DAY 10 / 16 — LABOR & DELIVERY NGN REVIEW

Obstetric Bleeding *Emergencies*

Placenta Previa · Placental Abruption · Uterine Rupture · Vasa Previa. The four diagnoses every NCLEX-RN candidate must distinguish in seconds — because the wrong move kills the mother, the fetus, or both. Today you build the clinical-judgment pattern recognition that turns a sea of cues into a single first action.

FRAMEWORK: 2026 NCLEX-RN TEST PLAN **MODEL:** NCSBN CLINICAL JUDGMENT MEASUREMENT MODEL

FOCUS: RECOGNIZE → ANALYZE → PRIORITIZE → ACT **DIFFICULTY:** APPLICATION / ANALYSIS

Today's Lesson Map

§ 01

High-Yield *Overview*

Obstetric hemorrhage is a leading cause of maternal death worldwide and a leading cause of perinatal death. The NGN tests your ability to **pattern-match four classic presentations**, anticipate physiologic deterioration, and pick the single action that protects the mother and fetus. Memorize the picture, not the textbook paragraph.

DIAGNOSIS 01

Placenta Previa

- Placenta implants over / near internal cervical os
- Classic: **painless, bright-red** vaginal bleeding, usually after 20 wks
- Soft, non-tender uterus
- Fetus usually stable until severe bleed
- Risk factors: prior C-section, multiparity, AMA, smoking, prior previa

> *Signature: **PAINLESS bright-red bleeding** + soft uterus + reassuring FHR (early). NO vaginal exam.*

DIAGNOSIS 02

Placental Abruption

- Premature separation of a normally implanted placenta
- Classic: **painful, dark-red** bleeding + rigid, board-like uterus
- May have **concealed** bleeding (bleeding behind placenta)
- Tachysystole / hypertonic uterus, frequent low-amplitude contractions
- Risk factors: HTN/preeclampsia, cocaine, trauma, smoking, PROM, prior abruption
- High risk for **DIC** and fetal demise

> *Signature: **PAINFUL dark bleeding** + rigid uterus + non-reassuring FHR + maternal shock disproportionate to visible blood loss.*

DIAGNOSIS 03

Uterine Rupture

- Tearing through the uterine wall — partial or complete
- Classic: **sudden, sharp, "tearing" abdominal pain**
- **Sudden loss of contractions** & loss of fetal station
- Fetal bradycardia or prolonged deceleration (often first sign)
- Palpable fetal parts through maternal abdomen, maternal shock
- Risk: prior C-section (TOLAC/VBAC), oxytocin tachysystole, grand multipara, trauma

> *Signature: VBAC client + sudden severe pain + **FHR bradycardia** + contractions stop + station rises. Surgical emergency.*

DIAGNOSIS 04

Vasa Previa

- Unprotected fetal vessels traverse the membranes near or over the internal os
- Classic: **painless bleeding at the moment of ROM** + sudden fetal compromise
- **Sinusoidal FHR pattern** or sudden bradycardia
- It is **fetal blood** — fetal exsanguination occurs in minutes
- Detected prenatally on ultrasound; plan scheduled C-section ≈ 34–36 wks

> *Signature: ROM → small bleed + **sudden fetal bradycardia or sinusoidal pattern**. Emergent C-section.*

⚠ THE ONE SENTENCE YOU CANNOT FORGET

Painless = Previa. Painful = Abruption. Pain + lost contractions + bradycardia in a VBAC client = Rupture. Bleeding the second the membranes rupture + sudden fetal bradycardia = Vasa Previa.

§ 02

10 Must-Know *Rules*

If a question asks "what is most important?" or "what is the priority?" — one of these rules is almost always the reason the correct answer is correct.

01 **NEVER perform a vaginal exam on a client with active or undiagnosed third-trimester bleeding** until placenta previa has been ruled out by ultrasound. A digital exam can perforate a previa and cause catastrophic hemorrhage.

02 **The amount of visible bleeding does NOT equal the actual blood loss** in abruption. A concealed abruption may show little external blood while the mother is going into shock. Always trend vital signs, fundal height, and pain.

03 **Painless bleeding = previa until proven otherwise. Painful bleeding + rigid uterus = abruption until proven otherwise.**

04 **A sudden loss of fetal station with loss of contractions and severe pain in a VBAC patient is uterine rupture until proven otherwise.** Prepare for emergent laparotomy.

05 **A sinusoidal FHR pattern is fetal anemia/hemorrhage until proven otherwise.** In labor with bleeding at ROM, think vasa previa and prepare for STAT C-section.

06 **Two large-bore IVs (16–18 gauge), type & crossmatch, CBC, coagulation studies (PT/PTT/INR/fibrinogen), and continuous EFM** are standard for any third-trimester bleed.

07 **Stop oxytocin immediately** with any sign of tachysystole, fetal distress, or abruption-like presentation. Oxytocin can worsen abruption and precipitate rupture.

08 **Position the bleeding client in lateral position** (left-lateral or modified Sims) to improve uteroplacental perfusion and prevent supine hypotension.

09 **Rh-negative clients with any antepartum bleeding need Rh immune globulin** (RhoGAM) within 72 hours, after a Kleihauer-Betke test if significant fetomaternal hemorrhage is suspected.

10 **DIC is a real and rapid risk in abruption, severe preeclampsia, and amniotic fluid embolism.** Watch for oozing from IV sites, bleeding gums, hematuria, falling fibrinogen (<200 mg/dL), and rising D-dimer.

§ 03

Maternal–Fetal *Safety Table*

For each finding, ask: what does this mean, who is in danger, what do I do *first*, and when do I escalate?

