels → decels → contractions → category. The order matters because each finding only makes sense against the one before it.

► SCHEMATIC — CATEGORY I (REASSURING) TRACING



Read above: baseline ≈ 140 bpm, moderate variability, an acceleration at minute 4, no decelerations. This is a textbook **Category I** tracing. Action: document and continue.

► SCHEMATIC — EARLY DECELERATION (BENIGN)



Each FHR dip **begins, bottoms out, and recovers in lockstep with the contraction**. The nadir falls at the peak. This is head compression — physiologic and benign. **Document only.**

VEAL CHOP MINE — The Mnemonic, Decoded

PATTERN → CAUSE

- V** Variable decel → Cord compression
- E** Early decel → Head compression
- A** Acceleration → Okay (oxygenated)
- L** Late decel → Placental insufficiency

MINE — NURSING RESPONSE

- M** Move (reposition) — variable
- I** Identify / document — early
- N** No action needed — accels
- E** Execute interventions (LION) — late

Categorizing the Strip — The Three-Tier System

Category	Findings	Interpretation & Action
Category I Normal	Baseline 110–160, moderate variability, no late or variable decels. Accels and early decels may or may not be present.	Reassuring. Continue routine monitoring; document at intervals.
Category II Indeterminate	Anything that is not Category I or III. Most strips at some point. Tachycardia, minimal variability, recurrent variables, prolonged decel <10 min, late decels with moderate variability.	Requires evaluation. Intrauterine resuscitation, identify cause, reassess. Most NGN questions live here.
Category III Abnormal	Absent variability <i>plus</i> any of: recurrent late decels, recurrent variable decels, bradycardia. Or a sinusoidal pattern.	Emergency. Full intrauterine resuscitation; prepare for expedited delivery (operative vaginal or cesarean).

Lay a vertical line through the peak of the contraction. **Early:** the nadir of the FHR drop sits *on* that line. **Late:** the nadir sits *after* that line — the FHR keeps falling while the contraction is already easing off. Late is the dangerous one.

§ 07

Advanced NGN *Practice*

Eleven mixed item types. Reveal the rationale after you commit to your answer — not before.

Q1 MULTIPLE CHOICE RECOGNIZE CUES

A nurse is reviewing the electronic fetal monitoring strip of a client at 39 weeks gestation in active labor. The baseline is 140 bpm with fluctuations between 132 and 152 bpm. There are two 20-second accelerations of 18 bpm above baseline in the past 10 minutes, and no decelerations. Contractions are every 3 minutes lasting 60 seconds. Which interpretation is most accurate?

- A. Category I tracing; continue routine monitoring
- B. Category II tracing; reposition and increase IV fluids
- C. Category III tracing; prepare for emergency cesarean
- D. Indeterminate tracing requiring fetal scalp stimulation

► ► REVEAL RATIONALE

Q2 SATA ANALYZE CUES

A nurse is monitoring a laboring client. The baseline FHR has been 175 bpm for the past 25 minutes. Select all findings that should be assessed as possible causes of the tachycardia.

- ☐ Maternal temperature
- ☐ Maternal blood pressure
- ☐ Recent terbutaline administration
- ☐ Maternal hydration status
- ☐ Fetal sleep cycle
- ☐ Color and odor of amniotic fluid
- ☐ Maternal anxiety and pain level

► ► REVEAL RATIONALE

Q3

MATRIX / GRID

PRIORITIZE HYPOTHESES

For each FHR finding below, indicate whether the nurse should **Continue monitoring**, **Intervene at bedside**, or **Notify the provider immediately**.

Finding	Continue monitoring	Intervene at bedside	Notify provider immediately
Baseline 145, moderate variability, accels present	✓		
Early decelerations mirroring contractions, baseline 138	✓		
Baseline 170 × 30 min, minimal variability, maternal temp 100.8°F			✓
Sudden FHR drop to 90 lasting 4 minutes			✓
Variability decreased after 5 mg IV morphine, baseline 142		✓	
Absent variability with recurrent late decelerations			✓

► ► REVEAL RATIONALE

Q4

BOW-TIE

GENERATE SOLUTIONS

A multiparous client in active labor is being induced with oxytocin. The strip shows baseline 142, moderate variability, no decels, and a contraction pattern of every 90 seconds lasting 70 seconds with palpable resting tone between. Complete the bow-tie.

