NCLEX-RN • 2026 NGN REVIEW LABOR & DELIVERY • DAY 06 OF 16 CLINICAL JUDGMENT MEASUREMENT MODEL

Pain in Labor: *opioids, epidurals & the nurse's first move.*

A working knowledge of comfort measures, IV opioid timing, regional anesthesia complications, and the maternal-fetal red flags that demand action — not just recognition.

NONPHARMACOLOGIC COMFORT | IV OPIOIDS | EPIDURAL / SPINAL | NALOXONE | HYPOTENSION PROTOCOL

On today's pages

§ 01 High-yield *overview*

Labor pain is not just a comfort issue — every pain intervention has maternal AND fetal consequences. The NCLEX-RN expects you to think two patients, not one. The same opioid that calms the laboring client can suppress the newborn. The same epidural that gives relief can drop maternal BP and crash fetal heart tones in five minutes.

THE BIG PICTURE

Pain management in labor moves along a ladder: **nonpharmacologic → IV opioids → regional anesthesia (epidural/spinal/CSE) → nitrous oxide or local for repair**. The nurse's job is not to pick the method — it's to assess **safety thresholds** before, during, and after each intervention.

Three high-yield safety frames define this content:

- **Maternal hemodynamics** — BP, perfusion, bladder, respiratory drive
- **Fetal oxygenation** — FHR baseline, variability, decelerations, accelerations
- **Labor progress** — contractions, descent, maternal urge to push

WHY THIS MATTERS ON THE NGN

NGN items pile on cues: BP 88/52, FHR 100, no variability, epidural placed 8 minutes ago, bladder distended, mom drowsy after IV fentanyl 5 min ago. Your job is to **recognize** which cue is most dangerous, **analyze** the link to the intervention, and **take action** that addresses the cause — not the symptom. Giving oxygen to a hypotensive mom without a fluid bolus and left lateral repositioning is a wrong answer.

§ 02 Ten *must-know* rules

01

IV opioids are avoided within 1–4 hours of expected birth because of neonatal respiratory depression. If given close to delivery, **naloxone must be at the bedside** for the newborn.

02

Before an epidural: **500–1000 mL IV crystalloid preload/coload**, baseline BP, baseline FHR strip, empty bladder, and informed consent **verified**.

03

Post-epidural **maternal hypotension** (drop ≥20% or SBP <100) is the #1 complication and the #1 cause of **fetal bradycardia within minutes**.

04

For post-epidural hypotension: **turn to left lateral, IV bolus, ephedrine or phenylephrine per order, O_2 if FHR non-reassuring, notify anesthesia**. Reposition first — it costs nothing and works fastest.

05

A **distended bladder** after epidural can stall labor and cause uterine atony postpartum. Straight-cath q2–4h or as ordered — the client cannot feel the urge.

06

Never ambulate a client with a working epidural. Motor block + sensory loss = fall risk. Two-person assist only for repositioning.

07

Butorphanol & nalbuphine are **mixed agonist-antagonists**. Giving them to an opioid-dependent client can **precipitate withdrawal** — screen for opioid use first.

08

Post-dural-puncture headache: **positional, frontal/occipital, worse upright, better supine**. Treatment = hydration, caffeine, bedrest, **blood patch** if not resolving.

09

For high spinal: **respiratory paralysis, hypotension, bradycardia, loss of consciousness**. Call rapid response, prepare for intubation, support BP and HR.

10

Nonpharmacologic measures are **not optional** — they reduce opioid use, support coping, and are NCLEX-favored. Position changes, counterpressure,

hydrotherapy, breathing, and continuous labor support all earn credit.