FINDING	WHAT IT MEANS	MOTHER RISK	FETAL / NEWBORN RISK	PRIORITY NURSING ACTION	NOTIFY / ACTIVATE
Painless bright-red bleeding, 3rd trimester	Placenta previa likely	Hemorrhage, shock, hysterectomy	Hypoxia from maternal hypotension, preterm birth	Lateral position, large-bore IV ×2, NS bolus per order, continuous EFM, weigh pads, **NO vaginal exam**, prepare for C-section	Notify provider immediately; activate OB hemorrhage protocol if heavy
Painful dark-red bleeding + rigid uterus	Placental abruption	Hemorrhage, DIC, shock, AKI, hysterectomy	Hypoxia, fetal demise, preterm birth, neuro injury	Lateral position, O_2 per policy for non-reassuring FHR, IV fluids, draw CBC/coags/fibrinogen/type & cross, continuous EFM, prepare for emergent C-section	Provider STAT; activate massive transfusion / OB hemorrhage protocol; alert OR & neonatal team
Sudden severe abdominal "tearing" pain + loss of contractions + FHR bradycardia (esp. VBAC)	Uterine rupture	Massive hemorrhage, hysterectomy, death	Hypoxia → fetal demise within minutes	STOP OXYTOCIN, large-bore IV ×2, lateral position, O_2 10 L NRB per policy, type & cross 4 units PRBCs, prepare for emergent laparotomy/C-section	Rapid response / OB emergency team, OR, anesthesia, neonatal team — all STAT
Bleeding immediately after ROM + sudden fetal bradycardia or sinusoidal pattern	Vasa previa with ruptured vessel	Generally minimal maternal blood loss (it's fetal blood)	Rapid fetal exsanguination — **death in minutes**	Call for emergent C-section, IV fluids, lateral or knee-chest position, continuous EFM, prepare neonatal resuscitation team and O-negative blood	OB emergency team STAT; neonatal team STAT; prepare OR within minutes
Tachysystole (>5 contractions/10 min averaged over 30 min)	Excessive uterine activity; placental perfusion compromised	Uterine rupture, abruption	Fetal hypoxia, acidosis	**Stop oxytocin**, lateral reposition, IV fluid bolus, assess FHR, consider terbutaline per order	Notify provider if FHR Cat II/III or persistent tachysystole after intrauterine resuscitation

FINDING	WHAT IT MEANS	MOTHER RISK	FETAL / NEWBORN RISK	PRIORITY NURSING ACTION	NOTIFY / ACTIVATE
Oozing from IV sites, bleeding gums, hematuria	Developing DIC	Hemorrhagic shock, multi-organ failure, death	Hypoxia, demise	Draw STAT coags + fibrinogen + platelets + d-dimer; prepare blood products (PRBC, FFP, platelets, cryoprecipitate); monitor labs & bleeding	Provider + OB hemorrhage / MTP activation
BP 80/50, HR 128, pale & diaphoretic	Hypovolemic shock	Cardiovascular collapse, death	Hypoxia, demise	Trendelenburg or lateral, O_2 per policy, NS/LR wide-open through large-bore IVs ×2, draw labs & cross-match, monitor urine output	Rapid response / OB code; OR; anesthesia; blood bank
Late decelerations + bleeding	Uteroplacental insufficiency from blood loss / abruption	Hypoxia → shock	Hypoxia / acidosis	Intrauterine resuscitation: stop oxytocin, lateral, IV bolus, O_2 per policy, prepare for delivery	Provider STAT; OR & neonatal team on standby
Sinusoidal FHR pattern	Fetal anemia (vasa previa, severe abruption, fetomaternal hemorrhage, Rh disease)	Depends on cause	Imminent demise	Prepare emergent C-section, IV access, neonatal team, O-negative blood for newborn	OB emergency team STAT; neonatal resuscitation team STAT

§ 04

Red-Flag *Cues*

These cues should immediately raise the priority hypothesis. Anchor each to one of the four diagnoses, then think first action.

IMMEDIATE ASSESSMENT REQUIRED

- Any third-trimester bleeding — quantify, characterize (color, amount, painless vs painful), and assess fetal status before doing anything else.
- Rigid, board-like, or exquisitely tender uterus.
- FHR < 110 bpm sustained > 10 minutes (bradycardia).
- Loss of palpable contractions in a previously laboring client.
- Sudden change in fetal station (head feels higher than before).
- Palpable fetal parts through the maternal abdomen.
- Sinusoidal FHR pattern (smooth wave-like undulations 3–5/min, no variability).

REPOSITION / IV FLUID BOLUS / O_2 PER POLICY

- Maternal hypotension (SBP < 90 or > 20 mmHg drop) → left lateral, IV bolus, recheck.
- Late or prolonged decelerations on EFM in a bleeding client.
- Tachysystole on oxytocin (> 5 contractions/10 min averaged over 30 min).
- Maternal tachycardia > 110 (early shock indicator) with any bleeding.
- Category II tracing with bleeding — initiate intrauterine resuscitation.

STOP OXYTOCIN IMMEDIATELY

- Tachysystole with or without Category II/III tracing.
- Any suspicion of abruption (worsening pain, dark bleeding, hypertonic uterus).
- Any suspicion of uterine rupture (loss of contractions, sudden pain, FHR bradycardia, lost station).
- Category III tracing (absent variability + bradycardia, recurrent late decels, or sinusoidal).

PROVIDER NOTIFICATION / RAPID RESPONSE / EMERGENCY BIRTH PREP

- Heavy or saturating bleeding (≥ 1 saturated pad/hour, or visible pooling).
- Maternal vital signs consistent with shock (SBP < 90, HR > 120, narrow pulse pressure, cool/clammy skin, altered mental status).
- Category III tracing not resolving with intrauterine resuscitation.

- Any suspicion of vasa previa, rupture, severe abruption, or complete previa with active bleeding.
- Signs of DIC: oozing IV sites, hematuria, petechiae, abnormal coags.

OXYGEN — USE JUDICIOUSLY

Per current AWHONN / ACOG guidance, routine maternal oxygen is no longer first-line for Category II tracings. **Apply oxygen 10 L/min via non-rebreather only when fetal status is non-reassuring (Category II/III) and other intrauterine resuscitation steps are insufficient, or per facility policy.** First-line interventions remain: stop oxytocin, lateral reposition, IV fluid bolus, identify reversible causes.

§ 05

Medication *Safety*

Postpartum hemorrhage uterotonics, antifibrinolytics, blood products, and Rh prophylaxis. Know the indications, the contraindications, and the trap NCLEX writes.

