NCLEX-RN · L&D DAILY REVIEW

DAY 11 OF 16

When the Birth *Stalls.*

Malpresentation, shoulder dystocia, difficult birth, and the moment-to-moment emergency nursing actions that save a mother and her baby.

TEST PLAN · 2026 | NGN CLINICAL JUDGMENT MODEL | APPLICATION-LEVEL | MATERNAL–FETAL SAFETY

IN THIS LESSON

01 · HIGH-YIELD OVERVIEW

§ 1 The Difficult Birth, Decoded

> *A "difficult birth" on NCLEX is rarely about strength. It's about **geometry**—a fetus that won't fit, won't turn, or won't descend—and a nurse who must act in seconds, not minutes.*

Malpresentation means anything other than a vertex (head-down, occiput-anterior) presentation. The fetus may present *breech* (buttocks/feet first), *face*, *brow*, *shoulder*, or lie *transverse*. Each one changes the diameter the fetus must move through the pelvis, and each one carries its own complication profile: cord prolapse with footling breech, obstructed labor with transverse lie, fetal facial trauma with face presentation, and almost guaranteed cesarean delivery for persistent brow.

Shoulder dystocia is a true obstetric emergency that occurs *after* the head delivers. The anterior shoulder gets trapped behind the maternal symphysis pubis, the head retracts against the perineum (the classic *turtle sign*), and within minutes the umbilical cord is compressed, oxygenation falls, and brachial plexus, clavicle, and hypoxic-ischemic injury become very real risks. There is no medication that fixes this—only maneuvers and a coordinated team.

Macrosomia (estimated fetal weight ≥ 4,000–4,500 g, or ≥ 4,500 g in diabetes) is the single largest modifiable risk factor for shoulder dystocia. Add gestational diabetes, post-term gestation, prior shoulder dystocia, maternal obesity, or prolonged second stage, and the suspicion index climbs. The NCLEX expects you to *recognize the risk before delivery* and have the right people in the room.

The clinical judgment skill the test will probe relentlessly: **recognize the cue, act first, document after.** If the head delivers and does not restitute (turtle sign), the next nurse action is not to chart, not to call the partner over—it is to **call for help, drop the bed flat, and bring the mother's thighs to her abdomen (McRoberts)**. Every second of delay measurably increases neonatal injury.

CORE TEST-PLAN ANCHOR

Under **Reduction of Risk Potential** and **Physiological Adaptation**: recognize trends and changes in client condition and intervene as needed; apply knowledge of pathophysiology to interventions; perform emergency care procedures; notify primary health care provider about unexpected client response/emergency situation. Day 11 lives squarely inside these activity statements.

02 · MUST-KNOW RULES

§ 2 10 Rules You Cannot Forget

01 **Turtle sign = shoulder dystocia until proven otherwise.** Head delivers, retracts tightly against the perineum, fails to restitute → call for help *immediately*, before the next contraction.

02 **Never apply fundal pressure for shoulder dystocia.** It impacts the shoulder more tightly against the symphysis and increases the risk of uterine rupture and brachial plexus injury. *Suprapubic pressure—yes. Fundal pressure—never.*

03 **McRoberts is first.** Hyperflex the mother's thighs onto her abdomen. This flattens the sacrum, rotates the symphysis cephalad, and resolves roughly half of shoulder dystocias by itself.

04 **Suprapubic pressure (Rubin I) is second**—just above the symphysis, directed downward and laterally, to dislodge the anterior shoulder. Never confuse this with fundal pressure.

05 **Footling and complete breech with ruptured membranes = high cord-prolapse risk.** If a cord is felt or seen on perineum, place the client in *knee-chest* or *Trendelenburg*, lift the presenting part off the cord with a sterile gloved hand, and do *not* remove the hand until delivery.

06 **Transverse lie cannot deliver vaginally.** If labor begins with a persistent transverse lie or shoulder presentation, the answer is cesarean—often urgent—because of obstructed labor and uterine rupture risk.

07 **Face presentation can deliver vaginally only if mentum (chin) is anterior.** Mentum posterior cannot deliver vaginally → cesarean. Expect facial bruising, edema, and transient feeding difficulty in the newborn.

08 **Macrosomia + GDM + prolonged second stage = anticipate dystocia.** Bring extra staff to the bedside *before* delivery. NCLEX rewards anticipation, not reaction.

09 **After a shoulder dystocia, examine the newborn for clavicle fracture and brachial plexus injury** (Erb's palsy: arm extended, internally rotated, "waiter's tip"). Examine the mother for fourth-degree lacerations, hematoma, and postpartum hemorrhage.

10 **Document the sequence of maneuvers, the time the head delivered, and the time the body delivered.** Head-to-body interval guides neonatal evaluation and is medically and legally critical.

03 · MATERNAL-FETAL SAFETY

§ 3 Findings, Risks, and Priority Action

FINDING	WHAT IT MEANS	MOTHER RISK	FETAL / NEWBORN RISK	PRIORITY NURSING ACTION	NOTIFY / ESCALATE
Turtle sign after head delivery	Shoulder dystocia	**4th-degree laceration, PPH, uterine rupture**	**Hypoxic-ischemic injury, brachial plexus injury, clavicle fracture, death**	Call for help; drop bed flat; **McRoberts** + **suprapubic pressure**; start HELPERR sequence; note time of head delivery	**Activate OB emergency team, NRP team, anesthesia, NICU—*immediately***
Footling breech with ROM	Foot/feet through cervix; high cord-prolapse risk	Operative delivery, uterine rupture if VBAC	**Cord prolapse, asphyxia**	Sterile vaginal exam to confirm; assess FHR; prepare for **STAT cesarean**	**Notify provider STAT; alert OR and anesthesia**
Cord palpated/visible on perineum	Overt umbilical cord prolapse	Emergency surgery	**Cord compression → hypoxia → death within minutes**	**Lift presenting part off cord** with sterile gloved hand—do NOT remove; **knee-chest or Trendelenburg**; O_2 10 L/min non-rebreather; IV fluids; prepare STAT cesarean	**Call OB emergency team; provider in-room within minutes**
Transverse lie in active labor	Fetal shoulder presenting; vaginal birth impossible	**Uterine rupture, obstructed labor**	**Hypoxia, traumatic delivery**	Stop oxytocin if running; assess contractions and FHR; prepare for cesarean; nothing PO	Notify provider; expedite OR
Mentum posterior face presentation	Chin pointing toward sacrum—cannot deliver vaginally	Obstructed labor, uterine rupture	Facial trauma, asphyxia	Prepare for cesarean; do *not* attempt manual rotation	Notify provider