§ 03 Maternal-fetal *safety table*

FINDING	WHAT IT MEANS	MOTHER RISK	FETAL / NEWBORN RISK	PRIORITY NURSING ACTION	NOTIFY / ESCALATE
BP 84/50 five min after epidural bolus	Sympathetic blockade causing vasodilation	**Hypoperfusion, syncope**	**Bradycardia, hypoxia**	Turn **left lateral**, IV fluid bolus, O_2 10 L NRB if non-reassuring FHR, ephedrine/phenylephrine per order	Notify anesthesia immediately
RR 8, drowsy 5 min after IV morphine	Maternal opioid respiratory depression	**Hypoxia, apnea**	**Decreased uteroplacental O_2**	Stimulate, O_2, prepare **naloxone 0.4 mg IV**	Call provider; rapid response if no improvement
Newborn delivered 30 min after maternal IV opioid; RR 18, weak cry	Neonatal respiratory depression	—	**Apnea, poor Apgar**	Positive-pressure ventilation, **naloxone per neonatal protocol**, warm/stim	Neonatal team / NICU
Severe headache 24 h post-epidural, worse sitting	Post-dural puncture headache (spinal HA)	Dural CSF leak; debilitating HA	—	Bedrest, hydration, caffeine, analgesia, prepare for **blood patch**	Notify anesthesia
Sudden dyspnea, tinnitus, metallic taste during epidural dosing	Local anesthetic systemic toxicity (LAST) / intravascular injection	**Seizure, cardiac arrest**	**Fetal compromise**	**STOP infusion**, O_2, call anesthesia, prepare **20% lipid emulsion**	Rapid response / code team
Bladder palpable above umbilicus, FHR variables increasing	Bladder distention from sensory block	Atony, hemorrhage risk	Variable decels, cord compression	Straight catheterize, reposition	If FHR doesn't recover after emptying → notify

FINDING	WHAT IT MEANS	MOTHER RISK	FETAL / NEWBORN RISK	PRIORITY NURSING ACTION	NOTIFY / ESCALATE
Itching after epidural with fentanyl	Opioid-mediated pruritus (not allergy)	Distress, scratching	—	Reassure, cool compress, **nalbuphine** or diphenhydramine per order	Routine; notify if airway/rash develops
Sudden FHR drop to 70, mom feels nothing	Likely uteroplacental insufficiency from anesthetic effect	—	**Profound hypoxia**	**Intrauterine resuscitation bundle**: reposition, fluids, stop oxytocin, O_2, check BP, vaginal exam to rule out prolapse	Anesthesia + provider STAT
Maternal SpO_2 89%, sluggish, after butorphanol	Opioid sedation	**Respiratory depression**	**Hypoxia**	Stimulate, O_2, naloxone ready	Provider notification
Bilateral leg numbness extending to chest 10 min after spinal	High spinal block ascending	**Respiratory paralysis**	**Hypoxia**	Trendelenburg-modified, O_2, support BP/HR, **prepare to intubate**	Code team / anesthesia STAT

§ 04 Red-flag *cues*

If you see *any* of these in a stem, your hand is moving — to the client first, to the call light or phone right after.

IMMEDIATE ASSESSMENT
Sudden change in maternal LOC, slurred speech, or "I don't feel right" after regional anesthesia.

REPOSITION LEFT LATERAL
Any post-epidural hypotension OR new fetal decelerations within 30 minutes of epidural placement.

IV FLUID BOLUS
Maternal SBP <100 or 20% drop from baseline post-epidural — bolus 500–1000 mL LR per order.

STOP OXYTOCIN
Tachysystole OR Category II/III tracing developing after pain intervention. Pitocin off, mainline open.

OXYGEN IF INDICATED
Non-reassuring FHR with maternal hypoxia, hypotension unresolved by repositioning + fluid. 10 L via NRB per facility policy.

NALOXONE READY
Maternal RR <10, sedation level 4, OR newborn delivered <4 hours after opioid with respiratory depression.

NOTIFY ANESTHESIA
Inadequate block, one-sided block, hot spots, rising sensory level, severe headache, or LAST signs.

RAPID RESPONSE / EMERGENCY BIRTH PREP
High spinal with respiratory compromise, LAST with seizure or arrest, sudden severe hypotension with non-

recoverable FHR, suspected uterine rupture.

