N305 Care Plan #

Lakeview College of Nursing

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N305 Care Plan and Grading Rubric

Instructions: The care plan is to be typed into a WORD document and submitted to the labor &Delivery or Postpartum Drobox within 72 hours after your clinical has ended. Be sure and compare your work with the attached rubric before submitting this to the dropbox. The care plan is worth 150 points. In order to pass you must achieve at least 116 points to acquire a pass. If you do not pass, you will have one opportunity to do a newborn care plan on a different patient. You must pass the care plan in order to pass your clinical and thus your course.

Demographics (3 points)

Date of Admission& Time of Admission	Patient Initials	Age	Gender
7/18/19	NP	28	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
white	housewife	Married	None
Code Status	**Height**	**Weight**	**Father of Baby involved**
Full code	5'10"	174lbs	

Medical History (5 Points)

Prenatal History: Gravida 3 (1 live birth, 1 Etopic, and current pregnancy)

Past Medical History: Anemia , Prior birth

Past Surgical History: N/A

Family History: N/A

Social History (tobacco/alcohol/drugs): No Smoke No Alcohol use No Substance Abuse

Living Situation: Married

Education Level: N/A

Admission Assessment (12 points)

Chief Complaint (2 points):Elected Induction

Presentation to Labor & Delivery (10 points): The patient is a 28 year old female presenting to labor and delivery department currently pregnant thirty-nine weeks and two days. Today patient is on the schedule today for an

elected induction. One IV is in the right arm; labs were drawn to confirm blood type, vitals were done; all consent forms have been signed. The patient was provided education on induction, and all questions have been answered at this time. The patient currently understands the procedure and expectations of labor and deliver. The patient does want all-natural childbirth. The patient did have an epidural with the last pregnancy but has elected for a more natural approach this time. The patient is cooperative and excited about the expected delivery: the patient's mother and grandmother at the bedside.

. **Diagnosis (2 points)**

Primary Diagnosis on Admission (2 points): Elected Induction

Secondary Diagnosis (if applicable):N/A

Stage of Labor (20 points):

Stage of Labor write up in APA format (see grading rubric) (18 points)-

The patient is a 28 year old female presenting to labor and delivery department currently pregnant thirty-nine weeks and two days. Patient was dilated to 5 cm and had an artificial of rupture of membranes on 7/18/2019 at 1410. The membrane fluid was clear with no odor or meconium present with blood show.

The patient has elected for a natural childbirth with no epidural. Patient started receiving Oxytocin to help the labor progress. Over the next few hours the patient dilated to 7cm and +1 . The first stage of labor lasted from 1410-1552. Then the progression of 2nd stage labor began bolus was turned off at 1509 and Oxytocin was paused when the client reached 8cm +2 at 1510. Patient was at 10cm and fully effaced before pushing to avoid tearing the cervix. Baby is in vertex position. The patient's blood pressure along with fetal heart rate would vary with the strength of the contractions increasing due to the increasing progression of the labor. Sacral Pressure or counter pressure was applied from 1537-1544. At 1552 the patient began pushing baby delivered at 1617 in vertex/ROA position. Patient has blood loss of 200ml patient delivered only had minor abrasion with no lacerations or stitches. Baby girl was 7lbs 8 ounces and 21 inches long. Head circumference was 34 chest was 34. At 1620 vitals were temp 97.9 pulse 150 and respirations 56 and at 1650 temp was 97.9 and pulse was 126 and 44 respiration cord did exhibit 3 vessels and grandmother cut the cord. Patient elected to do skin to skin and breastfeed. Infant's mouth and nose

was suctioned after birth and dried off to help with thermoregulation along with skin to skin application. The APGAR scores were 7 and 9. Erythromycin was given in the eyes at 1728 and Vitamin K injection was given at 1715. The third stage of labor patient delivery placenta within the next fifteen minutes with no complication placenta was intact. Oxytocin was started briefly again to help with post delivery uterine contractions and fundus massage given every 15 minutes and assessment of lochia.

The delivery went very well patient was pleased to not have an epidural. This was a very straight forward with no complications. The family, physician, and nurses were all a very supportive team for the mother when working with her throughout the delivery process. The family is very happy to receive the newborn as a wonderful addition to their family. Patient happy and newborn resting comfortably after breastfeeding currently in bed in high fowlers position. The labor and delivery was a very positive experience.

Stage of Labor References (2) (APA format):

Ricci, S., Carman, S. and Kyle, T. (2017). Maternity and pediatric nursing. 3rd ed. Philadelphia: Wolters Kluwer.

Sorenson, M., Quinn, L., Klien, D. (2019). Pathophysiology: concepts of human disease. Hoboken, NJ: Pearson, Education, Inc.

