CASE STUDY - INDUCTION OF LABOR

A G3, P2 patient at 41 weeks gestation is admitted for induction of labor. Assessment data reveals: cervix dilated 2 cm, 40% effaced, -2 station, cervix firm, and membranes intact. The patient's last baby was delivered at 40 weeks and weighed 9 pounds. The physician has ordered Prostaglandin administration the evening before Oxytocin in the morning.

1. What is the indication for induction of labor?

   The indication for induction of labor is that she is already 41 weeks and only dilated at 2 cm. She is already past due in this pregnancy and not making any progress in labor.

2. Why did the physician order prostaglandins the evening before the induction?

   The physician ordered prostaglandin the evening before the induction to soften and thin out the cervix for delivery.

3. What tests or evaluation should be performed prior to the induction?

   Prior to the induction, you would want to perform a non-stress test and possibly a contracting stress test if consented by the mother. Want to use the Bishop scoring system to assess if the cervix is favorable for induction.

4. What are the nursing considerations when administering an Oxytocin infusion?

   The nurse wants to take into consideration of tachysystole occurring once Oxytocin is infusing. You want to administer it in its own primary tubing, own pump, and in the port closest to the mother.

CASE STUDY - Diabetes in Pregnancy

A 30-year-old, G2, P1, is in her 10th week of pregnancy. Her first baby was stillborn at 32 weeks, so she is very worried about this pregnancy. Initial lab work obtained two weeks ago included testing for diabetes, due to the patient's history a stillborn. The physician explains during the first prenatal visit there is a concern for diabetes due to an elevated glucose level. The nurse realizes patient education regarding diabetes, the effects of diabetes on both the patient and baby and how to manage diabetes it is essential.

1. Discuss maternal risks associated with diabetes and pregnancy.

   The maternal risks associated with diabetes and pregnancy are in the first trimester it could lead to a spontaneous abortion or fetal malformations, preeclampsia, urinary tract infections are more common, premature rupture of the membranes, and a large fetus which could lead to injury to the birth control.

2. Discuss fetal-neonatal risks associated with diabetes and pregnancy.

   The fetal-neonatal risks associated with diabetes and pregnancy are congenital anomalies, prenatal death, intrauterine fetal growth restriction, pre-term labor, hypocalcemia, and hyperbilirubinemia.

3. What educational topics should be covered to assist the patient in managing her diabetes?

   Educational topics that should be covered to assist the patient in managing her diabetes are medication education about insulin administration, diet, exercise, and glucose monitoring.

4. What classification (SGA, AGA, LGA) will this patient's baby most likely be classified as? Discuss your answer.

   This patient's baby most likely will be classified as a LGA. This is because diabetic mothers tend to have larger babies due to the increase of blood sugar that the baby is receiving.

CASE STUDY - Pregnancy Induced Hypertension

A single 17-year-old patient Gr 1 Pr 0 at 34 weeks gestation comes to the physician's office for her regular prenatal visit. The patient's assessment reveals BP 160/110, DTR's are 3+ with 2 beats clonus, weight gain of 5 pounds, 3+ pitting edema, facial edema, severe headache, blurred vision, and 3 + proteinuria.

Patient's history – single, lives with her parents, attending high school, works at local grocery store in the evenings as a cashier, began prenatal care at 18 weeks, has missed two of her regularly scheduled appointments for prenatal care, never eats breakfast, snacks for lunch and eats dinner after she gets off work at 10:00 pm.

1. What disease process is this patient exhibiting? What in the assessment supports your concern?

   This patient is exhibiting preeclampsia or pregnancy induced hypertension. The patient has a high blood pressure, protein in her urine, and edema.

2. What in the patient's history places her at risk for Pregnancy-Induced Hypertension?

   The patient's age, first pregnancy, missing prenatal care appointments, starting prenatal care late, and not maintaining a healthy weight all place her at risk for pregnancy induced hypertension.

3. Describe how Pregnancy-Induced Hypertension affects each organ and how these effects are manifested.

   Pregnancy- induced Hypertension affects the cardiovascular system by causing hypertension, pulmonary edema, CHF, and a risk of future cardiac diseases. It can affect the respiratory system by causing pulmonary edema and hypoxemia. It can affect the renal system by causing oliguria and acute renal failure. It can affect the neuro system by causing seizures, stroke, visual disturbances, and cerebral edema. In the hepatic system it can cause hepatic rupture, coagulation effects, and hypoglycemia.

4. What will the patient's treatment consist of?

   The patient's treatment will consist of activity restrictions, blood pressure monitoring, daily weights, urine analysis to test for proteins, and fetal assessment.

5. What is the drug of choice for this condition? What other medication(s) might be ordered for this patient?

   The drug of choice for this condition is a beta blocker. You can also see labetalol, hydralazine, nifedipine, and a diuretic might be ordered for this patient.

6. What are the Nursing considerations when administering the drug of choice? (Side effects & medication administration guidelines)

   The nursing considerations when administering the drug of choice is too check the apical heart rate, check the blood pressure to make sure they are not too low prior to administering medication.