FINDING	WHAT IT MEANS	MOTHER RISK	FETAL / NEWBORN RISK	PRIORITY NURSING ACTION	NOTIFY / ESCALATE
Persistent brow presentation	Largest fetal diameter against pelvis	Prolonged/obstructed labor	Hypoxia, traumatic delivery	Continuous EFM; prepare for cesarean if not converted to vertex or face	Notify provider
Estimated fetal weight ≥ 4,500 g in diabetes	Macrosomia —high dystocia risk	3rd/4th-degree laceration, PPH	Shoulder dystocia, hypoglycemia, birth injury	Notify charge nurse; ensure extra staff, NRP team present at delivery; review HELPERR plan	Provider should counsel re: planned cesarean per ACOG criteria
Sudden **fetal bradycardia** with palpable cord	Cord prolapse with compression	Emergency surgery	**Severe hypoxia, death**	Same as overt cord prolapse: elevate presenting part, knee-chest, O_2, prepare STAT cesarean	**OB emergency team; level-of-acuity Cat III tracing**
Persistent **OP (occiput posterior)**	"Sunny-side up" — back labor, slower descent	Prolonged labor, perineal trauma, instrumental delivery	Caput, molding, possible asphyxia if prolonged	Hands-and-knees position, pelvic rocking, counterpressure on sacrum, continuous EFM	Notify provider if arrest of descent
Newborn arm **flaccid, "waiter's tip"**	Erb's palsy (C5–C6 brachial plexus injury)	—	**Permanent motor deficit if not recognized**	Position arm in adduction with elbow flexion; gentle handling; PT referral; document	Notify pediatrics/neonatology

04 · RED-FLAG CUES

§ 4 What Must Trigger an Action *Right Now*

IMMEDIATE ASSESSMENT

- Head delivered, no restitution (turtle sign)
- Sudden FHR deceleration after ROM
- Visible/palpable cord at introitus
- Maternal report of "something coming out"
- Loss of contraction rhythm + sharp pain

REPOSITION NOW

- Suspected dystocia → **McRoberts** (thighs to chest)
- Cord prolapse → **knee-chest** or Trendelenburg
- Persistent OP → **hands-and-knees**
- Variable decels with breech labor → side-lying
- Maternal hypotension after epidural → left lateral

IV BOLUS (IF ORDERED/POLICY)

- Suspected cord prolapse
- Maternal hypotension
- Category II/III tracing during preparation for cesarean
- Anticipated PPH after macrosomic delivery
- Pre-cesarean fluid optimization

STOP OXYTOCIN

- Any shoulder dystocia
- Cord prolapse
- Transverse lie identified
- Category III tracing
- Tachysystole (>5 contractions/10 min averaged over 30 min)

OXYGEN (PER POLICY/INDICATION)

- Cord prolapse with non-reassuring FHR
- Category III tracing not resolving with position/fluids
- Maternal hypoxia (SpO_2 < 95%)
- Not routine — only when fetal status warrants
- 10 L/min non-rebreather is standard for emergent fetal indications

PROVIDER / RAPID RESPONSE

- Turtle sign — call BEFORE McRoberts is fully set up
- Overt cord prolapse — STAT cesarean team
- Transverse lie in labor
- Mentum posterior face presentation
- Suspected uterine rupture (sudden loss of station, severe pain)

H • E • L • P • E • R • R

The standard sequence for shoulder dystocia. Memorize it. The NCLEX expects you to know the order and what is not on this list.

H — **Help.** Call additional nursing, OB, anesthesia, and NRP/neonatal team. Note the time of head delivery.

E — **Evaluate for episiotomy.** Considered to make room for maneuvers, but not always required. Provider decision.

L — **Legs (McRoberts).** Hyperflex maternal thighs onto the abdomen to flatten sacrum and rotate symphysis.

P — **Suprapubic pressure.** Just above the symphysis, downward and lateral, to dislodge the anterior shoulder. *NOT fundal pressure.*

E — **Enter (internal maneuvers).** Rubin II, Woods corkscrew, reverse Woods—performed by provider to rotate the fetal shoulders.

R **Remove posterior arm.** Provider sweeps the posterior arm across the chest and out.

R **Roll the patient** (Gaskin maneuver) onto hands and knees. Often used earlier or in combination depending on team protocol.

NEVER DO THIS DURING SHOULDER DYSTOCIA

- **Fundal pressure** — worsens impaction, risks uterine rupture and brachial plexus injury
- **Excessive lateral traction** on the fetal head — causes Erb's palsy
- **Forced flexion or extension** of the fetal neck
- Delaying the call for help to "try one more push"
- Documenting before the baby is delivered (assign a separate scribe)

05 · MEDICATION SAFETY

§ 5 Medications Around the Difficult Birth

Shoulder dystocia itself has no pharmacologic fix—maneuvers come first. But the difficult birth occurs inside a medication-heavy environment: oxytocin running, anesthesia at the bedside, postpartum hemorrhage agents ready, and—for a hypoxic newborn—naloxone *off the table* if the mother received opioids near delivery. Know each one.