MED	WHY GIVEN	ASSESS BEFORE	MOST DANGEROUS AE	HOLD / NOTIFY IF	ANTIDOTE / REVERSAL
Oxytocin (Pitocin)	Induction/augmentation; postpartum hemorrhage from atony (1st-line uterotonic)	FHR baseline + variability, contraction pattern, BP, prior C-section status	Uterine tachysystole → rupture, abruption, fetal distress; water intoxication with prolonged high doses	Tachysystole, Category II/III FHR, abruption signs, suspected rupture	None — stop infusion; consider terbutaline 0.25 mg SC per order to relax uterus
Methylergonovine (Methergine)	Postpartum hemorrhage from atony (2nd-line)	**Blood pressure** — must not be elevated	Severe hypertension, stroke, MI	**HTN, preeclampsia, eclampsia, CAD** — do NOT give	Supportive; treat HTN crisis if it occurs
Carboprost (Hemabate)	Postpartum hemorrhage from atony (3rd-line)	Lung history — **contraindicated in asthma**	Bronchospasm, severe diarrhea, hypertension	**Asthma**, active cardiac/renal/hepatic disease	Supportive; bronchodilator for spasm
Misoprostol (Cytotec)	Cervical ripening; PPH (off-label uterotonic, often rectal/sublingual)	Pregnancy status, current gestation, FHR	Tachysystole, fetal distress, uterine rupture (esp. with prior C-section)	**Prior C-section** (rupture risk); tachysystole; Cat III tracing	None — stop dose; terbutaline if rupture risk
Tranexamic Acid (TXA)	PPH adjunct — antifibrinolytic given within 3 hr of birth	Renal function; thromboembolism history	Thrombosis (DVT/PE, stroke)	Active intravascular clotting; severe renal impairment without dose adjustment	Supportive; treat clot per protocol

MED	WHY GIVEN	ASSESS BEFORE	MOST DANGEROUS AE	HOLD / NOTIFY IF	ANTIDOTE / REVERSAL
Rh Immune Globulin (RhoGAM)	Prevent maternal sensitization in Rh-negative clients exposed to Rh-positive fetal blood (any bleeding event, after birth, after amnio, trauma)	Maternal Rh-negative status; indirect Coombs (negative confirms candidate); Kleihauer-Betke if large bleed	Generally well-tolerated; rare anaphylaxis	Already sensitized (positive antibody screen) — give per provider	None
Magnesium Sulfate	Seizure prophylaxis in preeclampsia (note: preeclampsia is a risk factor for abruption)	BP, RR, DTRs, urine output, baseline mag if repeat dosing	Magnesium toxicity → respiratory depression, cardiac arrest	RR < 12, absent DTRs, urine < 30 mL/hr, mag > 7–9 mEq/L	**Calcium gluconate 1 g IV**
Terbutaline	Tocolytic for tachysystole with non-reassuring FHR; relax uterus before emergent C-section	HR, BP, FHR, blood glucose	Maternal tachycardia, pulmonary edema, hyperglycemia, hypokalemia	Maternal HR > 120, chest pain, dyspnea	Discontinue; supportive (beta-blocker rarely needed)

§ 06

Fetal *Monitoring* — Bleeding Edition

In a bleeding client, the fetus tells you what's happening before the mother's vital signs do. Read the strip in this order: **baseline → variability → accelerations → decelerations → contractions → category.**

STRIP ELEMENT	EXPECTED / NORMAL	CONCERNING FINDING IN A BLEEDING CLIENT	LIKELY PATHOLOGY
Baseline	110–160 bpm	Tachycardia > 160 (early hypoxia, maternal fever, hypovolemia); bradycardia < 110 sustained	Abruption, fetal hypoxia, vasa previa (bradycardia), maternal shock
Variability	Moderate (6–25 bpm)	Minimal or absent variability — fetus is decompensating	Hypoxia/acidosis from abruption, rupture, severe maternal hypotension
Accelerations	Present, reassuring	Absent — fetus may be hypoxic or sleeping; correlate with rest of strip	Hypoxia (with other features); benign if isolated
Early decelerations	Mirror contractions — benign, head compression	Not concerning by themselves	None — benign
Variable decelerations	Abrupt drop ≥ 15 bpm, recovery within 2 min	Repetitive / deep / late-returning — cord compromise	Cord prolapse, oligohydramnios, abruption
Late decelerations	Should not be present	Any recurrent lates — uteroplacental insufficiency	Abruption, maternal shock, severe preeclampsia, tachysystole
Prolonged deceleration	None	FHR drop ≥ 15 bpm lasting 2–10 minutes	Cord prolapse, abruption, rupture, maternal hypotension, vasa previa
Sinusoidal pattern	Never normal	Smooth wave-like undulations 3–5/min, no variability, lasting ≥ 20 min	**Fetal anemia — vasa previa, severe abruption, fetomaternal hemorrhage, Rh disease**
Contractions	≤ 5 in 10 min averaged over 30 min; resting tone soft	Tachysystole, hypertonic uterus, "board-like" abdomen, no relaxation between contractions	Abruption (hypertonic), tachysystole, rupture (then contractions stop)

Category Interpretation & Priority Action

CATEGORY I — NORMAL

Baseline 110–160, moderate variability, no late or variable decels, accelerations present or absent. **Action:** continue routine care; reassess.

CATEGORY II — INDETERMINATE (MOST STRIPS)

Anything that isn't I or III: minimal variability, recurrent variables, tachycardia without other findings, prolonged decels < 10 min, etc. **Action — Intrauterine resuscitation:** stop oxytocin, lateral reposition, IV fluid bolus, identify cause (vaginal exam if no previa, BP, contraction pattern), oxygen per policy if non-reassuring, notify provider, prepare for further intervention.

CATEGORY III — ABNORMAL — EMERGENCY

Absent variability + recurrent lates, recurrent variables, or bradycardia; **OR sinusoidal pattern. Action:** intrauterine resuscitation + **immediate provider notification + prepare for emergent delivery** (operative vaginal or C-section). Activate OR & neonatal team.

