

STUDY STAT

OBSTETRIC + ANTENATAL

Track the pregnancy. Recognize the pattern. Protect two patients.

DATE

ASSESS

SCREEN

MONITOR

ESCALATE

PAIRED PRACTICE: OB PRIORITY ROUND

Use current prenatal records, provider guidance, and facility policy.

Pregnancy is organized by gestational age

Gestational age is counted from the first day of the last menstrual period.

FIRST TRIMESTER

Through 13 weeks 6 days. Organ development, early screening, dating, and initial prenatal labs are major themes.

SECOND TRIMESTER

14 weeks through 27 weeks 6 days. Anatomy evaluation, fetal growth, and continued maternal screening.

THIRD TRIMESTER

28 weeks to birth. Growth, fetal well-being, birth preparation, and surveillance for complications.

ESTIMATED DUE DATE

Classic Naegele approach: LMP + 7 days - 3 months + 1 year.
Electronic tools and ultrasound dating follow clinical criteria.

DATING CAUTION

Irregular cycles, uncertain LMP, fertility treatment, and ultrasound findings may change the best obstetric estimate.

USE THE ESTABLISHED DUE DATE

Once a best obstetric estimate is documented, do not casually recalculate it from each later scan.

GTPAL compresses the obstetric history

Count pregnancies and outcomes carefully; twins do not increase para counts twice.

G - GRAVIDA

Total number of pregnancies, including the current pregnancy, regardless of outcome.

T - TERM

Pregnancies ending at term, commonly 37 weeks or later. Follow course definitions.

P - PRETERM

Pregnancies ending after the viability threshold but before term; exact threshold follows course or policy.

A - ABORTION

Pregnancies ending before the defined viability threshold, spontaneous or induced.

L - LIVING

Number of currently living children. Multiple gestation can increase this count by more than one.

PARA

Number of pregnancies reaching the defined viability threshold, not number of infants born.

EXAMPLE

Currently pregnant; one prior term singleton; one prior preterm twin birth; one early loss; three living children = G4 T1 P1 A1 L3.

Prenatal care builds a changing risk picture

Timing and exact panels vary with history, gestational age, shared decisions, and local guidance.

INITIAL HISTORY

Prior pregnancies, medical and surgical history, medications, substances, mental health, safety, social needs, and genetic history.

BASELINE LABS

ABO/Rh, antibody screen, CBC, urine testing, and infection screening are common components.

GENETIC OPTIONS

Carrier and aneuploidy screening or diagnostic testing require informed, patient-centered counseling.

MIDPREGNANCY

Anatomy ultrasound and other testing are scheduled by gestational age and clinical indication.

LATER SCREENING

Glucose screening, repeat CBC or antibody testing, and group B strep screening occur according to current guidance.

EACH CONTACT

Maternal vital signs, symptoms, fetal status as appropriate, education, medications, and new risks.

A TEST IS NOT A DIAGNOSIS

Screening estimates risk. Abnormal screening results require confirmation, interpretation, or follow-up under the prenatal plan.

Expected adaptations still need assessment

Normal physiology can overlap with signs of complications.

CARDIOVASCULAR

Blood volume and cardiac output rise. Mild heart-rate increase may occur; supine positioning can reduce venous return later in pregnancy.

HEMATOLOGIC

Plasma volume rises more than red-cell mass, contributing to physiologic dilution. Pregnancy is also hypercoagulable.

RESPIRATORY

Oxygen demand and minute ventilation rise. Mild dyspnea may occur, but sudden or severe breathlessness is not routine.

RENAL

Renal blood flow and filtration increase. Urinary frequency is common; dysuria, fever, or flank pain need evaluation.

GI + MUSCULOSKELETAL

Nausea, reflux, constipation, ligament discomfort, and back strain may occur; severity and associated symptoms matter.

SKIN + ENDOCRINE

Pigment changes and altered insulin sensitivity occur. Screening identifies when adaptation becomes disease.

DO NOT NORMALIZE A RED FLAG

Persistent severe pain, chest pain, syncope, severe headache, visual change, fever, heavy bleeding, fluid leakage, or marked shortness of breath needs prompt evaluation.

Fetal assessment asks different questions

Gestational age changes what can be measured and how findings are interpreted.

FETAL HEART RATE

A common baseline reference is 110-160 bpm. Interpret baseline, variability, accelerations, decelerations, and clinical context.

FUNDAL HEIGHT

After the midpoint of pregnancy, serial measurement can screen growth trends. Dating, body habitus, fibroids, fluid, and multiples affect it.

FETAL MOVEMENT

Movement patterns are individualized. A meaningful decrease or stopping compared with usual activity requires prompt contact and evaluation.

NONSTRESS TEST

Assesses fetal heart-rate response over time. Reactive criteria depend on gestational age and current protocol.

BIOPHYSICAL PROFILE

Combines ultrasound observations with fetal heart-rate assessment to evaluate well-being when indicated.

ULTRASOUND

Dating, anatomy, growth, placental location, fluid, and other questions guide the type and timing of examination.

MATERNAL STATUS COMES FIRST TOO

Positioning, blood pressure, symptoms, medications, contractions, and gestational age help explain fetal findings.

Hypertensive disorders are pattern plus timing

Confirm blood-pressure technique and assess symptoms, labs, urine, and fetal status.

