CASE STUDY - INDUCTION OF LABOR - Megan Dull

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?

   This is considered post term. Post can cause low viability in the placenta, reducing oxygen and nutrients to the fetus. Considering she is one 2cm dilated, 40% effaced, -2 station and membranes intact, its indicated for the health of mom and baby to induce labor. Size of baby would also be something to consider.

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

   Prostaglandins relax the muscles, and dilate the uterus, which will help baby start to descend and quicken the labor process. This could cause natural rupture of membranes and send the body into labor before have to administer Oxytocin.

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

   Bishop Score, fetal heart monitoring, vaginal exam

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

   Always start at the lowest dose, can titrate up, monitor for tachycardia or tachysystole, always hung on its on piggy back so it can be stopped immediately. Monitor contractions, if they are progressing and consistent, it might not be indicated to administer and communicate with the HCP.

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.

   With gestational diabetes we are concerned with babies that could be LGA. Theis can increase risk during labor including shoulder dystocia. Many times babies have to be delivered via C-section, preventing mom from being able to have any vaginal births following. Also babies after birth are at a high risk for being hypoglycemic, and might need to be transferred to NICU, decreasing skin to skin time.

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

   Fetal risks would be hypoglycemia, due to the high levels of Moms insulin. Respiratory distress from being too big for the birth canal.

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

   Lower carb foods, decreased sugars, high protein, sugar free drinks, plenty of water. Exercise, compliant with meds. Not overindulging on food and check BGL

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

   LGA., discussed above.

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?

   Preeclampsia, textbook signs and symptoms. Teenagers are at number one risk for pregnancy induced HTN

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

   Age, not attending appointments, poor nutrition, late start in prenatal care/

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

   High blood pressure has a systemic effect on the body. Heart is already pushing about 30% to 50% more blood flow through Mom's circulatory system. HTN can cause narrowing or arteries, decreasing blood flow to the heart, causing issues with blood flow to body and importantly the fetus. Can cause fetal respiratory distress.

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

   Medications- antihypertensives, mag sulfate, anticonvulsants. Must attend regular OBGYN checkups, and will need to monitor BP at home. Rest may also be indicated.

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

   Mag Sulfate

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

   Can be risky for fetus, teach mom signs to look for fetal distress i.e.., kick counts. S/S of hypermagnesemia