§ 05 Medication *safety*

Fentanyl (IV / Epidural)

Why given	Short-acting opioid for labor pain; used IV for rapid relief and in epidural infusions for synergy with bupivacaine/ropivacaine.
Assess before	RR, SpO_2, sedation level, allergy hx, time since last dose, expected time to delivery, FHR baseline & variability.
Most dangerous adverse effect	**Maternal & neonatal respiratory depression; chest wall rigidity at high doses.**
Hold / notify if	RR <12, sedation level ≥3, expected birth within 1 hour (IV route), allergy.
Antidote	**Naloxone** 0.4 mg IV (maternal); neonatal naloxone per resuscitation protocol.
Monitoring	RR, SpO_2, sedation, FHR, BP, nausea, pruritus.
Teach client	Quick onset/short duration; possible itching, nausea; report dizziness, trouble breathing.
NCLEX trap	Don't give within ~1 h of expected delivery; route matters — epidural fentanyl has less neonatal effect than IV.

Morphine (IV / IM)

Why given	Longer-acting opioid; sometimes used in early latent labor or after cesarean (intrathecal/epidural form for post-op analgesia).
Assess before	RR, BP, sedation, allergy, hx of substance use, time to expected birth.
Most dangerous adverse effect	**Respiratory depression (mom & newborn — duration 4–6 h IV).**
Hold / notify if	RR <12, hypotension, sedation level ≥3, anticipated birth within 4 hours.
Antidote	Naloxone.
Monitoring	RR, SpO_2, sedation, FHR (look for ↓ variability — expected effect, not always pathologic), itch, urinary retention.

NCLEX trap	Morphine commonly causes *decreased FHR variability* — recognize as drug effect if otherwise reassuring tracing; don't mistake for hypoxia.

Butorphanol & Nalbuphine (mixed agonist-antagonists)

Why given	Labor analgesia with *ceiling effect* on respiratory depression; less neonatal depression than pure opioids.
Assess before	Opioid use history (chronic users → withdrawal), RR, BP, FHR.
Most dangerous adverse effect	**Precipitated withdrawal in opioid-dependent clients; sedation; nausea.**
Hold / notify if	Known/suspected opioid use disorder, MAT (methadone, buprenorphine).
Antidote	Naloxone (will also precipitate withdrawal — use with caution).
NCLEX trap	"Best" opioid for labor in opioid-naive clients — but disastrous in opioid-dependent ones.

Naloxone (Narcan)

Why given	Reverses opioid-induced respiratory depression in mother or newborn.
Assess before	RR, LOC, recent opioid administration, opioid dependence history.
Most dangerous adverse effect	**Acute pain crisis, hypertension, withdrawal, rebound respiratory depression as naloxone wears off (shorter half-life than most opioids).**
Monitoring	RR continuously for at least 1–2 h; repeat doses may be needed.
Contraindication	Do **NOT** give to newborn whose mother is opioid-dependent (will precipitate severe neonatal withdrawal/seizure).
NCLEX trap	Half-life shorter than opioid → resedation; client must remain monitored.

Bupivacaine & Ropivacaine (epidural local anesthetics)

Why given	Local anesthetic in epidural infusion (often combined with fentanyl) for sensory block.
Assess before	BP, FHR, allergies, anticoagulation, platelets, infection at site, neurologic baseline.

Most dangerous adverse effect	**LAST (Local Anesthetic Systemic Toxicity) — tinnitus, metallic taste, perioral numbness, seizures, cardiac arrest.**
Hold / notify if	Signs of intravascular injection, ascending block, severe hypotension.
Antidote	**20% lipid emulsion** (Intralipid) per LAST protocol; ACLS as needed.
Monitoring	BP q5 min × 15–30 min after bolus, then q15–30 min; sensory/motor level; FHR continuous.
NCLEX trap	Bupivacaine is more cardiotoxic than ropivacaine — recognize LAST signs early; don't wait for arrest.

Ephedrine & Phenylephrine (vasopressors for post-epidural hypotension)

Why given	Restore maternal BP after sympathetic blockade.
Assess before	BP, HR, FHR; ephedrine ↑ HR, phenylephrine may ↓ HR (reflex bradycardia).
Most dangerous adverse effect	**HTN, dysrhythmia, reflex bradycardia (phenylephrine).**
Monitoring	BP q1–5 min after dose, continuous FHR, maternal HR.
NCLEX trap	Phenylephrine is now first-line in many protocols; ephedrine still chosen with maternal bradycardia. Always reposition + fluid **before** drug.