MEDICATION	WHY GIVEN	ASSESS BEFORE	MOST DANGEROUS EFFECT	HOLD / NOTIFY	A R
Oxytocin (Pitocin)	Augment labor; postpartum uterine tone after a difficult birth	FHR baseline + variability; contraction pattern; maternal BP	**Tachysystole → fetal hypoxia; water intoxication (hyponatremia) at high doses**	**STOP** for tachysystole, Cat II/III tracing, shoulder dystocia, suspected uterine rupture	N a o i b C
Terbutaline	Uterine relaxation for tachysystole, internal version, uterine inversion	Maternal HR, BP, lung sounds, glucose, K+	**Maternal tachycardia (>120), pulmonary edema, hyperglycemia, hypokalemia**	Hold if maternal HR > 120 or chest pain; not for routine/long-term tocolysis	N s o b t
Magnesium sulfate	Neuroprotection if preterm; seizure prophylaxis in preeclampsia	DTRs, RR, urine output, LOC, baseline magnesium	**Respiratory depression (RR < 12), loss of DTRs, cardiac arrest**	RR < 12, absent DTRs, UO < 30 mL/hr, mag level > 8 mEq/L	**C g**
Methylergonovine (Methergine)	Uterine atony / PPH after difficult delivery	BP — *contraindicated in hypertension/preeclampsia*	**Severe hypertension, stroke, MI, seizure**	BP > 140/90, preeclampsia, eclampsia, cardiovascular disease	N a s n
Carboprost (Hemabate)	PPH from uterine atony, often after macrosomic delivery	Lung status — *contraindicated in asthma*	**Bronchospasm, severe diarrhea, hypertension, fever**	Asthma, severe HTN, cardiac/renal/hepatic disease	N b s
Misoprostol (Cytotec) rectal	PPH (off-label, often after Methergine contraindicated)	Baseline temperature; allergy history	Hyperthermia, shivering, GI upset	Hypersensitivity to prostaglandins	N s

MEDICATION	WHY GIVEN	ASSESS BEFORE	MOST DANGEROUS EFFECT	HOLD / NOTIFY	A R
Tranexamic acid (TXA)	Adjunct for PPH; works best within 3 hr of delivery	Clotting status; renal function; history of thrombosis	Thrombosis (rare), seizures (rare, high doses)	Active thromboembolic disease; recent intracranial bleed	N
Naloxone (Narcan)	Reverse opioid-induced neonatal respiratory depression	Maternal opioid history; *NOT* to be used if mother is opioid-dependent (precipitates neonatal withdrawal/seizures)	**Acute opioid withdrawal in dependent infants**	Maternal long-term opioid use, methadone/buprenorphine therapy	–
Local anesthetic (lidocaine) for episiotomy/laceration	Anesthesia for repair after difficult delivery	Allergy; check for inadvertent IV injection (aspirate)	Local anesthetic systemic toxicity (LAST): tinnitus, perioral numbness, seizures, cardiac arrest	Allergy; max dose by weight	**I** f t

06 · FETAL MONITORING

§ 6 The Tracing During a Difficult Birth

Shoulder dystocia happens too quickly to show a clear EFM pattern, but the moments around malpresentation, prolonged labor, and macrosomia produce predictable tracings the NCLEX expects you to recognize.

ELEMENT	NORMAL / REASSURING	CONCERNING IN DIFFICULT BIRTH	INTERPRETATION	PRIORITY ACTION	RATIONALE
Baseline FHR	110–160 bpm	Tachycardia > 160 (chorioamnionitis, fetal hypoxia early); bradycardia < 110 (cord compression)	Trend matters more than a single number	Reassess every 5 min in 2nd stage; intrauterine resuscitation if abnormal	Tachycardia often *precedes* deterioration
Variability	Moderate (6–25 bpm)	Minimal or absent variability after prolonged labor or sedation	Most important predictor of fetal acid–base status	Stimulate scalp; consider reposition; notify provider if persistent	Moderate variability = fetal acid–base is intact
Accelerations	≥ 15 bpm × ≥ 15 sec (≥ 32 wk)	Absent accelerations during prolonged 2nd stage	Presence rules out current acidemia	Scalp stimulation to elicit; if absent + minimal variability + decels → escalate	Accels = oxygenated fetus
Early decelerations	Mirror contractions; head compression	Common in late labor with descent; benign	Category I	Continue routine monitoring	No fetal compromise
Variable decelerations	Abrupt; cord compression	Common in breech labor, oligohydramnios, post-ROM	Cat II if recurrent; Cat III if recurrent with absent variability	**Reposition** (lateral, knee-chest); IV fluid bolus; assess for cord prolapse; amnioinfusion if ordered	Variable decels = "V"ariable = cord — change the cord's environment by changing position
Late decelerations	—	**Uteroplacental insufficiency — common with tachysystole, abruption, post-term**	Cat II (recurrent) or Cat III (with absent variability)	**Stop oxytocin**; reposition left lateral; IV bolus; O_2 per policy; notify provider	Lates = "L"ate = pLacenta. Always concerning
Prolonged deceleration	—	**≥ 2 min, < 10 min — cord prolapse, rupture, abruption, eclampsia**	Always abnormal	Full intrauterine resuscitation; rule out cord prolapse *with vaginal exam*; prepare for delivery	A sudden prolonged decel post-ROM is cord prolapse until proven otherwise

ELEMENT	NORMAL / REASSURING	CONCERNING IN DIFFICULT BIRTH	INTERPRETATION	PRIORITY ACTION	RATIONALE
Category III	—	**Absent variability + recurrent late or variable decels OR bradycardia OR sinusoidal pattern**	Predictive of abnormal acid-base status	Activate emergency team; prepare for STAT delivery (vaginal if imminent, cesarean if not)	Cat III = act now, deliver now

INTRAUTERINE RESUSCITATION BUNDLE

Lateral position (or knee-chest if cord prolapse) · **I**V fluid bolus per orders · **O**xygen 10 L/min non-rebreather *only when fetal status warrants* · **N**otify provider · **S**top oxytocin if running. The mnemonic some programs use is **LIONS** or **SLOPE** (Stop oxytocin, Lateral, O_2, Provider, Examine/Elevate presenting part).

07 · NGN PRACTICE QUESTIONS

§ 7 10 Advanced NGN Practice Questions

> *Every question is application-level or higher. Read the stem twice. Ask: "What finding is most dangerous for the mother or fetus, and what should the nurse do first?"*

Question 01

MULTIPLE CHOICE · TAKE ACTION

A nurse is assisting with a vaginal delivery when the fetal head delivers and immediately retracts tightly against the perineum without restitution. The next nurse action is to:

A Apply firm fundal pressure to expedite delivery.