§ 07

10 Advanced NGN *Practice Questions*

Mixed item types. Each is mapped to a clinical-judgment step. Read the rationale even when you got it right — the NCLEX trap is half the lesson.

QUESTION 01

MULTIPLE CHOICE

A 32-week pregnant client arrives at L&D triage reporting "bright red blood when I went to the bathroom — there's no pain at all." Vital signs: BP 118/72, HR 92, RR 18, T 98.6°F (37°C). Which action does the nurse take first?

A. Perform a sterile vaginal exam to assess cervical dilation.

B. **Place the client on continuous external fetal monitoring and obtain IV access.** ✓ CORRECT

C. Insert an indwelling urinary catheter and obtain a urine specimen.

D. Administer betamethasone 12 mg IM.

WHY B IS CORRECT

Painless, bright-red, third-trimester bleeding = suspected placenta previa until ultrasound confirms placental position. **NEVER perform a vaginal exam** until previa is ruled out — a digital exam can cause catastrophic hemorrhage. The nurse first establishes fetal and maternal monitoring, IV access, and labs (CBC, type & cross, coags).

A: Contraindicated in undiagnosed third-trimester bleeding. **C:** Not the first priority; bleeding evaluation comes first. **D:** May ultimately be ordered, but not before stabilization and assessment.

NCLEX trap: jumping to interventions before completing the assessment phase.

CJMM: Take Action

QUESTION 02

SELECT ALL THAT APPLY

A 36-week pregnant client with chronic hypertension presents with sudden onset of severe abdominal pain and dark-red vaginal bleeding. The uterus is rigid and tender. Which findings would the nurse expect to support a diagnosis of placental abruption? *Select all that apply.*

A. **Frequent low-amplitude contractions with elevated resting tone** ✓ CORRECT

B. **Category II or III FHR tracing with late decelerations** ✓ CORRECT

C. **Maternal tachycardia and falling blood pressure** ✓ CORRECT

D. Soft, non-tender uterus

E. Falling fibrinogen and rising D-dimer ✓ CORRECT

F. Concealed bleeding with shock disproportionate to visible blood loss ✓ CORRECT

G. Sinusoidal FHR pattern at the moment of ROM

WHY A, B, C, E, F ARE CORRECT

Classic abruption: **hypertonic uterus + painful dark bleeding + Category II/III tracing + maternal shock**. Concealed bleeding behind the placenta makes the external blood loss look small relative to the maternal compromise. DIC develops in ~20% of abruption cases — falling fibrinogen (< 200 mg/dL) and rising D-dimer are key.

D: Soft, non-tender uterus suggests previa, not abruption. **G:** Sinusoidal pattern at ROM is the classic presentation of vasa previa, not abruption (though severe abruption can produce sinusoidal patterns from fetal anemia — but the timing "at ROM" points away from abruption).

NCLEX trap: assuming the amount of visible bleeding equals total blood loss.

CJMM: Recognize Cues + Analyze Cues

QUESTION 03

ORDERED RESPONSE

A client undergoing trial of labor after a previous low-transverse cesarean (TOLAC) suddenly reports severe, "tearing" abdominal pain. Contractions have stopped on the monitor. The fetal heart rate drops to 70 bpm and remains there. Place the nurse's actions in priority order, from **first** (1) to **last** (6).

1. Stop the oxytocin infusion.
2. Reposition the client to the left lateral position.
3. Call the provider / activate OB emergency response.
4. Increase the rate of the IV mainline fluid bolus.
5. Apply oxygen 10 L/min via non-rebreather mask per facility policy.
6. Prepare the client for emergent cesarean birth (consent witnessed, bladder prep, abdominal prep).

RATIONALE

The presentation is classic uterine rupture. The priority sequence applies intrauterine resuscitation while simultaneously calling for help and preparing for STAT delivery. **Stop oxytocin first** (you are actively making it worse with every drop), then reposition, call the team, push fluids, apply oxygen per policy for the non-reassuring FHR, and prepare for emergent surgery. In real practice these happen nearly simultaneously, but NCLEX wants the priority sequence.

NCLEX trap: putting oxygen or calling the provider first while still infusing oxytocin into a ruptured uterus.

CJMM: Generate Solutions + Take Action

QUESTION 04

DROP-DOWN / CLOZE

A 34-week pregnant client whose prenatal ultrasound showed *vasa previa* presents in early labor with spontaneous rupture of membranes. A small amount of bright-red blood is noted on the perineal pad, and the fetal heart rate immediately drops from 140 to 80 bpm.

Complete the following statement using the most appropriate options:

> The blood loss represents **[fetal blood]**, the fetus is at immediate risk for **[exsanguination]**, and the nurse's priority action is to **[prepare for emergent cesarean birth and notify the neonatal team]**.

RATIONALE

In vasa previa, unprotected fetal vessels run through the membranes. When membranes rupture, the vessels tear and the fetus bleeds. Because total fetal blood volume is only about 80–100 mL/kg, fetal exsanguination occurs in minutes. The only intervention that saves the fetus is **immediate cesarean birth**, and the neonate will need O-negative blood and resuscitation.

Distractor logic: "maternal hemorrhage" is wrong (bleeding is fetal); "umbilical cord prolapse" is wrong (cord prolapse is a separate diagnosis with palpable cord); "intrauterine resuscitation alone" is inadequate — only delivery saves this fetus.

CJMM: Analyze Cues + Prioritize Hypotheses

QUESTION 05

MATRIX / GRID

Match each clinical finding to the most likely diagnosis: **Placenta Previa, Placental Abruption, Uterine Rupture, or Vasa Previa.**

CLINICAL FINDING	PREVIA	ABRUPTION	RUPTURE	VASA PREVIA
Painless bright-red bleeding, soft uterus	✓			
Rigid, board-like, tender uterus		✓		
Bleeding immediately at ROM + sudden fetal bradycardia				✓
Sudden loss of contractions + loss of station + severe pain (VBAC)			✓	
DIC, concealed bleeding, shock disproportionate to visible loss		✓		
Sinusoidal FHR pattern at moment of ROM				✓
Strong association with cocaine use, HTN, or trauma		✓		

CLINICAL FINDING	PREVIA	ABRUPTION	RUPTURE	VASA PREVIA
Strong association with prior cesarean section	✓		✓✓	

RATIONALE

This is the core pattern-recognition test. Note that **prior C-section is a risk factor for BOTH placenta previa AND uterine rupture** — that's a high-yield NGN trap. The diagnosis depends on the rest of the picture (painless & soft → previa; painful + lost contractions → rupture).