Nitrous Oxide 50/50 (inhalation analgesia)

Why given	Self-administered short-acting analgesic in labor; doesn't eliminate pain but blunts perception.
Assess before	Client able to self-administer (hold mask), no contraindications (B12 deficiency, pneumothorax, recent eye surgery, bowel obstruction).
Most dangerous adverse effect	Hypoxia if used with other CNS depressants; dizziness, nausea.
Monitoring	Maternal SpO_2, LOC; ensure no second person holds mask (safety = self-administration only).
NCLEX trap	Nurse/support person *never* holds the mask for the client — self-titration is the safety feature.

§ 06 Fetal monitoring *after pain interventions*

Expected vs. concerning patterns

PATTERN	AFTER IV OPIOID	AFTER EPIDURAL	NURSING ACTION
Baseline	May slightly decrease; should stay 110–160	Usually unchanged unless hypotensive	Trend over 10 min; one number isn't enough
Variability	**Decreased — expected drug effect, esp. morphine**	Usually maintained	Decreased variability + reassuring rest of strip → likely drug; if persistent, escalate
Accelerations	May ↓ in frequency	Usually preserved	Absent accels + decreased variability = closer look
Decelerations	Generally not directly caused	**Late decels from maternal hypotension within 30 min**	Late decels post-epidural = think BP first
Contractions	Pattern usually intact	Can briefly slow then return; oxytocin titrated to need	Watch for arrest; reposition; assess descent
Category	Usually I; possibly II if variability drop	Watch for II within 30 min of placement	Cat II → intrauterine resuscitation bundle; Cat III → emergency response

RATIONALE

Pain medications affect FHR in **predictable, recognizable ways**. The NCLEX wants you to distinguish a *drug effect* from *hypoxia*. Decreased variability with no decels and an otherwise normal strip after morphine is a drug effect. Decreased variability + late decels + maternal BP 80/50 after epidural is uteroplacental insufficiency — and your action is repositioning, fluids, and stop oxytocin, not "continue monitoring."

§ 07 NGN *practice* questions

Q1

MULTIPLE CHOICE · TAKE ACTION

Eight minutes after an epidural bolus, a laboring client at 6 cm has BP 84/52 (was 124/76), HR 102, and the FHR drops from 140 with moderate variability to 95 with minimal variability. Which action does the nurse take **first**?

A. Administer ephedrine 10 mg IV per protocol

B. Apply oxygen at 10 L/min via non-rebreather

C. Turn the client to the left lateral position and open the IV mainline

D. Notify anesthesia immediately

Q2

SATA · RECOGNIZE CUES

A laboring client received IV morphine 30 minutes ago. Which findings would the nurse interpret as **expected drug effects** rather than fetal compromise? *Select all that apply.*

☑ Decreased FHR variability with baseline 132 and no decelerations

☑ Maternal drowsiness with RR 14, SpO_2 97%

☑ Mild itching to face and chest

☐ Repetitive late decelerations

☑ Slowed gastric emptying with mild nausea

☐ Maternal RR 8 and oxygen saturation 88%

Q3

DROP-DOWN / CLOZE · ANALYZE CUES

Complete the sentence: A client 4 hours post-epidural reports a **[severe positional]** headache that is worse when sitting up and improves when supine. This is most consistent with **[post-dural puncture headache]**, and the treatment of choice if conservative measures fail is **[epidural blood patch]**.

Q4

ORDERED RESPONSE · TAKE ACTION

A laboring client develops sudden tinnitus, metallic taste, and perioral numbness during epidural bolus dosing. Place the nursing actions in correct order:

1. 1. Stop the epidural infusion immediately
2. 2. Call for anesthesia and rapid response
3. 3. Administer O_2 via non-rebreather and ensure airway
4. 4. Prepare 20% lipid emulsion per LAST protocol
5. 5. Reposition client left lateral and monitor FHR continuously
6. 6. Document time, dose, symptoms, and response

Q5

MATRIX / GRID · GENERATE SOLUTIONS

For each scenario, mark whether the action is **Indicated** or **Contraindicated**.