TWO ACTIONS TO TAKE

1. Discontinue the oxytocin infusion
2. Reposition client to left lateral and notify provider

*Tachysystole
without
fetal decompensation*

TWO PARAMETERS TO MONITOR

1. FHR baseline & variability for next 30 minutes
2. Contraction frequency, duration, and resting tone

► ► REVEAL RATIONALE

Q5 ORDERED RESPONSE TAKE ACTION

A nurse notices the FHR has dropped to 95 bpm and remained there for 90 seconds. Place the following actions in correct order from **first** to **last**.

1. Reposition the client to left lateral
2. Stop the oxytocin infusion
3. Administer IV fluid bolus per protocol
4. Apply oxygen 10 L via non-rebreather mask
5. Perform a sterile vaginal exam to rule out cord prolapse
6. Notify the provider

► ► REVEAL CORRECT ORDER & RATIONALE

Q6 DROP-DOWN / CLOZE ANALYZE CUES

Complete the statement:

A baseline FHR of 152 bpm with fluctuations between 148 and 158 bpm demonstrates [**minimal** | **moderate** | **marked**] variability. The presence of this finding suggests the fetal [**heart** | **central nervous system** | **adrenal gland**] is intact and the fetus is [**hypoxic** | **well-oxygenated** | **acidotic**].

► ► REVEAL ANSWER & RATIONALE

Q7 PRIORITIZATION PRIORITIZE HYPOTHESES

A nurse is caring for four laboring clients. Which client should the nurse assess **first**?

- A. G1P0 at 6 cm dilation with early decelerations and moderate variability
- B. G2P1 at 9 cm dilation with FHR 168 and minimal variability for 35 minutes
- C. G3P2 at 4 cm dilation reporting "the contractions feel different now"
- D. G1P0 at 5 cm with a spontaneous acceleration just charted by the prior nurse

► ► REVEAL RATIONALE

Q8 CASE-STUDY STYLE RECOGNIZE + ANALYZE

Nurse's note 0930: "G2P1 at 40 wk 2 d, 7 cm/100%/0 station, ROM clear at 0815, oxytocin running at 8 mU/min. FHR baseline 145, moderate variability, accelerations present, no decels. Contractions q3min × 70 sec, moderate intensity, resting tone soft. Client requesting epidural."

Which statement by the nurse demonstrates correct interpretation of the strip?

- A. "I will stop the oxytocin before the epidural is placed."
- B. "The strip is reassuring, so I will administer the IV fluid bolus and call anesthesia."
- C. "I will place the client supine for the epidural to optimize spread of the medication."
- D. "Because the fetus has accelerations, I will hold the next vaginal exam for two hours."

► ► REVEAL RATIONALE

Q9 MEDICATION SAFETY TAKE ACTION

A nurse is preparing to titrate oxytocin from 6 mU/min to 8 mU/min for a client at 4 cm dilation. The FHR is 168, variability is minimal, no decelerations are noted, and contractions are every 4 minutes lasting 50 seconds. The most appropriate nursing action is:

- A. Increase oxytocin to 8 mU/min as ordered
- B. Hold the oxytocin increase and notify the provider
- C. Decrease oxytocin to 4 mU/min and recheck in 15 minutes
- D. Increase oxytocin to 8 mU/min and administer 1 L LR bolus

► ► REVEAL RATIONALE

Q10 STRIP INTERPRETATION RECOGNIZE CUES

The nurse observes recurrent gradual FHR decreases that begin with the onset of each contraction, reach their lowest point at the peak of the contraction, and return to baseline as the contraction ends. Baseline is 142 with moderate variability. The nurse identifies this pattern as:

- A. Late decelerations from uteroplacental insufficiency
- B. Variable decelerations from cord compression
- C. Early decelerations from fetal head compression
- D. Prolonged decelerations requiring emergency response

► ► REVEAL RATIONALE

Q11 **EMERGENCY ACTION** **TAKE ACTION + EVALUATE**

After repositioning a client to left lateral and starting an IV fluid bolus for a Category II tracing with minimal variability, the nurse reassesses 10 minutes later. The new findings show baseline 142, *moderate* variability returned, no decelerations, accelerations present. Which conclusion is most appropriate?

- A. The intervention failed; prepare for cesarean delivery
- B. The intervention was effective; document and continue current plan
- C. The tracing change is unrelated to the intervention; notify the provider for new orders
- D. The improvement is transient; stop the IV fluids to test fetal reserve

► ► REVEAL RATIONALE

§ 08

Unfolding NGN *Case Study*

Read every piece of data before answering. The cues build on each other across the case.

Client: Maria L., G2P1, 39 weeks 4 days

Admitted to L&D at 0700 for spontaneous labor. Prenatal care complete. GBS-positive. BMI 32. No other significant history.