CJMM: Recognize Cues + Prioritize Hypotheses

QUESTION 06

MEDICATION SAFETY

A postpartum client diagnosed with severe preeclampsia has 800 mL of vaginal bleeding 30 minutes after a vaginal birth. The fundus is boggy and displaces to the right. Which of the following uterotonics is **CONTRAINDICATED** for this client?

A. Oxytocin (Pitocin) IV infusion

B. **Methylergonovine (Methergine) 0.2 mg IM** ✓ CORRECT

C. Tranexamic acid (TXA) 1 g IV over 10 minutes

D. Misoprostol (Cytotec) 800 mcg rectally

WHY B IS CORRECT

Methylergonovine causes profound vasoconstriction and significantly raises blood pressure. It is **contraindicated in clients with hypertension, preeclampsia, or coronary artery disease** because of the risk of severe HTN, stroke, and MI.

A: First-line uterotonic, safe in this client. **C:** TXA is appropriate within 3 hours of the start of hemorrhage. **D:** Misoprostol is acceptable here. Note: the boggy fundus displaced to the right also signals a **distended bladder** — empty the bladder as part of fundal management.

NCLEX trap: the classic "PPH in a preeclamptic — what NOT to give" question.

CJMM: Take Action (Medication Safety)

QUESTION 07

BOW-TIE

A 30-week pregnant client with chronic hypertension and prior cocaine use is brought to L&D with sudden severe abdominal pain and dark vaginal bleeding. The uterus is rigid. The FHR shows a baseline of 170 bpm with minimal variability and recurrent late decelerations.

Actions to Take (Pick 2)

- ✓ Stop oxytocin if running and prepare for emergent C-section
- ✓ Initiate intrauterine resuscitation (lateral, IV bolus, O_2 per policy)
- Perform a digital cervical exam
- Administer methylergonovine
- Encourage ambulation

Potential Condition

Placental Abruption

Parameters to Monitor (Pick 2)

- ✓ Fibrinogen, platelets, PT/PTT (DIC labs)
- ✓ Continuous FHR + maternal vital signs q5–15 min
- Bishop score q1h
- Patellar reflexes q4h
- Blood glucose q4h

RATIONALE

Painful dark bleeding + rigid uterus + HTN/cocaine risk factors + Cat II/III tracing = abruption. Priority actions are intrauterine resuscitation and preparation for emergent delivery. Critical monitoring is for DIC (the deadliest abruption complication) and continuous maternal-fetal status.

Wrong actions: digital exam (could worsen hemorrhage if previa is also present); methylergonovine (HTN contraindication, and there's no atony yet); ambulation (active hemorrhage). **Wrong monitors:** Bishop score (irrelevant during a hemorrhage emergency); DTRs (for mag toxicity); glucose (not the primary issue).

CJMM: Full Bow-Tie — Analyze, Prioritize, Act

QUESTION 08

FETAL MONITORING STRIP INTERPRETATION

During induction with oxytocin in a client with a prior low-transverse cesarean, the EFM shows: **baseline 145, contractions every 90 seconds lasting 80 seconds, resting tone 25 mmHg between contractions, and recurrent late decelerations.** The client suddenly reports sharp abdominal pain. Which is the priority nursing action?

A. Increase the oxytocin to advance labor.

B. Administer IV opioid for pain control.

C. **Stop the oxytocin infusion immediately and call the provider.** ✓ CORRECT

D. Perform a sterile vaginal exam to assess progress.

WHY C IS CORRECT

This client has **tachysystole** (contractions q90 sec is > 5 in 10 min), **elevated resting tone**, **recurrent late decelerations**, and **sudden sharp pain in a VBAC client** — all consistent with impending or actual uterine rupture / severe abruption. **First action: STOP the oxytocin.** Then notify provider, reposition lateral, IV bolus, oxygen per policy, prepare for emergent delivery.

A: Catastrophic — would worsen rupture. **B:** Treats the symptom, not the cause. **D:** Not first; could worsen if there's hemorrhage, and time is the fetus's enemy.

NCLEX trap: any time you see "VBAC + oxytocin + sudden pain" — stop the oxytocin first.

CJMM: Take Action

QUESTION 09

PRIORITIZATION

The L&D charge nurse receives report on four clients. Which client requires the nurse's **first** assessment?

A. A 34-week client with mild contractions q6 min and intact membranes, FHR Cat I.

B. A 39-week client at 4 cm dilation requesting an epidural.

C. **A 36-week client with known complete placenta previa reporting "a sudden gush of bright red blood."** ✓ CORRECT

D. A 41-week postpartum day 1 client whose fundus is firm and at U-1 with moderate lochia rubra.

WHY C IS CORRECT

Active bleeding in a known complete placenta previa is a life-threatening hemorrhage — both maternal hypovolemia and fetal hypoxia are imminent. This client supersedes labor pain, routine triage, and a stable postpartum client.

A: Stable preterm contractions; assess next but not first. **B:** Requesting epidural — comfort, not emergency. **D:** Reassuring postpartum exam.

NCLEX trap: selecting the laboring client with pain over the silently bleeding client — bleeding kills faster than labor pain.

CJMM: Prioritize Hypotheses

QUESTION 10

EMERGENCY NURSING ACTION

A postpartum client who delivered vaginally 1 hour ago has saturated three perineal pads, has a boggy fundus that does not respond to firm fundal massage, and the bladder is non-distended. Oxytocin 30 units in 500 mL LR is already infusing. Which action does the nurse take next?