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80-5.30	4.52	4.12	N/A	N/A
Hgb	12.0-15.8	13.2	12.1	N/A	N/A
Hct	36.0-47.0	37.9	36.4	N/A	N/A
Platelets	140-440	230	219	N/A	N/A
WBC	4.00-12.00	7.8	8.30	N/A	N/A
Neutrophils	47.0	72	71.0	N/A	High levels can be a result of neutrophil apoptosis. (VanLeeuwen, 2017)

Lymphocytes	**18.0-42.0**	**19**	**20.4**	**N/A**	**N/A**
Monocytes	**4.0-12.0**	**7**	**7.4**	**N/A**	**N/A**
Eosinophils	**0.0-5.0**	**1**	**0.9**	**N/A**	**N/A**
Bands	**3-5%**	**N/A**	**N/A**	**N/A**	**N/A**

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal
Blood type	**N/A**	**O**	**O**	**O**	**N/A**
Rh factor	**N/A**	**+**	**+**	**+**	**N/A**
Serology (RPR/ VDRL)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Rubella Titer	**IMM**	**IMM**	**IMM**	**IMM**	**N/A**
Hct& Hgb	**N/A**	**N/A**	**35.3/11.9**	**N/A**	**N/A**
HIV	**neg**	**neg**	**neg**	**neg**	**N/A**
HbSAG	**Non Reactive**	**Non Reactive**	**Non Reactive**	**Non Reactive**	**N/A**
Group Beta Strep Swab	**Neg**	**Neg**	**Neg**	**Neg**	**N/A**
Glucose at 28 weeks	**Neg**	**Neg**	**Neg**	**N/A**	**N/A**
Genetic testing: if done	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal
Color &	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Clarity					
pH	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Specific Gravity	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Glucose	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Protein	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Ketones	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
WBC	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
RBC	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Leukoesterase	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal
Urine Culture	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Other Tests	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal
N/A	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
N/A	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
N/A	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (APA):

Van Leeuwen, A. M.,& Bladh, M.L. (2017). ***Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications*** **(7ed.) Philadelphia, PA:F.A. Davis Company.**

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	**125 Normal Range**
Are there accelerations, if so describe them and explain what these mean i.e. how high do they go and how long do they last? **What is the variability?**	**Yes 15 by 15 Positive accelerations are a good sign of healthy fetal movement** **(minimal to moderate)**
Are there decelerations, if so describe them. **What do these mean?** **Did the nurse perform any interventions with these?** **Did these interventions benefit the patient or fetus?**	**Minimal to moderate variability ----depending on the minute** **Using –birthing ball during this time prior to the rupture of membranes to help increase dilation** **Patient was able to remain calm during contractions which helped the fetal heartrate stay within normal limits during the birthing process.**

Describe the contractions i.e. frequency, length, strength, patient's response.	**Every 2-3 (60-90 sec they lasted) Pt comfortable contractions are mild to moderate and increased in strength with the intensity of contractions/Pt was dilated to 5cm when I came on the floor—contractions were moderate –at this time patient was bouncing on a ball to help with the contractions and cervical dilation**

APA reference:

Ricci, S., Carman, S. and Kyle, T. (2017). Maternity and pediatric nursing.3rd ed. Philadelphia: Wolters Kluwer.

Current Medications (10 points total -1 point per completed med)

7 different medications must be completed

Home Medications (2 required) *This woman was very natural and wanted a natural birth—this was her only home medication.

Brand/Generic	**Prenatal vitamin**	**N/A**	**N/A**	**N/A**	**N/A**
Dose	**1 capsule**	**N/A**	**N/A**	**N/A**	**N/A**
Frequency	**Once a day**	**N/A**	**N/A**	**N/A**	**N/A**
Route	**Oral**	**N/A**	**N/A**	**N/A**	**N/A**
Classification	**Multivitamin**	**N/A**	**N/A**	**N/A**	**N/A**

Mechanism of Action	**multivitamins contain essential vitamins and minerals such as folic acid, iron, iodine, and calcium which are released into the body to be absorbed**	**N/A**	**N/A**	**N/A**	**N/A**
Reason Client Taking	**Prevent vitamin deficiency during pregnancy**	**N/A**	**N/A**	**N/A**	**N/A**
Contraindications (2)	**Iron metabolism disorder that causes an increase in iron storage -- ulcerated colon**	**N/A**	**N/A**	**N/A**	**N/A**
Side Effects/Adverse Reactions (2)	**constipation -- diarrhea**	**N/A**	**N/A**	**N/A**	**N/A**
Nursing Considerations (2)	**Prenatal vitamins should be taken daily to ensure the woman obtains the necessary vitamins during pregnancy – Patient should avoid taking any OTC**	**N/A**	**N/A**	**N/A**	**N/A**

	products				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**A patient with vitamin B12 deficiency should see a provider before taking folic acid because it could alter certain lab tests regarding B12 but not actually treat the anemia– Past history of drug or alcohol abuse info is needed**	**N/A**	**N/A**	**N/A**	**N/A**
Client Teaching needs (2)	**Maintain a well balanced healthy prenatal diet and following dietary guidelines provided by the prescriber -- store at room temperature away from light and moisture**	**N/A**	**N/A**	**N/A**	**N/A**