B Call for help and assist the client into the McRoberts position.

C Encourage the client to push harder with the next contraction.

D Insert a Foley catheter to empty the bladder.

Correct — B. The turtle sign is shoulder dystocia. Immediate steps are to call for help and initiate the HELPERR sequence beginning with McRoberts (hyperflexion of the thighs). This is the single most effective initial maneuver, resolving roughly half of shoulder dystocias alone.

A — Wrong. Fundal pressure is contraindicated. It impacts the anterior shoulder more tightly and increases the risk of uterine rupture and brachial plexus injury. **Suprapubic** pressure—not fundal—is appropriate.

C — Wrong. Pushing alone does not resolve the impaction and wastes critical time.

D — Wrong. Bladder management is appropriate in some emergencies (e.g., before cesarean) but is not the first action in active dystocia.

NCLEX Trap: Confusing suprapubic and fundal pressure.

CLINICAL JUDGMENT · TAKE ACTION

Question 02

SELECT ALL THAT APPLY · RECOGNIZE CUES

A nurse is caring for a client at 39 weeks gestation with insulin-dependent gestational diabetes. The estimated fetal weight is 4,600 g. Which findings increase the risk for shoulder dystocia during delivery? Select all that apply.

- A Macrosomia
- B Maternal diabetes
- C Post-term gestation (≥ 42 weeks)
- D Previous shoulder dystocia
- E Prolonged second stage of labor
- F Maternal short stature/obesity
- G Persistent occiput anterior fetal position

Correct — A, B, C, D, E, F. All of these are recognized risk factors. Macrosomia (particularly with diabetes), post-term gestation, prior dystocia, prolonged second stage, and maternal obesity/short stature all increase risk. The combination of GDM + macrosomia is especially predictive because diabetic fetuses deposit fat asymmetrically in the shoulders and trunk.

G — Wrong. Persistent *occiput posterior* (OP) is associated with prolonged labor and instrumental delivery, but *occiput anterior* (the most common and favorable position) is not a dystocia risk factor.

NCLEX Trap: Marking OA as a risk factor — it is the *most favorable* position.

CLINICAL JUDGMENT · RECOGNIZE CUES

Question 03

ORDERED RESPONSE · TAKE ACTION

Shoulder dystocia is identified. Place the following nursing actions in the correct sequence (1 = first, 6 = last):

- **1.** Call for help and note the time of head delivery
- **2.** Drop the head of the bed flat and position client with thighs hyperflexed onto abdomen (McRoberts)
- **3.** Apply suprapubic pressure directed downward and laterally
- **4.** Provider performs internal rotational maneuvers (Rubin, Woods)
- **5.** Examine newborn for clavicle fracture and brachial plexus injury
- **6.** Document the sequence and times of each maneuver

Correct sequence is exactly as listed. HELPERR begins with calling for **H**elp; **L**egs (McRoberts) is the first physical maneuver; **P**ressure (suprapubic) follows; then **E**nter (internal maneuvers) and **R**emove posterior arm if needed. After delivery, examine the newborn for trauma and document the full timeline.

NCLEX Trap: Putting documentation before delivery, or applying suprapubic pressure before McRoberts.

CLINICAL JUDGMENT · TAKE ACTION

Question 04

MATRIX · ANALYZE CUES

For each finding, indicate whether the nurse should take immediate action, continue monitoring, or escalate to the provider for STAT cesarean.

FINDING	IMMEDIATE ACTION	CONTINUE MONITORING	ESCALATE · STAT CESAREAN
Footling breech in labor with ROM	✓		✓
Transverse lie at 41 weeks, in active labor	✓		✓
Mentum anterior face presentation, dilating		✓	
Mentum posterior face presentation, full dilation	✓		✓
Persistent OP at 8 cm, FHR Category I		✓	
Visible cord on perineum after AROM	✓		✓
Suspected macrosomia (EFW 4,200 g) without diabetes		✓	

Rationale: Mentum anterior face presentation *can* deliver vaginally because the head can hyperextend through the pelvis. Mentum posterior cannot. Persistent OP is monitored unless arrest occurs. Macrosomia < 4,500 g without diabetes is not an absolute indication for cesarean per ACOG. Footling breech, transverse lie, and cord prolapse all require STAT action.

NCLEX Trap: Treating all face presentations as needing cesarean — chin position matters.

CLINICAL JUDGMENT · ANALYZE CUES

Question 05

BOW-TIE · GENERATE SOLUTIONS + TAKE ACTION

A G3P2 client at 40 weeks with a history of GDM and a previous 4,300-g infant is in second stage. The estimated fetal weight is 4,500 g. The head has just delivered; the chin retracts firmly against the perineum.

Choose the most likely condition: Shoulder Dystocia · Cord Prolapse · Uterine Rupture · Precipitous Labor

Choose 2 priority actions:

A Apply fundal pressure

B Call for help and assist into McRoberts position

C Apply suprapubic pressure

D Encourage the mother to push harder

E Administer terbutaline

Choose 2 parameters to monitor:

F Time interval from head delivery to body delivery

G Maternal blood pressure

H Newborn movement and tone of the arms after delivery

I Maternal cervical dilation

Correct — Condition: Shoulder Dystocia. Actions: B + C. Parameters: F + H.

Turtle sign + macrosomia + GDM + previous large baby is a classic stem. Actions are McRoberts and suprapubic pressure (never fundal). Monitor the head-to-body interval (clinically and legally critical—each minute beyond 5 increases neonatal morbidity) and assess the newborn for brachial plexus injury (Erb's palsy: "waiter's tip" arm).

A — Wrong. Fundal pressure is contraindicated.

D — Wrong. Pushing alone won't resolve impaction.

E — Wrong. Terbutaline relaxes the uterus and is used for uterine inversion, hypertonus, or tocolysis—not shoulder dystocia.