A. Decrease the oxytocin infusion rate.

B. Wait 15 minutes and reassess fundal tone.

C. **Notify the provider and prepare to administer a second-line uterotonic (methylergonovine, carboprost, or misoprostol) per protocol.** ✓ CORRECT

D. Encourage the client to ambulate to promote uterine involution.

WHY C IS CORRECT

This is a classic uterine atony picture — boggy fundus, ongoing bleeding, bladder ruled out, fundal massage and first-line oxytocin already in use. Per OB hemorrhage protocols, the next step is escalation to a **second-line uterotonic**. Selection depends on contraindications: avoid methylergonovine if HTN; avoid carboprost if asthma; misoprostol is broadly safe. Notify provider, activate OB hemorrhage protocol, quantify blood loss, ensure large-bore IV access ×2, send STAT labs (CBC, type & cross, coags, fibrinogen).

A: Wrong — you need MORE uterotonic effect, not less. **B:** Dangerous delay. **D:** Unsafe; she is actively hemorrhaging.

NCLEX trap: "wait and reassess" is rarely the right answer in active bleeding.

`CJMM: Evaluate Outcomes + Take Action`

§ 08

Unfolding NGN *Case Study*

Walk through this case as if you're at the bedside. Pause at each prompt and answer before reading the analysis.

Client: Ms. Reyes, 34 y/o G3P2002, 35+4 weeks

NURSE'S NOTES — 14:22

Client arrives to L&D triage via wheelchair with husband. States: "I was just sitting down for dinner and felt this awful tearing pain, and now I'm bleeding really badly." Reports no recent trauma. PMH: chronic hypertension on labetalol, prior low-transverse cesarean for breech (2 yrs ago), denies tobacco/alcohol/illicit drug use this pregnancy. Has had irregular prenatal care. Currently grimacing, rocking, holding abdomen. Vaginal pad saturated with dark red blood and clots. Abdomen rigid, exquisitely tender to palpation. Husband states, "She was fine an hour ago."

MATERNAL VITAL SIGNS — 14:25

BP	HR	RR	TEMP	SPO_2
92/54	124	22	98.4°F	97%

PAIN
10/10

FETAL HEART TRACING DESCRIPTION — 14:28

Baseline: 170 bpm · **Variability:** minimal (1–5 bpm) · **Accelerations:** none · **Decelerations:** recurrent late decelerations following nearly every contraction.

CONTRACTION PATTERN

Contractions q 90–120 seconds lasting 50 seconds, palpates as continuous/hypertonic with elevated resting tone between contractions. Uterus described by examiner as "board-like."

CERVICAL EXAM (DEFERRED INITIALLY; PERFORMED BEDSIDE AFTER PREVIA RULED OUT BY POINT-OF-CARE ULTRASOUND AT 14:35)

3 cm / 60% effaced / -2 station. Membranes intact. Bleeding ongoing dark red.

MEMBRANE STATUS

Intact. No fluid noted.

PROVIDER ORDERS — 14:36

Type and crossmatch 4 units PRBCs · CBC, BMP, PT/PTT/INR, fibrinogen, D-dimer · 2× 16-gauge IVs · 1000 mL LR bolus then 125 mL/hr · Continuous EFM · Indwelling Foley · NPO · Prep for emergent C-section · Anesthesia & neonatal team to bedside · OB hemorrhage protocol activated.

MEDICATION ADMINISTRATION RECORD

Labetalol 200 mg PO BID (home med, last dose 08:00) · No oxytocin running · No magnesium sulfate.

LAB VALUES — 14:55 (STAT)

HGB	HCT	PLATELETS	FIBRINOGEN	D-DIMER
9.4 g/dL	28%	108,000	178 mg/dL	elevated

BLOOD TYPE
O-negative

CLIENT / FAMILY STATEMENT

Husband: "Will the baby be okay? Should we have come in earlier? She's been having a lot of headaches and her ankles have been so swollen..."

Clinical Judgment Prompts

CJMM PROMPT 01 — RECOGNIZE CUES

Which findings are most concerning and warrant immediate attention? *Select all that apply.*

- **A.** BP 92/54, HR 124 ✓ CORRECT
- **B.** Rigid, board-like uterus with severe pain ✓ CORRECT
- **C.** Baseline FHR 170 with minimal variability and recurrent late decelerations ✓ CORRECT
- **D.** Fibrinogen 178 mg/dL with platelets 108,000 ✓ CORRECT
- **E.** Husband's report of recent headaches and ankle edema ✓ CORRECT
- **F.** Temperature 98.4°F

WHY A–E ARE CORRECT

A: maternal shock. B: hypertonic, tender uterus → abruption. C: Cat III tracing → emergency. D: developing DIC (fibrinogen normally rises in pregnancy to 350–600 mg/dL; < 200 is alarming). E: undiagnosed preeclampsia, a risk factor for abruption. F: temperature is normal — not the concern.

CJMM Step 1

CJMM PROMPT 02 — ANALYZE CUES

Drag each cue to the most likely contributing condition.

CUE	MOST LIKELY LINKED TO
Sudden severe pain + dark bleeding + rigid uterus	Placental abruption
Prior cesarean, headaches, ankle edema, chronic HTN	Risk factors for abruption (HTN, preeclampsia)
Falling fibrinogen, low platelets, elevated D-dimer	Developing DIC
BP 92/54, HR 124	Hypovolemic shock from concealed/revealed bleeding
FHR 170, minimal variability, recurrent lates	Fetal hypoxia from uteroplacental insufficiency

CJMM Step 2

CJMM PROMPT 03 — PRIORITIZE HYPOTHESES

Which condition is the highest priority hypothesis?

A. Placenta previa with hemorrhage

B. Placental abruption with developing DIC and Category III tracing ✓ CORRECT

C. Uterine rupture

D. Vasa previa

Abruption is the best fit: chronic HTN (likely superimposed preeclampsia given headaches/edema), painful dark bleeding, rigid uterus, hypertonic contractions, Cat III tracing, falling fibrinogen (DIC). Uterine rupture is possible given prior cesarean, but contractions are still palpable and station has not changed — the picture is most consistent with severe abruption. Previa is ruled out by ultrasound; vasa previa is ruled out by intact membranes.