0800 - NURSE'S NOTE

► 0800

Client arrived ambulatory in active labor. Cervical exam: 5 cm / 90% / -1 station. Contractions every 3 min × 60 sec, moderate intensity. SROM at 0745, clear fluid, no odor. Maternal vitals stable. FHR baseline 140, moderate variability, accels present, no decels. IV LR at 125 mL/hr started. Penicillin G 5 million units IV started for GBS prophylaxis. Pain 6/10; epidural anesthesia consultation requested.

0800 - MATERNAL VITALS

BP 122/74	HR 92	RR 18	Temp 98.6°F
SpO ₂ 99%	Pain 6/10	FHR 140 bpm	Cervix 5/90/-1

0930 - UPDATED NURSE'S NOTE

► 0930 (90 min later, post-epidural)

Epidural placed at 0845, level T10, working well. Pain now 1/10. Position: semi-Fowler with right hip wedge. FHR over the past 30 min: baseline 155, variability minimal, two episodes of FHR drop to 110

lasting 35 sec, both with onset after the contraction peak and gradual recovery to baseline well after contraction ends. Contractions every 2.5 min × 75 sec. Maternal BP 96/52, HR 102. Client reports "feeling a little lightheaded."

0930 — MATERNAL VITALS

BP 96/52 ↓	HR 102 ↑	RR 18	Temp 98.7°F
SpO ₂ 98%	Pain 1/10	FHR 155, min variability	Contractions q 2.5 min × 75 s

0930 — ACTIVE ORDERS

- Oxytocin 4 mU/min IV, titrate q30 min per protocol to adequate labor
- LR at 125 mL/hr; bolus 500–1000 mL IV LR for maternal hypotension
- Penicillin G 2.5 million units IV q4h × GBS
- Continuous EFM
- Notify provider for non-reassuring tracing, BP < 90/60, temp ≥100.4°F, or change in clinical status

Case Question 1 — Recognize Cues

Highlight (select all that apply) the findings at 0930 that require immediate attention:

- BP 96/52
- HR 102
- FHR baseline of 155
- Minimal variability
- FHR drops with nadir after the contraction peak
- Contractions every 2.5 minutes lasting 75 seconds
- Maternal report of lightheadedness
- Temperature 98.7°F

► ► REVEAL ANSWER

Case Question 2 — Analyze Cues

Drag and drop the most likely cause of the FHR pattern. The client's recurrent late decelerations are most likely caused by:

1. Cord compression secondary to oligohydramnios
2. Maternal hypotension secondary to epidural anesthesia, producing uteroplacental insufficiency
3. Fetal head compression during second-stage descent
4. Maternal sepsis from undetected chorioamnionitis

► ► REVEAL ANSWER

Case Question 3 — Prioritize Hypotheses

Rank the hypotheses from **highest** to **lowest** priority:

1. Uteroplacental insufficiency from maternal hypotension
2. Tachysystole from oxytocin contributing to perfusion problem
3. Possible fetal acidosis if pattern continues
4. Risk for falls from maternal lightheadedness

► ► REVEAL PRIORITY ORDER

Case Question 4 — Generate Solutions

Which interventions are appropriate for this client at 0930? (Select all that apply.)

- Reposition to left lateral with hip wedge removed
- Discontinue oxytocin infusion
- Increase IV LR with 500 mL bolus
- Administer oxygen 10 L via non-rebreather mask
- Notify the obstetric provider
- Perform sterile vaginal exam to assess descent
- Increase oxytocin to strengthen contractions
- Prepare ephedrine or phenylephrine per anesthesia order for hypotension

► ► REVEAL ANSWER

Case Question 5 — Take Action

Place the actions in correct chronological order, from first to last:

1. Reposition to left lateral
2. Stop the oxytocin infusion
3. Open IV LR wide for 500 mL bolus
4. Apply oxygen 10 L NRB
5. Page obstetric provider and anesthesia
6. Document findings, interventions, and FHR response

► ► REVEAL ORDER

Case Question 6 — Evaluate Outcomes

Ten minutes after the interventions, the nurse reassesses. Which findings indicate the interventions were **effective**? (Select all that apply.)

- FHR baseline now 145 with moderate variability
- Maternal BP 116/72, HR 88
- Resolution of late decelerations
- Contractions every 3 minutes × 60 seconds
- Maternal SpO₂ 96%
- Client no longer reports lightheadedness
- Two spontaneous accelerations noted
- Cervical change to 6 cm

► ► REVEAL ANSWER

§ 09

What Should the Nurse *Do First*?

Five prioritization micro-cases. The first action is rarely the dramatic one — it's the action that buys you the most safety in the next 30 seconds.