NCLEX Trap: Listing parameters that sound clinically important (BP, dilation) but are not the priority during a brief intrapartum emergency.

CLINICAL JUDGMENT · GENERATE SOLUTIONS + TAKE ACTION

Question 06

CLOZE · ANALYZE CUES

Complete each sentence by choosing the correct option in brackets.

1. A footling breech presentation in active labor with ruptured membranes places the fetus at greatest risk for **[cord prolapse / shoulder dystocia / hypoglycemia]**.

2. A face presentation with the chin **[posterior / anterior]** can usually deliver vaginally.

3. The most effective *initial* maneuver for shoulder dystocia is **[suprapubic pressure / McRoberts / Woods corkscrew]**.

4. The maneuver that is contraindicated in shoulder dystocia is **[suprapubic pressure / fundal pressure / Gaskin maneuver]**.

5. A newborn with an arm hanging limp at the side, internally rotated and extended after a difficult delivery has signs of **[Erb's palsy / Klumpke's palsy / clavicle fracture]**.

Answers: 1 — cord prolapse · 2 — anterior · 3 — McRoberts · 4 — fundal pressure · 5 — Erb's palsy.

Why: Footling breech allows the cord to slip past the small presenting part once membranes rupture. Mentum anterior accommodates the largest fetal diameters through the pelvis. McRoberts resolves about half of dystocias alone. Fundal pressure is the contraindicated maneuver. Erb's palsy (C5–C6) presents as the classic "waiter's tip"; Klumpke's (C7–T1) affects the wrist/hand and is far less common.

NCLEX Trap: Confusing Erb and Klumpke palsies — Erb is the common one with the proximal "waiter's tip" presentation.

CLINICAL JUDGMENT · ANALYZE CUES

Question 07

PRIORITIZATION · MULTIPLE CHOICE

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

A A G2P1 at 39 weeks, 7 cm, vertex, mild variable decelerations resolving with repositioning

B A G1P0 at 40 weeks, 9 cm, persistent OP, mother reporting strong back pain

C A G3P2 at 41 weeks, just had AROM, footling breech now confirmed, FHR baseline 135 with moderate variability

D A G2P1 at 38 weeks, 5 cm, FHR Category I, contractions every 3 minutes

Correct — C. Footling breech with ruptured membranes carries the highest immediate risk of cord prolapse, which can cause catastrophic fetal hypoxia within minutes. The reassuring FHR does not eliminate the urgent need for assessment — the prolapse can occur after any subsequent contraction.

A — Wrong. Variable decels resolving with repositioning indicate effective intervention.

B — Wrong. OP causes discomfort and prolonged labor but is not immediately life-threatening.

D — Wrong. A stable Category I client is the lowest priority.

NCLEX Trap: Choosing the symptomatic but stable client (B) over the asymptomatic but high-risk client (C). "Most stable now" is not "least at risk now."

CLINICAL JUDGMENT · PRIORITIZE HYPOTHESES

Question 08

MEDICATION SAFETY · MULTIPLE CHOICE

A G4P3 client experienced a shoulder dystocia and gave birth to a 4,750-g infant. The fundus is now boggy, and lochia is heavy. The provider orders methylergonovine 0.2 mg IM. The most recent BP is 158/96 mm Hg. The nurse should:

A Administer the medication immediately because the bleeding is life-threatening.

B Hold the medication, notify the provider of the BP, and request an alternative such as carboprost.

C Administer half the dose and re-evaluate.

D Give the medication IV instead of IM to act faster.

Correct — B. Methylergonovine is *absolutely contraindicated* in hypertension because it causes systemic vasoconstriction and can precipitate stroke, MI, and seizure. The BP of 158/96 is severe-range. The nurse holds, notifies, and requests an alternative such as carboprost (Hemabate)—provided the client does not have asthma.

A — Wrong. Hemorrhage is urgent, but giving a contraindicated drug can kill the client. Alternatives exist (oxytocin, carboprost, misoprostol, TXA).

C — Wrong. Nurses do not split prescribed doses unilaterally; contraindication is not dose-dependent here.

D — Wrong. IV methylergonovine is generally avoided because of severe hypertension and stroke risk; it does not solve the contraindication.

NCLEX Trap: The classic — giving Methergine to a hypertensive client. Always check BP first.

CLINICAL JUDGMENT · TAKE ACTION

Question 09

FETAL MONITORING · MULTIPLE CHOICE

A G2P1 client at 39 weeks just had AROM at 5 cm. Within 90 seconds, the FHR drops from 140 to 70 bpm and remains there. The amniotic fluid is clear. The nurse's *first* action is to:

A Perform a sterile vaginal exam to check for cord prolapse and lift the presenting part off the cord if present.

B Place the client supine and call the provider.

C Administer oxytocin to strengthen contractions and expedite delivery.

D Wait one more contraction to see if the deceleration recovers.

Correct — A. A prolonged deceleration within minutes of AROM is cord prolapse until proven otherwise. The first action is a sterile vaginal exam to detect the cord and—if found—keep the gloved hand in place to elevate the presenting part. Then call for help, place client in knee-chest or Trendelenburg, administer O_2 per policy, and prepare for STAT cesarean.

B — Wrong. Supine worsens cord compression and reduces venous return.

C — Wrong. Oxytocin increases contractions and worsens cord compression.

D — Wrong. Watchful waiting on a prolonged decel post-ROM is unsafe.

NCLEX Trap: Choosing supine because "you need to assess." Supine = worsened cord compression.

CLINICAL JUDGMENT · TAKE ACTION

Question 10

EMERGENCY ACTION · SATA

A nurse identifies a cord prolapse during a vaginal exam at 6 cm dilation. Which actions should the nurse take? Select all that apply.

- **A** Keep a sterile gloved hand in the vagina lifting the presenting part off the cord
- **B** Place the client in supine position with legs straight
- **C** Place the client in knee-chest position or Trendelenburg
- **D** Administer oxygen 10 L/min via non-rebreather mask
- **E** Push the cord back into the uterus to relieve compression
- **F** Begin or increase the IV fluid bolus per orders
- **G** Call for the OB emergency / cesarean team
- **H** Stop the oxytocin infusion if running

Correct — A, C, D, F, G, H.