SCENARIO	INDICATED	CONTRAINDICATED
Giving butorphanol to client on chronic methadone		✓ **Contraindicated — precipitates withdrawal**
Encouraging ambulation 30 min after epidural placement		✓ **Contraindicated — motor block / fall risk**
Administering IV fentanyl 30 min before expected birth		✓ **Contraindicated — neonatal respiratory depression risk**
500 mL LR bolus before epidural placement	✓ **Indicated**	
Straight catheterizing a client with palpable bladder 4 h after epidural	✓ **Indicated**	
Naloxone to newborn whose mother is on chronic opioids		✓ **Contraindicated — neonatal withdrawal/seizure**

Q6

BOW-TIE · PRIORITIZE HYPOTHESES

A G2P1 at 8 cm has an epidural in place. Her BP is 86/50, HR 108, FHR 100 with minimal variability and late decelerations. Construct the bow-tie.

BOW-TIE

2 Actions to take:

1. Turn left lateral and open IV mainline (rapid bolus)
2. Administer O_2 10 L NRB and notify anesthesia

Condition most likely:

Post-epidural maternal hypotension causing uteroplacental insufficiency

2 Parameters to monitor:

1. Maternal BP every 1–5 minutes until stable, then per protocol
2. Continuous FHR for return of variability and resolution of late decels

Q7

CASE STUDY ITEM · EVALUATE OUTCOMES

After interventions for post-epidural hypotension, the nurse reassesses. Which finding indicates that interventions were **effective**?

A. FHR baseline 100, minimal variability, no decels for 10 minutes

B. BP 118/72, FHR 138 with moderate variability and no decels

C. BP 100/60, FHR 130 with absent variability

D. Client now reports complete numbness from chest down

Q8

MEDICATION SAFETY · TAKE ACTION

A laboring client receives IV nalbuphine. She is G3P2 with a history of chronic opioid use disorder treated with buprenorphine. Within 5 minutes she develops diaphoresis, yawning, abdominal cramping, and agitation. What does the nurse do **first**?

A. Administer diphenhydramine for anxiety

B. Stop further nalbuphine, notify the provider, and prepare supportive measures

C. Administer naloxone IV

D. Place the client supine and increase IV fluids

Q9

FETAL MONITORING INTERPRETATION

Strip findings: baseline 140, minimal variability, no accelerations, no decelerations. Client received IV morphine 25 minutes ago, BP 122/74, no contractions stronger than mild-moderate, no vaginal bleeding. What is the nurse's **best** interpretation?

A. Category III tracing — prepare for emergency cesarean

B. Category II tracing likely related to opioid effect — continue monitoring and reassess

C. Category I tracing — no further action

D. Fetal acidemia — initiate intrauterine resuscitation

Q10

EMERGENCY NURSING ACTION

A client receiving a CSE (combined spinal-epidural) suddenly reports difficulty breathing, tingling in the arms and shoulders, and inability to lift her arms. SpO_2 drops to 88%. What is the nurse's **priority** action?

A. Administer diphenhydramine for suspected allergy

B. Reposition Trendelenburg and continue routine monitoring

C. Call rapid response, support airway/ventilation, and prepare for intubation

D. Stop oxytocin and reassess in 15 minutes

Q11

SATA · CLIENT TEACHING

The nurse teaches a primigravida about epidural anesthesia. Which client statements indicate **understanding**? *Select all that apply.*

☑ "I should tell you if I feel sudden shortness of breath or my lips tingle."

☑ "I won't be able to walk while the epidural is working — I'll need help repositioning."

☐ "If I get a headache later, that's normal and I should just take ibuprofen at home."

☑ "The nurse will check my bladder because I may not feel the urge to urinate."

☐ "An epidural usually slows the baby's heart for the rest of labor."

☑ "It's normal for my legs to feel heavy or numb."

§ 08 Unfolding *NGN case study*

Mariela R., 28 y/o, G2P1 at 39+2 weeks

ACTIVE LABOR · ADMIT → EPIDURAL → REASSESSMENT

NURSE'S NOTE · 1410

Client arrived in active labor, contractions q3 min × 60 sec, moderate-strong. SVE: 5 cm / 90% / 0 station, cephalic. Membranes ruptured at home 2 h ago, clear fluid, no foul odor. GBS +. Penicillin started on admission. Reports pain 8/10, requests epidural. Denies allergies. Hx: well-controlled asthma, no opioid use. Tolerated 1000 mL LR bolus.