01 A laboring client has just had artificial rupture of membranes. Fluid is clear. Immediately afterward, the FHR drops to 80 bpm.

First action: Perform a sterile vaginal exam to assess for **cord prolapse**. AROM + sudden FHR drop = prolapse until proven otherwise. If the cord is felt, elevate the presenting part off the cord with your gloved hand and do not remove it until cesarean.

02 A client at 7 cm dilation has been receiving oxytocin at 10 mU/min. Contractions are now every 90 seconds with no rest between, baseline FHR 152, variability moderate, no decels.

First action: Discontinue the oxytocin infusion. Tachysystole is identified by contraction pattern — the fetus is currently compensating, but uteroplacental perfusion is at risk. Remove the cause first; reposition and IV bolus follow.

03 A post-epidural client is now hypotensive (BP 84/48). FHR has dropped from 145 to 105 over the past 3 minutes.

First action: Reposition to left lateral. Aortocaval compression and post-epidural sympathetic blockade together cause maternal hypotension and fetal bradycardia. Left lateral is the fastest fix — done in 5 seconds. IV bolus and vasopressor follow.

04 A nurse notices the FHR baseline has shifted from 140 to 170 and stayed there for the past 30 minutes. Mother's temperature has just been charted at 100.6°F.

First action: Assess for additional signs of chorioamnionitis — uterine tenderness, foul-smelling amniotic fluid, maternal tachycardia. Then notify the provider. Antibiotics and cooling measures will follow.

05 A G3P2 client at 9 cm reports "I feel like I have to push" but the bag of waters is intact and the strip shows variable decels with each contraction.

First action: Reposition (hands-and-knees or side-to-side) to relieve cord compression. The urge to push at 9 cm without rupture is common; do not encourage active pushing until full dilation. Reassess strip after reposition; the variables will likely improve.

§ 10

Stop, Hold, *or Escalate*

Five decision-points where the nurse's job is to know what to not do as much as what to do.

01 Oxytocin at 6 mU/min. Contractions every 2 minutes, lasting 95 seconds, with palpable resting tone (uterus does not fully relax between).

STOP the oxytocin. Tachysystole + no resting tone = uteroplacental compromise even if FHR currently normal. Pattern returns to normal in 3–5 minutes (short half-life). Restart at half the dose when contractions $\leq 5/10$ min.

02 Provider order: increase magnesium sulfate from 2 g/hr to 3 g/hr for severe preeclampsia. Most recent assessment: DTRs 1+, respirations 11/min.

HOLD the increase and notify the provider. Hyporeflexia + RR < 12 = early magnesium toxicity. Do not titrate up. Have calcium gluconate 1 g available at bedside as the antidote.

03 FHR drops to 75 bpm and stays for 4 minutes. Repositioning, IV bolus, and oxygen do not restore baseline.

ESCALATE — call rapid response / OB emergency team. A prolonged decel that does not respond to intrauterine resuscitation requires expedited delivery. Prepare for emergency cesarean.

04 A client with severe preeclampsia and a Category II tracing is hypotensive after epidural. Order says "bolus 1 L LR for hypotension."

HOLD or modify bolus and CALL provider. Severe preeclamptics are at very high risk of pulmonary edema. Do not give a full liter without listening to lungs and reassessing every 250 mL. Consider phenylephrine over a large bolus.

05 After AROM the nurse sees fluid is meconium-stained and FHR drops to 88 bpm.

ESCALATE — prepare for emergency birth and notify NICU/neonatal team. Meconium + bradycardia = high risk of fetal compromise and meconium aspiration. Set up neonatal resuscitation equipment now, including bulb suction and intubation supplies if institutional protocol requires.

§ 11

Common NCLEX *Traps*

The five mistakes that fail more candidates than any others on a fetal monitoring item.

01 Trap 1 — *Confusing early and late decelerations.*

Both are gradual. Both happen with contractions. The only reliable distinguisher is the timing of the nadir. **Early = nadir at the peak. Late = nadir after the peak.** When stems describe a decel "that begins after the contraction starts" — that is late.

02 Trap 2 — *Treating decreased variability after opioids as a Category III tracing.*

Morphine, fentanyl, and butorphanol all reduce variability briefly. If the rest of the strip is reassuring and the timing matches medication administration, the right answer is "continue monitoring" — not "prepare for cesarean."