GESTATIONAL HYPERTENSION

New hypertension after 20 weeks without the defining features of preeclampsia at that time.

PREECLAMPSIA

New hypertension after 20 weeks with proteinuria or other maternal organ dysfunction; severe features change urgency.

CHRONIC HYPERTENSION

Hypertension predating pregnancy, diagnosed before 20 weeks, or persisting postpartum under clinical criteria.

SUPERIMPOSED PREECLAMPSIA

Preeclampsia develops in a patient with chronic hypertension; look for new symptoms, labs, proteinuria, or worsening control.

SEVERE-FEATURE WARNING PATTERN

Severe or persistent headache, visual symptoms, right-upper-quadrant or epigastric pain, dyspnea, concerning blood pressure, neurologic change, or abnormal labs requires urgent escalation.

Screen, interpret, then coordinate follow-up

Antenatal management protects maternal and fetal health now and after pregnancy.

GESTATIONAL DIABETES

Pregnancy-related insulin resistance can uncover hyperglycemia. Screening and diagnostic methods vary. Management may include nutrition, activity, glucose monitoring, medication, fetal surveillance, and postpartum testing.

WHY GLUCOSE MATTERS

Poor control can increase maternal and fetal risks. Teach the specific monitoring targets and treatment plan rather than using one universal number.

RH + ANTIBODY SCREEN

Rh-negative status is not itself disease. The antibody screen determines sensitization risk; Rh immune globulin timing depends on the clinical situation and current guidance.

INFECTION PREVENTION

Vaccination, STI testing, urine screening, group B strep planning, and exposure counseling follow gestational timing and individual risk.

FOLLOW THE ACTUAL PLAN

Use the prenatal record for glucose targets, medications, antibody status, Rh immune globulin, vaccines, and follow-up testing.

Labor recognition begins with change over time

Contractions alone do not establish labor; cervical change and the whole assessment matter.

TRUE LABOR PATTERN

Contractions become more regular, stronger, and closer together and are associated with progressive cervical change.

BRAXTON HICKS

Often irregular and may ease with rest, hydration, or position change; they do not cause progressive cervical change.

RUPTURE OF MEMBRANES

Report suspected fluid leakage promptly. Note time, amount, color, odor, contractions, movement, and symptoms; avoid digital examination unless directed.

VAGINAL BLEEDING

Small blood-tinged mucus may accompany cervical change, but bleeding like a period or heavier is an urgent warning sign.

PRETERM SYMPTOMS MATTER

Before term, regular contractions, pelvic pressure, low backache, bleeding, or fluid leakage requires prompt contact and evaluation.

Urgent maternal warning signs require action

These can occur during pregnancy and through the year after birth.

NEURO

Headache that will not go away or worsens, vision changes, dizziness, fainting, or seizure.

CARDIOPULMONARY

Chest pain, fast or irregular heartbeat, trouble breathing, or inability to lie flat.

BLEEDING + FLUID

Vaginal bleeding more than spotting during pregnancy, fluid leakage, heavy postpartum bleeding, or foul discharge.

PAIN + SWELLING

Severe belly pain; extreme face or hand swelling; or unilateral arm/leg swelling, redness, or pain.

SYSTEMIC + MENTAL HEALTH

Fever 100.4 F (38 C) or higher, severe vomiting, overwhelming weakness, or thoughts of harming self or baby.

FETAL MOVEMENT

Baby movement stopping or slowing compared with the patient's usual pattern.

LISTEN AND ESCALATE

If a pregnant or postpartum patient says something feels wrong, assess promptly, communicate pregnancy status, and follow emergency guidance. Do not dismiss the concern as normal pregnancy.

Practice recognition and priority

Answer before checking your course resources.

1

A patient is currently pregnant after one term birth and one early loss. What is gravida?

2

Why can a twin birth change L by two but T or P by only one?

3

What does an antibody screen add beyond ABO/Rh typing?

4

Which common prenatal test is a screen rather than a diagnosis?

5

What fetal heart-rate baseline range is commonly referenced?

6

Which symptom cluster raises concern for preeclampsia with severe features?

7

What is most important about a change in fetal movement?

8

How does true labor differ from Braxton Hicks contractions?

9

What details should be collected with suspected membrane rupture?

10

Which postpartum symptoms still require urgent maternal evaluation?

Sources + clinical boundaries

Reviewed July 2026; use current local standards and prenatal records.

CDC Hear Her - Urgent Maternal Warning Signs

Current maternal warning signs during pregnancy and through one year postpartum.

cdc.gov/hearher/maternal-warning-signs/

ACOG Patient Education

Prenatal testing, pregnancy complications, labor, Rh factor, and patient education.

acog.org/womens-health/pregnancy

CDC Pregnancy

Pregnancy health, prevention, vaccination, and complication resources.

cdc.gov/pregnancy/

NIH MedlinePlus - Pregnancy

Pregnancy testing, conditions, and patient education links.

medlineplus.gov/pregnancy.html

OpenStax Maternal-Newborn Nursing

Pregnancy physiology, prenatal assessment, fetal well-being, and nursing care.

openstax.org/details/books/maternal-newborn-nursing

BOUNDARY

This is a nursing-student learning aid, not prenatal care, fetal-monitor interpretation, a diagnosis, treatment direction, or emergency guidance. Verify gestational age, prenatal record, maternal and fetal assessment, current orders, provider guidance, and facility protocol.