CJMM Step 3

CJMM PROMPT 04 — GENERATE SOLUTIONS

Which interventions are appropriate? *Select all that apply.*

A. Prepare for emergent cesarean birth ✓ CORRECT

B. Activate the massive transfusion / OB hemorrhage protocol ✓ CORRECT

C. Place client in left lateral position, oxygen 10 L NRB per facility policy, increase IV LR bolus ✓ CORRECT

D. Insert second large-bore IV; type and cross 4 units PRBCs; prepare FFP, platelets, cryoprecipitate ✓ CORRECT

E. Notify neonatal resuscitation team for delivery of a likely preterm, hypoxic neonate ✓ CORRECT

F. Administer methylergonovine 0.2 mg IM

G. Administer misoprostol 400 mcg PO to induce labor

A–E are all appropriate emergency actions. F is contraindicated (HTN, plus there is no atony — the uterus is hypertonic). G is wrong — labor induction would be too slow and is contraindicated when the fetus is in distress and Cat III tracing is present.

CJMM Step 4

CJMM PROMPT 05 — TAKE ACTION

Which is the priority FIRST action?

A. Document the assessment findings.

B. Insert a Foley catheter.

C. Notify provider / activate OB emergency response while initiating intrauterine resuscitation and preparing for emergent cesarean. ✓ CORRECT

D. Call the family to the bedside.

This is a Cat III, hemorrhaging, shock-state client with developing DIC. The first action is to mobilize the team and begin emergency interventions. Documentation, Foley, family — all happen, but not first.

CJMM Step 5

CJMM PROMPT 06 — EVALUATE OUTCOMES

After emergent C-section, the client is now in PACU 30 minutes post-delivery. Which findings indicate her condition is **improving**? *Select all that apply.*

A. BP 116/74, HR 88, urine output 60 mL in the last hour ✓ CORRECT

B. Fibrinogen rising to 220 mg/dL after FFP and cryoprecipitate ✓ CORRECT

C. Fundus firm at U, lochia rubra moderate ✓ CORRECT

D. Continued oozing from IV sites and gums

E. SpO_2 98% on room air

F. Hgb 6.9 g/dL, continued saturation of perineal pad q15 min

A: vitals and urine output normalizing → improving perfusion. B: fibrinogen rising → DIC resolving with product replacement. C: firm fundus → no atony. E: oxygenation maintained. D and F are signs of **ongoing bleeding/coagulopathy** — NOT improvement.

CJMM Step 6

§ 09

What Should the Nurse *Do First?*

Five mini-scenarios. Force yourself to commit to an answer before reading.

Scenario 1

A 30-week pregnant client with no prenatal care presents to triage saying, "I just woke up in a pool of bright red blood. There's no pain." Vitals stable. FHR Cat I.

First action: Place on continuous EFM, obtain IV access ×2, draw CBC + type & cross + coags, and **defer any vaginal exam until ultrasound confirms placental location.** Painless, bright-red bleeding = previa until ruled out.

Scenario 2

A laboring client on oxytocin suddenly reports tearing pain, fetal station rises, contractions stop, FHR drops to 60 bpm. Prior LTCS.

First action: STOP THE OXYTOCIN. Then mobilize team, lateral position, IV bolus, O_2 per policy, prepare emergent C-section. This is uterine rupture until proven otherwise.

Scenario 3

A 36-week client with prenatal ultrasound diagnosis of vasa previa presents in early labor. Membranes spontaneously rupture. A trickle of bright red blood follows. FHR drops abruptly from 145 to 75 bpm.

First action: Call for emergent cesarean immediately and have the neonatal team and O-negative blood ready. The blood loss is fetal — minutes matter.

Scenario 4

A postpartum client 1 hour after vaginal birth has saturated 2 pads in 15 minutes. The fundus is firm at U, displaced to the right. BP 102/68, HR 102.

First action: Have her empty her bladder (or insert a straight catheter). A firm fundus displaced laterally with hemorrhage = full bladder preventing involution. Bladder distention is the most common reversible cause of "firm-but-still-bleeding" PPH.

Scenario 5

A client at 32 weeks with chronic HTN presents with painful, dark vaginal bleeding and rigid abdomen. BP 90/52, HR 130, FHR baseline 175 with absent variability and recurrent late decelerations.

First action: Call the provider / activate OB emergency response while simultaneously initiating intrauterine resuscitation (stop oxytocin if running, lateral position, large-bore IV ×2 with fluid bolus, O_2 per policy) and preparing for emergent C-section. This is

severe abruption with Cat III tracing and likely DIC pending.

§ 10

Stop, Hold, or *Escalate*

Five drill scenarios. The right action almost always involves one of: **stop oxytocin · hold a med · notify provider · activate rapid response · prep for emergent birth.**

1. Tachysystole + Cat II tracing on oxytocin

Action: STOP oxytocin. Reposition lateral, IV bolus, oxygen per policy if non-reassuring. Notify provider. Consider terbutaline 0.25 mg SC per order if no improvement.

2. PPH in a client with severe preeclampsia, BP 168/106, atonic uterus

Action: HOLD methylergonovine (HTN contraindication). Use oxytocin (continue), carboprost (if no asthma), misoprostol, TXA. Treat HTN per protocol. **Notify provider/activate hemorrhage protocol.**

3. Asthmatic with PPH, atonic uterus, oxytocin already running

Action: HOLD carboprost (Hemabate) — bronchospasm risk. Use methylergonovine (if BP normal), misoprostol, TXA. **Notify provider/escalate hemorrhage protocol.**

4. VBAC client with cervical ripening planned

Action: HOLD misoprostol (and any prostaglandin). Prostaglandins are **contraindicated in prior cesarean** because of rupture risk. Cervical Foley balloon is the preferred mechanical method. Notify provider.

5. Client on magnesium sulfate develops RR 8, absent DTRs

Action: STOP the magnesium infusion immediately. Administer calcium gluconate 1 g IV over 3 minutes per order. Support airway/breathing, call rapid response, notify provider. Draw STAT magnesium level. (Note: magnesium is often used in preeclampsia, which co-exists with bleeding-emergency risk.)