03 Trap 3 — *Calling the provider before performing nursing actions.*

For a decel that the nurse can address with independent interventions (reposition, stop oxytocin, IV bolus, oxygen), do those first. If a colleague can call while you intervene, that is correct delegation. *The wrong NCLEX answer is "Page the physician first."*

04 Trap 4 — *Increasing oxytocin during a Category II tracing.*

Standing orders to "titrate to adequate labor" do not apply when the fetus is showing signs of distress. The RN holds the dose and notifies. *Hold first, then call.*

05 Trap 5 — *Forgetting to reassess the FHR immediately after rupture of membranes (AROM or SROM).*

The most common time for cord prolapse is in the seconds after rupture. The nurse always reassesses FHR immediately after rupture and again 5–10 minutes later. NGN cases love to test whether the student remembered this beat.

§ 12

End-of-Day *Quick Review*

Pocket-sized. Read this on a break before clinical.

Ten Must-Remember One-Liners

MEMORY LINES

- Baseline normal: 110–160 bpm.
- Baseline = 10-min average; exclude accels, decels, marked variability.
- Moderate variability (6–25 bpm) = fetal well-being.
- Accelerations confirm intact pH and oxygenation.
- Early decels mirror contractions — benign.

MEMORY LINES (CONTINUED)

- Late decel nadir is AFTER the peak.
- Variable decels = cord compression — reposition.
- Tachycardia > 160 × 10 min — think infection, dehydration, drugs.
- Sinusoidal = severe fetal anemia — emergency.
- Always recheck FHR immediately after ROM.

5 RED-FLAG FINDINGS

- Prolonged decel > 2 minutes
- Absent variability with recurrent decels
- Tachycardia + maternal fever
- Sinusoidal pattern
- Sudden FHR change after AROM or procedure

5 "NEVER DO THIS"

- Never put a laboring client supine
- Never increase oxytocin during Category II/III
- Never ignore minimal variability lasting > 60 min
- Never give methylergonovine to a hypertensive client
- Never delay reposition to "call first"

5 FETAL MONITORING CLUES

- "Mirror image of contraction" = early decel
- "Nadir after the peak" = late decel
- "V-shaped, abrupt drop" = variable decel
- "Range of 6–25 bpm" = moderate variability
- "Smooth, wave-like, no variability" = sinusoidal

5 MEDICATION SAFETY CLUES

- Stop oxytocin first for tachysystole
- Terbutaline → expect maternal tachycardia
- Magnesium → check DTRs, RR, urine output
- Bolus carefully in preeclampsia / cardiac disease
- Oxygen only for fetal indication, not anxiety

§ 13

Day 3 — *Infographic Summary*

Screenshot-ready. Everything Day 3 in one glance.

Fetal Monitoring Basics

DAY 03 / 16

① BASELINE FHR

NORMAL	110 – 160 bpm
TACHY	>160 × ≥10 min → fever, dehydration, drugs
BRADY	<110 × ≥10 min → hypoxia, hypotension
WINDOW	10-min average; exclude accels, decels, marked

② VARIABILITY

ABSENT	0 – danger
MINIMAL	≤5 – sleep, opioid, or hypoxia
MODERATE	6–25 – reassuring ✓
MARKED	>25 – acute stress

③ ACCELERATIONS

- Term: ↑15 bpm × ≥15 sec
- Preterm: ↑10 bpm × ≥10 sec
- → Confirm fetal well-being
- → No action needed

④ EARLY DECELERATIONS

- Gradual, symmetric ↓
- Mirror the contraction
- Nadir at the peak
- Cause: head compression
- → Benign – document only

VEAL CHOP MINE

V	Variable → Cord → Move
E	Early → Head → Identify
A	Accel → Okay → No action
L	Late → Placenta → Execute LION

LION RESUSCITATION

- Lateral position (left)
- IV fluids (bolus)
- Oxygen 10 L NRB (if indicated)
- Notify provider + stop oxytocin
- + Sterile vaginal exam (rule out prolapse)

CATEGORY TIERS

I	Normal – continue monitoring
II	Indeterminate – resuscitate & evaluate
III	Abnormal – emergency, expedite delivery

DON'T FORGET

- Re-check FHR *immediately* after ROM
- Never give O₂ "just because" – only for fetal indication
- Stop oxytocin BEFORE you call
- Reposition is always the 5-second first move
- Document last, never first

Today's clinical judgment question: "What finding is most dangerous for the mother or fetus, and what should the nurse do first?"

Next session: Day 4 — Fetal Monitoring Emergencies: Variable, Late, Prolonged Decelerations & Category II/III

Framework: 2026 NCLEX-RN® Test Plan • NCSBN Clinical Judgment Measurement Model. Study material for licensed candidate preparation; not a substitute for institution-specific policies.