A — The gloved hand stays in place until delivery to keep the presenting part off the cord. **C** — Knee-chest or Trendelenburg uses gravity to relieve pressure on the cord. **D** — O_2 optimizes maternal oxygenation, which crosses to the fetus. **F** — Fluid bolus optimizes maternal perfusion. **G** — Cesarean is required for an undelivered cord prolapse. **H** — Oxytocin worsens cord compression by intensifying contractions.

B — Wrong. Supine position worsens cord compression and causes aortocaval compression.

E — Wrong. Never attempt to replace the cord—handling causes vasospasm and worsens fetal hypoxia.

NCLEX Trap: Pushing the cord back. It is harmful and never an answer.

CLINICAL JUDGMENT · TAKE ACTION

08 · UNFOLDING NGN CASE STUDY

§ 8 Case: Suspected Macrosomia at 41 Weeks

Maria L., G3P2 · 41^{+2} weeks · GDM (insulin-controlled)

NURSE'S NOTES · 0710

Client admitted to L&D at 41^{+2} weeks for induction. History of GDM controlled with insulin, BMI 36, previous infants 3,950 g and 4,200 g, both vaginal deliveries. Estimated fetal weight today by US: 4,650 g, vertex. Membranes intact. Cervix 3 cm / 50% / -1 station. Vertex confirmed. GBS positive — penicillin started.

MATERNAL VITAL SIGNS · 0710

BP	HR	RR	TEMP	SPO₂	GLUCOSE
128 / 78	88	18	98.6 °F	98%	112 mg/dL

FHR TRACING · 0710

Baseline 140 bpm · moderate variability · accelerations present · no decelerations · **Category I**.

PROVIDER ORDERS

- Oxytocin per protocol, titrate to adequate contractions
- IV LR 125 mL/hr
- Continuous EFM
- Penicillin G 5 million units IV, then 2.5 million every 4 hr
- Strict glucose check every 1 hr; sliding scale insulin
- Notify provider for arrest of dilation/descent, Cat II/III, or change in fetal status

QUESTION 1 · RECOGNIZE CUES

Which findings should the nurse identify as *risk factors* for shoulder dystocia? Select all that apply.

A Estimated fetal weight 4,650 g

B Gestational diabetes

C 41^{+2} weeks gestation

D BMI 36

E GBS positive

F Cervix 3 cm / 50% / -1

G Previous infants ≥ 3,900 g

Correct — A, B, C, D, G. Macrosomia, GDM, post-term, maternal obesity, and history of macrosomic infants are all recognized risk factors. GBS status and current cervical exam do not predict shoulder dystocia.

STEP 1 · RECOGNIZE CUES

QUESTION 2 · ANALYZE CUES

Based on the risk profile, the nurse anticipates this client has highest risk for which complications? Place each in the correct category.

COMPLICATION	ANTICIPATED FOR THIS CLIENT	NOT PARTICULARLY ANTICIPATED
Shoulder dystocia	✓	
Postpartum hemorrhage from uterine atony	✓	
Neonatal hypoglycemia	✓	
Third- or fourth-degree laceration	✓	
Preterm labor		✓
Cord prolapse		✓

Macrosomia + multiparity + uterine overdistension is a strong PPH risk. Maternal GDM exposes the fetus to elevated insulin, causing rebound neonatal hypoglycemia after cord clamping. Macrosomic infants stretch the perineum and predispose to deep lacerations. Preterm labor is not anticipated at 41^{+2}. Cord prolapse risk is not elevated with vertex and intact membranes.

STEP 2 · ANALYZE CUES

UPDATE · 1530 (ACTIVE SECOND STAGE)

After 8 hours of induction and 90 minutes of pushing, the fetal head delivers but immediately retracts tightly against the perineum. The chin does not rotate. The provider says "shoulder dystocia."

MATERNAL HR	BP	PAIN	FHR (PRE-DELIVERY)
114	**132 / 84**	**8/10**	**90 bpm**

QUESTION 3 · PRIORITIZE HYPOTHESES

Order these potential complications from highest to lowest priority right now:

1. Fetal hypoxic-ischemic injury (cord compression in dystocia)
2. Brachial plexus injury
3. Maternal third- or fourth-degree laceration
4. Postpartum hemorrhage
5. Neonatal hypoglycemia

Each minute of head-to-body delay during dystocia compresses the cord and reduces fetal pH. Hypoxic injury is the most immediate and reversible-if-acted-on threat. Brachial plexus injury risk rises with traction during maneuvers. Maternal lacerations and PPH become priority after delivery. Hypoglycemia is a post-delivery concern.

STEP 3 · PRIORITIZE HYPOTHESES

QUESTION 4 · GENERATE SOLUTIONS

Which interventions are appropriate right now? Select all that apply.

A Call for help and additional staff

B Drop the bed flat

C Assist client into McRoberts position

D Apply suprapubic pressure

E Apply fundal pressure

F Note the time of head delivery

G Begin chest compressions on the mother

H Have the NRP team standing by

Correct — A, B, C, D, F, H. Fundal pressure (E) is contraindicated. Maternal chest compressions (G) are not indicated; the mother is hemodynamically stable.

STEP 4 · GENERATE SOLUTIONS

UPDATE · 1534 — DELIVERY

After McRoberts + suprapubic pressure + Rubin internal maneuver, the infant delivers at 1534. Total head-to-body interval: **4 minutes**. Infant: 4,720 g, limp, apneic, HR 50. NRP initiated. Mother's fundus is boggy and displaced to the right; lochia is heavy with clots.

QUESTION 5 · TAKE ACTION

Identify the next priority nursing action for the *newborn* and for the *mother*.