§ 11

Common NCLEX *Traps*

Each trap is a wrong answer NCLEX writes deliberately. Practice spotting them.

TRAP 01

Treating all third-trimester bleeding as "bloody show." Bloody show is small amounts of pink-tinged mucus near labor onset. *Frank red bleeding is not bloody show.*

> **Fix:** Any third-trimester bleeding beyond mucus → assume previa, abruption, vasa previa, or rupture until proven otherwise.

TRAP 02

Performing a vaginal exam on a bleeding client before ruling out placenta previa. This is one of the most-tested errors on the NCLEX.

> **Fix:** Defer all vaginal exams until ultrasound confirms the placenta is not over the cervical os.

TRAP 03

Giving methylergonovine to a hypertensive or preeclamptic client for PPH. The setup is classic: "BP 160/100, uterus is boggy — which med?" The student picks Methergine because they remember it stops bleeding.

> **Fix:** HTN/preeclampsia = NO methylergonovine. Use oxytocin, carboprost (if no asthma), misoprostol, TXA.

TRAP 04

Estimating blood loss by what's visible on the pad. Concealed abruption hides most of the blood behind the placenta. The mother can be in shock with minimal external bleeding.

> **Fix:** Trend HR, BP, urine output, hemoglobin, lactate, and uterine height/firmness — not just pad counts.

TRAP 05

Continuing oxytocin during tachysystole, Cat II/III tracings, or suspicion of rupture/abruption. Students hesitate because "the provider ordered it."

> **Fix:** Stopping oxytocin is a nursing action within scope of practice when there is fetal distress, tachysystole, or suspicion of rupture. STOP first, then notify.

TRAP 06 (BONUS)

Forgetting that bladder distention can mimic uterine atony. A firm fundus pushed to the side, plus ongoing bleeding, is bladder, not atony.

> **Fix:** Empty the bladder before assuming uterotonic failure.

TRAP 07 (BONUS)

Missing a sinusoidal FHR pattern. Some students mistake it for "decreased variability" and don't escalate.

> **Fix:** Sinusoidal = fetal anemia = vasa previa / severe abruption / fetomaternal hemorrhage / Rh disease. Prepare emergent delivery.

§ 12

End-of-Day *Quick Review*

10 Must-Remember Points

1. Painless bleeding = previa.
2. Painful bleeding + rigid uterus = abruption.
3. VBAC + sudden pain + bradycardia = rupture.
4. ROM + sudden fetal bradycardia + small bleed = vasa previa.
5. Sinusoidal FHR = fetal anemia.
6. No digital exam until previa ruled out.
7. Concealed abruption hides blood; trend vitals.
8. Stop oxytocin for tachysystole, distress, rupture.
9. RhoGAM for any bleeding event in Rh-negative mother.
10. DIC is the deadly complication of abruption.

5 Red-Flag Findings

1. Rigid, board-like uterus.
2. Sudden loss of contractions + lost station.
3. Sinusoidal FHR or sudden bradycardia.
4. Maternal HR > 120 + SBP < 90.
5. Oozing from IV sites (DIC).

5 "Never Do This" Rules

1. NEVER digitally exam an undiagnosed bleed.
2. NEVER give methylergonovine if HTN/preeclampsia.
3. NEVER give carboprost to an asthmatic.
4. NEVER give misoprostol to a VBAC client.
5. NEVER continue oxytocin during tachysystole / Cat III.

5 Fetal Monitoring Clues

1. Late decels = uteroplacental insufficiency.
2. Variable decels = cord compression.
3. Prolonged decel ≥ 2 min = emergency.
4. Tachycardia = fetal hypoxia, maternal fever, hypovolemia.
5. Sinusoidal = fetal anemia.

5 Medication Safety Clues

1. Oxytocin: stop for tachysystole/distress.
2. Methergine: HTN = no.
3. Hemabate: asthma = no.
4. Misoprostol: prior C/S = no.
5. Mag sulfate antidote = calcium gluconate.

Day 10 · Screenshot-Ready Summary

Obstetric Bleeding Emergencies

Placenta Previa

- PAINLESS bright-red bleed
- Soft uterus
- FHR usually reassuring early
- NO vaginal exam
- Risk: prior C/S, multiparity
- C-section delivery

Placental Abruption

- PAINFUL dark bleed
- Rigid, board-like uterus
- Cat II/III FHR
- DIC risk (↓ fibrinogen)
- Risk: HTN, cocaine, trauma
- Emergent delivery

Uterine Rupture

- Sudden tearing pain
- Loss of contractions
- Loss of fetal station
- Fetal bradycardia
- Risk: VBAC, oxytocin
- STOP oxytocin → STAT laparotomy

Vasa Previa

- Bleeding AT moment of ROM
- Sudden fetal bradycardia or sinusoidal
- It is FETAL blood
- Minutes to fetal demise
- Detected prenatally on US
- Scheduled C/S 34–36 wks

Side-by-Side Comparison

FEATURE	PREVIA	ABRUPTION	RUPTURE	VASA PREVIA
Pain	None	Severe	Sudden, tearing	None
Bleeding color	Bright red	Dark red	Variable	Bright red (fetal)
Uterine tone	Soft	Rigid, hypertonic	Lost (post-rupture)	Variable
FHR	Usually OK early	Cat II/III, lates	Bradycardia	Sudden brady / sinusoidal
Key risk factor	Prior C/S, AMA	HTN, cocaine	VBAC, oxytocin	Velamentous cord
Vaginal exam?	NO	Cautious	Defer	NO

FEATURE	PREVIA	ABRUPTION	RUPTURE	VASA PREVIA
Delivery	C-section	Often emergent C/S	Emergent laparotomy	Emergent C/S

Universal Bleeding Emergency Algorithm

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

DAY 10 OF 16 · LABOR & DELIVERY NGN REVIEW · NCLEX-RN 2026

"Painless = Previa · Painful = Abruption · Lost = Rupture · ROM = Vasa"