VITAL SIGNS · 1410

BP 128/74 · HR 92 · RR 18 · T 36.8 °C · SpO_2 98%

FETAL MONITOR · 1410

Baseline 140 · Moderate variability · Occasional accelerations · No decelerations · Contractions q3 min, 60–70 sec, strong by palp · Category I

PROVIDER ORDERS

- Penicillin G 5 million units IV now, then 2.5 million q4h
- Oxytocin titration per protocol if needed
- Epidural — bupivacaine 0.0625% + fentanyl 2 mcg/mL at 10 mL/hr after test dose
- 500 mL LR coload at epidural placement
- Continuous EFM

STEP 1 · RECOGNIZE CUES

Which baseline findings put this client at risk for complications after epidural placement?

Answer: Active labor with strong contractions (potential for tachysystole if oxytocin added), recent rupture of membranes (infection risk), GBS+ (newborn risk if delivery within 4 h of penicillin), asthma history (consider for any inhaled agents), and high pain level requesting epidural. **Most pertinent for epidural: baseline BP and FHR — both currently reassuring.**

NURSE'S NOTE · 1438 (12 MIN POST-EPIDURAL BOLUS)

Epidural placed at 1426 by anesthesia, test dose negative. 500 mL coload completed. Client repositioned supine for placement, now reports "I feel weird, kind of dizzy."

VITAL SIGNS · 1438

BP 82/48 · HR 116 · RR 20 · SpO_2 97% · sensory level T6 bilaterally, motor 2/4 in legs

FETAL MONITOR · 1438

Baseline drops to 95 over 4 min · Minimal variability · No accelerations · Recurrent late decelerations after each contraction · **Category III**

STEP 2 · ANALYZE CUES

What is the most likely cause of these new findings?

Answer: Post-epidural maternal hypotension from sympathetic blockade + supine position causing aortocaval compression → reduced uteroplacental perfusion → fetal bradycardia and late decels. The temporal

relationship (12 minutes after epidural), supine positioning during placement, and BP drop ≥30% all point to anesthesia-related hypotension as the cause.

STEP 3 · PRIORITIZE HYPOTHESES

Rank the threats from most urgent to least:

1. **Fetal hypoxia from uteroplacental insufficiency** — Category III, immediate threat.
2. **Maternal hypotension** — driving the fetal compromise; must be reversed.
3. **Ascending block / inadequate analgesia** — secondary, sensory at T6 is borderline.
4. **Tachycardia** — likely compensatory; will resolve with BP recovery.

STEP 4 · GENERATE SOLUTIONS

What interventions should the nurse plan?

- Turn LEFT lateral immediately
- Open IV mainline — 500–1000 mL LR bolus
- Stop oxytocin if running
- O_2 10 L via NRB
- Notify anesthesia + provider STAT
- Ephedrine 5–10 mg IV per protocol if no response
- Continuous FHR monitoring, BP q1–2 min
- Vaginal exam to rule out prolapse if not done
- Prepare for possible emergency cesarean if not recoverable

STEP 5 · TAKE ACTION

Sequence the FIRST FIVE actions:

1. Turn left lateral (fastest, cost-free, addresses cause)
2. Open IV mainline / start bolus
3. O_2 10 L NRB
4. Stop oxytocin if running
5. Call anesthesia + provider STAT

NURSE'S NOTE · 1445 (7 MIN AFTER INTERVENTIONS)

Client repositioned left lateral, 750 mL LR rapid infused, ephedrine 10 mg IV given, O_2 via NRB. Anesthesia and OB at bedside.

VITAL SIGNS · 1445

BP 116/72 · HR 92 · RR 18 · SpO_2 99% · sensory T8 bilaterally

FETAL MONITOR · 1445

Baseline 140 · Moderate variability · No decelerations × 5 min · Category I

STEP 6 · EVALUATE OUTCOMES

Which findings confirm interventions were effective?