Newborn:

A Administer naloxone IM

B Position, dry, stimulate, and begin positive-pressure ventilation

C Defer all action until 1-minute Apgar is calculated

D Begin chest compressions immediately

Mother:

E Catheterize the bladder and massage the fundus while initiating IV oxytocin per protocol

F Administer methylergonovine 0.2 mg IM

G Place client in Trendelenburg and observe

H Apply pressure on the fundus and discourage breastfeeding

Newborn — B. Ventilation is the cornerstone of neonatal resuscitation. Compressions are only added if HR < 60 despite 30 seconds of effective PPV. Naloxone is no longer routine in NRP.

Mother — E. A boggy, deviated fundus indicates atony with bladder distention. Catheterize, massage, and run oxytocin. Methylergonovine could be considered but BP must be acceptable first; oxytocin is the first-line uterotonic. Trendelenburg and fundal pressure are not interventions for atony.

STEP 5 · TAKE ACTION

QUESTION 6 · EVALUATE OUTCOMES

Thirty minutes after delivery, which findings would indicate the interventions are *effective*? Select all that apply.

A Maternal fundus firm and midline at U-1

B Lochia rubra, moderate, no clots larger than a nickel

C Maternal BP 110/70, HR 84

D Newborn Apgar 8 at 5 minutes, crying, pink centrally

E Newborn left arm flaccid, internally rotated, no spontaneous movement

F Newborn glucose 38 mg/dL

G Mother voiding 350 mL clear yellow urine

Correct — A, B, C, D, G.

E (Erb's palsy) indicates a brachial plexus injury — a complication of the dystocia, not a sign of effective intervention. Refer to peds/neonatology, position the affected arm, document.

F (glucose 38) is neonatal hypoglycemia — expected in this scenario but indicates intervention needed (feed, recheck, notify provider per protocol), not an effective outcome.

STEP 6 · EVALUATE OUTCOMES

09 · PRIORITIZATION DRILLS

§ 9 What Should the Nurse Do *First*?

SCENARIO 1 · TURTLE SIGN

The head delivers but does not restitute and the chin retracts against the perineum.

First action: Call for help and assist the client into McRoberts position (thighs hyperflexed to abdomen). Note the time of head delivery. Suprapubic pressure follows McRoberts.

SCENARIO 2 · VISIBLE CORD AFTER AROM

Immediately after AROM, a loop of umbilical cord is visible at the introitus. FHR drops to 70 bpm.

First action: Insert sterile gloved hand into vagina and lift presenting part off the cord. Do not remove the hand until delivery. Simultaneously call for help, place client in knee-chest or Trendelenburg.

SCENARIO 3 · TRANSVERSE LIE IN ACTIVE LABOR

A G2P1 at 39 weeks is 5 cm dilated with regular contractions. Ultrasound now confirms a persistent transverse lie.

First action: Stop oxytocin if running, notify the provider for STAT cesarean preparation, keep client NPO, place IV bolus per orders. Vaginal delivery is not possible.

SCENARIO 4 · SUDDEN LOSS OF STATION + SEVERE PAIN

A client with one prior cesarean attempting VBAC suddenly reports severe abdominal pain. The fetal head has receded from +1 to -2 station. FHR drops to 80 bpm.

First action: Suspect uterine rupture. Stop oxytocin, call for immediate provider and OR team, IV bolus, O_2 per policy, prepare for STAT cesarean. This is a true catastrophic emergency.

SCENARIO 5 · ERB'S PALSY IDENTIFIED POSTPARTUM

After a difficult shoulder-dystocia delivery, the newborn's left arm hangs flaccid at the side, internally rotated, with absent Moro on that side.

First action: Notify pediatrics/neonatology. Position the affected arm in adduction across the chest with the elbow flexed to limit further nerve stretch. Gentle handling. Document the finding clearly. Most resolve with time and physical therapy.

10 · STOP · HOLD · ESCALATE

§ 10 Five Stop, Hold, or Escalate Scenarios

STOP OXYTOCIN	**Shoulder dystocia is identified.** Tachysystole or further uterine activity worsens the impaction and reduces placental perfusion. Stop oxytocin *before* beginning maneuvers.
HOLD METHERGINE	Postpartum hemorrhage after macrosomic delivery, but client's BP is 158/96 mm Hg. Methylergonovine causes vasoconstriction and can precipitate stroke. **Hold, notify, request carboprost** (if no asthma) or misoprostol.
NOTIFY PROVIDER	Transverse lie confirmed in a laboring client at 39 weeks, regular contractions. Vaginal delivery is impossible. **Notify provider immediately**; prepare for cesarean; keep NPO; verify consent.
CALL OB EMERGENCY	Sudden prolonged FHR deceleration to 70 bpm one minute after AROM with palpable cord at introitus. **Activate OB rapid response / cesarean team**—surgical delivery within minutes is required.
PREPARE FOR EMERGENCY BIRTH	Footling breech in active labor, fully dilated, fetal feet visible at introitus, no provider yet in room. **Prepare for assisted breech vaginal birth**: open emergency delivery pack, notify pediatrics/NRP, do not pull on fetal limbs, support the body to allow head delivery. If provider arrives in time and delivery is not imminent, transfer to OR for cesarean.

11 · NCLEX TRAPS

§ 11 Five Common Traps to Avoid

TRAP

Trap 1 · Choosing fundal pressure over suprapubic pressure

Fundal pressure is *contraindicated* in shoulder dystocia—it worsens impaction and increases brachial plexus and rupture risk. Suprapubic pressure is performed just above the symphysis, directed downward and lateral. NCLEX writes options to look similar.

TRAP

Trap 2 · Pushing the cord back into the uterus during prolapse

Never. Handling the cord causes vasospasm and worsens hypoxia. The intervention is to *elevate the presenting part off the cord*—not to manipulate the cord itself.

TRAP

Trap 3 · Treating all face presentations the same

Mentum *anterior* can deliver vaginally. Mentum *posterior* cannot. Chin position matters more than the presentation itself.

TRAP

Trap 4 · Giving Methergine to a hypertensive postpartum client

Methylergonovine is contraindicated in hypertension and preeclampsia. NCLEX will dangle the dose in front of you while burying the BP elsewhere on the stem. Always check BP before pulling the cap off the syringe.