Effective: BP recovered to baseline range, FHR returned to 140 with moderate variability, late decels resolved, sensory level stabilizing (T8 — less risk of high block).
Continue to monitor: BP q5 min × 30 min, then per policy; FHR continuous; bladder status; sensory level for ascending block; reassess pain control and infusion rate.

§ 09 "What should the nurse *do first*?"

01 A client 5 minutes after epidural test dose reports a rapid heartbeat, ringing in the ears, and a strange taste in her mouth.

First: Stop the infusion and call anesthesia for suspected intravascular injection / LAST. Lipid emulsion ready, O_2, airway support.

02 A laboring client has had IV fentanyl 50 mcg twice in the last 90 minutes. SVE shows complete dilation, +2 station, urge to push.

First: Notify the provider — delivery is imminent and neonatal respiratory depression is a real risk. **Confirm naloxone is at the warmer.**

03 Two hours after epidural placement, the client's bladder is palpable above the umbilicus, contractions are spacing out, and FHR has new variable decelerations.

First: Straight catheterize — a full bladder displaces the uterus, can stall labor, and cause cord compression/variable decels.

04 A client is using nitrous oxide. The support person picks up the mask and holds it to the client's face while she rests her eyes.

First: Stop the support person and explain — only the client may hold the mask. Self-administration prevents over-sedation.

05 A newborn is delivered 25 minutes after maternal IV morphine. Apgar 4 at 1 min, RR 14, weak cry, poor tone.

First: Begin positive-pressure ventilation per NRP — not naloxone first. Once oxygenation is supported, give **neonatal naloxone** (only if mother is NOT opioid-dependent).

§ 10 Stop · hold · *escalate*

STOP ESCALATE

Tachysystole >5 contractions in 10 minutes with new Category II tracing after epidural and oxytocin running.

Action: Stop oxytocin, reposition left lateral, IV bolus, O_2 if non-reassuring, notify provider; terbutaline if no improvement.

HOLD ESCALATE

Order for IV morphine 4 mg in a client at 9 cm, +3 station, urge to push.

Action: Hold opioid — birth imminent → neonatal depression risk. Call provider to reconsider or switch to non-opioid measures; confirm naloxone availability.

STOP RAPID RESPONSE

Client 8 min after spinal develops ascending paralysis to chest, SpO_2 87%, weak cough, mumbled speech.

Action: Stop infusion, call rapid response + anesthesia, support airway/ventilation, prepare for intubation, support BP/HR — this is a high/total spinal.

HOLD ESCALATE

Order for nalbuphine in a client whose admission history shows daily prescribed buprenorphine.

Action: Hold dose — risk of precipitated withdrawal. Notify provider for alternative analgesia plan.

STOP EMERGENCY BIRTH

Post-epidural client with persistent FHR 70 despite full intrauterine resuscitation bundle for 6 minutes, BP recovered.

Action: Prepare for emergency cesarean / operative delivery — fetal status not recoverable. Notify OR, anesthesia, neonatal team; vaginal exam to rule out prolapse.

§ 11 Common NCLEX *traps*

TRAP 01

Decreased variability ≠ fetal distress

After IV morphine, **decreased variability** is expected. With a stable baseline, no decels, and a normal mom, this is a drug effect — not Category III. Continue monitoring rather than jumping to emergency action.

TRAP 02

Treating fetal heart with O_2 alone when mom is hypotensive

Post-epidural late decels start with **maternal BP**. Reposition + fluid bolus FIRST. Oxygen helps but doesn't address the upstream problem.

TRAP 03

Giving butorphanol/nalbuphine to opioid-dependent clients

Mixed agonist-antagonists **precipitate withdrawal** in clients on methadone, buprenorphine, or with substance use disorder. Always screen first.

TRAP 04

Forgetting the bladder

A distended bladder under epidural anesthesia is a silent saboteur: stalled labor, variable decels from cord compression, and postpartum atony. Palpate q1–2 h and cath as needed.

TRAP 05

Confusing PDPH with preeclampsia headache

Postpartum headache is not all PDPH. **Positional + frontal/occipital + worse upright** = PDPH. **Severe + persistent + visual changes + HTN** = preeclampsia. Wrong diagnosis = wrong treatment.

§ 12 End-of-day *quick review*

10 Must-Remember Points

1. Nonpharm always — they reduce med use.
2. Pre-epidural: 500–1000 mL LR + baseline BP & FHR.
3. Post-epidural hypotension → reposition first.
4. Decreased variability after morphine = expected.
5. IV opioids close to birth = neonatal depression.
6. Naloxone at the warmer if opioids given <4 h pre-birth.
7. Bladder distention causes atony & variable decels.
8. No ambulation with working epidural.
9. Mixed agonist-antagonists → withdrawal in opioid users.
10. PDPH = positional + worse upright. Blood patch treats it.

5 Red-Flag Findings

- SBP <100 or 20% drop post-epidural
- Ascending sensory block past T4
- Maternal RR <10 after opioid
- Tinnitus / metallic taste during dosing
- Persistent FHR <100 despite resuscitation bundle

5 "Never Do This" Rules

- Never ambulate with active epidural
- Never give naloxone to newborn of opioid-dependent mother
- Never hold the nitrous mask for the client
- Never give IV opioid right before birth

5 Fetal Monitoring Clues

- ↓ variability + stable baseline + no decels = drug effect
- Late decels post-epidural → think maternal BP
- Variable decels + full bladder → catheterize
- Cat III + ascending block → high spinal

- Never give butorphanol to opioid-dependent client

- Tachysystole + epidural → stop oxytocin first

5 Medication Safety Clues

- Fentanyl: short-acting, watch RR & FHR
- Morphine: longer DOA, ↓ variability expected
- Butorphanol/nalbuphine: ceiling effect — but withdrawal risk
- Naloxone: shorter half-life than opioid — re-sedation risk
- Bupivacaine: cardiotoxic — LAST signs & lipid emulsion

§ 13 Day 6 *at a glance*

DAY 06 · SCREENSHOT-READY SUMMARY

Pain in labor: *nurse's playbook for opioids & regional anesthesia.*

Before Epidural

→ Consent verified
→ 500–1000 mL LR bolus
→ Baseline BP & FHR strip
→ Empty bladder
→ Position: sitting or side-lying
→ Naloxone & emergency cart available

Post-Epidural Red Flags

⚠ SBP <100 or ↓20% from baseline
⚠ New late decels within 30 min
⚠ Sensory block above T4
⚠ Severe positional headache
⚠ Tinnitus, metallic taste, perioral numb
⚠ Bladder distention

Hypotension Bundle

✓ Left lateral position
✓ IV bolus 500–1000 mL LR
✓ O_2 10 L NRB if FHR non-reassuring
✓ Stop oxytocin

Opioid Safety

→ Fentanyl: short, watch RR & FHR
→ Morphine: ↓ variability expected
→ Butorphanol/nalbuphine: NOT in opioid users
→ Avoid IV opioid <1–4 h pre-birth

✓ Ephedrine or phenylephrine per order

✓ Notify anesthesia + provider

→ Naloxone at the warmer

→ Monitor neonatal RR & tone

Total / High Spinal

⚠ Ascending paralysis to chest/arms

⚠ ↓ SpO_2, ↓ BP, ↓ HR, ↓ LOC

⚠ Call rapid response & anesthesia

⚠ Support airway → prepare intubation

⚠ Vasopressors per protocol

LAST (Local Anesthetic Toxicity)

⚠ Tinnitus, metallic taste, perioral numb

⚠ Seizure, cardiac arrest

⚠ STOP infusion

⚠ O_2, airway, ACLS

⚠ 20% lipid emulsion (Intralipid)

PDPH

→ Positional, worse upright

→ Frontal/occipital

→ Hydration, caffeine, bedrest

→ Blood patch if refractory

→ NOT preeclampsia (no HTN, no visual sx)

Nonpharm Always Wins Partial Credit

✓ Position changes

✓ Hydrotherapy / shower

✓ Counterpressure (sacrum)

✓ Patterned breathing

✓ Continuous labor support (doula/partner)

✓ Sterile water injections (if available)

RECOGNIZE → ANALYZE → PRIORITIZE → GENERATE → ACT → EVALUATE
BP & FHR cue · post-epidural drop · UPI hypothesis · reposition + fluid plan · execute bundle · confirm recovery