TRAP

Trap 5 · Forgetting to assess the newborn's clavicle and arm after dystocia

Erb's palsy ("waiter's tip") and clavicle fracture (crepitus, absent Moro on one side) are missed when the focus is on the mother's hemorrhage risk. Both must be assessed and documented.

12 · END-OF-DAY QUICK REVIEW

§ 12 Quick Review — Five Categories

10 MUST-REMEMBER POINTS

1. Turtle sign = shoulder dystocia.
2. McRoberts first; suprapubic pressure second.
3. Fundal pressure is never an answer.
4. Footling breech + ROM = high cord-prolapse risk.
5. Transverse lie = cesarean.
6. Mentum anterior delivers; mentum posterior does not.
7. Macrosomia + GDM = anticipate dystocia and PPH.
8. Methergine is contraindicated in hypertension.
9. Erb's palsy = "waiter's tip" arm.
10. Document head-delivery time and body-delivery time.

5 RED-FLAG FINDINGS

1. Turtle sign after head delivery
2. Visible/palpable cord at perineum
3. Sudden prolonged FHR decel after ROM
4. Sudden loss of fetal station + severe pain (VBAC) — rupture
5. Newborn flaccid arm, "waiter's tip" position

5 NEVER-DO RULES

1. Never apply fundal pressure for shoulder dystocia
2. Never push a prolapsed cord back into the uterus
3. Never give Methergine if BP is elevated
4. Never give carboprost (Hemabate) to an asthmatic
5. Never pull on the fetal arms during a breech delivery

5 FETAL MONITORING CLUES

1. Variable decels post-ROM → assess for cord
2. Sudden prolonged decel → cord prolapse
3. Late decels with tachysystole → stop oxytocin
4. Cat III pattern → emergency delivery
5. Moderate variability + accels = oxygenated fetus

5 MEDICATION SAFETY CLUES

1. Oxytocin → stop for dystocia, tachysystole, Cat III
2. Methergine → contraindicated in HTN
3. Carboprost → contraindicated in asthma
4. Mag sulfate antidote → calcium gluconate
5. Naloxone → not first-line in NRP; ventilation first

5 POSITION CLUES

1. Shoulder dystocia → McRoberts (thighs to chest)
2. Cord prolapse → knee-chest or Trendelenburg
3. Persistent OP → hands-and-knees
4. Maternal hypotension post-epidural → left lateral
5. Routine labor with variable decels → side-lying

Day 11 · One-Page Summary

Screenshot this page. Everything you need on a difficult birth—shoulders, breech, cord, brow, face—in one frame.

The Difficult Birth at a Glance

SHOULDER DYSTOCIA · HELPERR

- → **H**elp — call team, note time
- → **E**valuate for episiotomy
- → **L**egs — McRoberts (1st)
- → **P**ressure — suprapubic (2nd)
- → **E**nter — Rubin / Woods
- → **R**emove posterior arm
- → **R**oll to hands-and-knees

NEVER DURING DYSTOCIA

- → Fundal pressure
- → Excessive head traction
- → Forced neck flexion/extension
- → Continuing oxytocin
- → Delay in calling for help

CORD PROLAPSE ACTIONS

- → Lift presenting part off cord
- → Knee-chest or Trendelenburg
- → O_2 10 L/min non-rebreather
- → IV bolus per orders
- → Stop oxytocin
- → STAT cesarean team
- → Never push cord back in

MALPRESENTATION RULES

- → Transverse lie → cesarean
- → Footling breech + ROM → ↑ ↑ ↑ cord risk
- → Mentum anterior → vaginal OK
- → Mentum posterior → cesarean
- → Brow persistent → cesarean
- → OP → hands-and-knees, ↑ back labor

RISK FACTORS · DYSTOCIA

- → Macrosomia (EFW ≥ 4,000–4,500 g)
- → Maternal diabetes
- → Post-term gestation
- → Prior shoulder dystocia
- → Prolonged 2nd stage
- → Maternal obesity / short stature
- → Operative vaginal delivery

AFTER A DIFFICULT BIRTH · MOTHER

- → Fundus → boggy? massage + oxytocin
- → Bladder → catheterize if distended
- → Lochia → assess clots, saturation
- → Perineum → 3rd/4th-degree?
- → Vitals → tachycardia = early shock
- → Methergine OK only if BP normal

AFTER A DIFFICULT BIRTH · NEWBORN

- → NRP if needed — ventilation first
- → Clavicle → crepitus, asymmetric Moro
- → Brachial plexus → "waiter's tip"
- → Glucose → ↓ in macrosomic/GDM infants
- → Temperature → thermoregulation
- → Skin-to-skin if stable

MED SAFETY · DAY 11 SPECIFICS

- → Methergine — NO if BP ↑
- → Carboprost — NO if asthma
- → Mag toxicity antidote — Ca gluconate
- → Terbutaline — caution HR > 120
- → Oxytocin — stop in dystocia / Cat III

The Decision Flow

HEAD DELIVERS → NO RESTITUTION? TURTLE SIGN → CALL HELP → MCROBERTS → SUPRAPUBIC PRESSURE → INTERNAL MANEUVERS → DOCUMENT TIMES

AROM DONE → FHR DROPS SUDDENLY? → VAGINAL EXAM → CORD FELT? LIFT & HOLD → KNEE-CHEST / TRENDELENBURG → O_2 + IV BOLUS → STAT CESAREAN

Memory Anchor

> *"When the head delivers and the chin won't turn — you don't push the fundus, you flex the legs.*
> *When the cord drops — you don't push it in, you push the head up.*
> *When the lie is sideways — you don't induce harder, you go to the OR.*
> *When the BP is high — you don't reach for Methergine, you reach for Hemabate (unless asthma).*
> *When the baby's arm is limp — you don't assume sleep, you suspect Erb's."*

— End of Day 11 —

NEXT: DAY 12 · PRETERM LABOR, PPROM, TOCOLYTICS, BETAMETHASONE, INFECTION CONCERNS

2026 NGN NCLEX-RN · L&D DAILY REVIEW