Hospital Medications (5 required)

Brand/Generic	**Ibuprofen**	**Calcium carbonate (Tums)**	**Hemabate** **Carboprost**	**(Pitocin)** **Oxytocin**	**Fentanyl**
Dose	**800mg**	**1000mg**	**250mcg**	**1-20 ml**	**25 mcg**
Frequency	**3 times daily**	**Every 8**	**Every 15 min**	**Continuous**	**Every 2 hours**

		hours PRN	**PRN**		**PRN**
Route	**oral**	**Oral**	**Intramuscular**	**IV**	**Intravenous**
Classification	**propionic acid derivative**	**Elemental cation**	**oxytocic**	**Exogenous hormones**	**To decrease response to pain or discomfort**
Mechanism of Action	**Blocks activity of cylcooxygenase, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response, and cause local pain, swelling, and vasodilation**	**Binds to Prostaglandin n E2 receptors to cause contractions (Hemabate)** **Tums (subsequent increases in ph may inhibit action of pepsin –neutralizing hydrochloric acid in gastric secretions)**		**Stimulates uterine contractions and mammary gland muscle**	**Blocks pain rectors**
Reason Client Taking	**Relieve mild to moderate pain**	**Heart burn**	**bleeding**	**Given for induction of pregnancy**	**pain**
Contraindications (2)	**bronchospasm -- angioedema**	**Leg cramp** **sweating Asthma** **Myasthenia gravis**		**Bleeding factors/high risk pregnancy may cause abortion**	
Side Effects/Adverse Reactions (2)	**heart failure -- hematuria**	**Parasthesia asystole** **Hypotension gumline erosion**		**Over stimulation/Arrythmias** **coma**	**Rash** **Respiratory distress**
Nursing Considerations (2)	**be aware that ibuprofen should not be used in pregnant women starting at 30 weeks**	**1)Urge to chew tabs/2 hours before meals(Tums)**		**Pt may have hypersensitivity to drug** **Monitor fluid intake and output /requires continuous monitoring**	**Report itching or swelling and any adverse reactions** **Monitor respirations**

	gestation because premature closure of the ductus arteriosus may occur in the fetus -- know that the risk of heart failure increases with the use of NSAIDs such as ibuprofen	**1)Watch for Hemorrhage (Hemabate)** **2) assess B/P (Hemabate)** **2)Observe calcium Levels prior to admin (Tums)**		**and fetal heart rate** **Asthma or other breathing problems can be contraindicated**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**CBC/liver enzymes/ BUN & creatinine/blood clotting factors should all be monitored and evaluated before administration of ibuprofen**	**ASSESS calcium levels (Tums)** **Avoid Hazardous Activities(Hemabate)** **Monitor Platelet level(Hemabate)**	**Explain risks of drug** **Drug may decrease appetite** **Drug comes in two strengths check box before giving** **Creatinine check should be cleared prior to giving**	**Pain scale** **Check patient band and chart for allergies** **Respirations- and B/P prior to administration**
Client Teaching needs (2)	**Take medication with full glass of water, and avoid laying down for 15 min to 30 min to minimize GI irritation-- take drug with food**	**Report blood loss (Hemabate)** **Abdominal cramping (Hemabate)** **Avoid taking 2 hours of another oral drug /take with a glass of water (Tums)** **Avoid hazardous activities due to bleeding risks of Hemabate and make sure patient doesn't have a history of asthma** **Drug may cause constipation(Tums)**	**Explain use to patient and family** **Instruct patient to report adverse reactions promptly**	**Report and S/S such as nausea or excessive drowsiness** **Do not drink alcohol while taking /Take as ordered**

Medications Reference (APA): (2 points)

Burlington: Jones & Bartlett Learning.*2018 Nurse's Drug Handbook*. (2018). 17th ed. Burlington:MA

Assessment (20 points)

Physical Exam (20 points)

GENERAL (0.5 point): **Alertness: Awake and alert** **Orientation:x3** **Distress: none at this time** **Overall appearance: Pt is calm and happy**	**Pt alert and oriented times three. No distress noted. Patient did well through labor. Patient elected skin to skin. Patient elected to breastfeed infant. Nurse in room when attempt was made infant latched on and currently breastfeeding with no distress or difficulties noted**
INTEGUMENTARY (2 points): **Skin color: normal pink to tan skin tone** **Character: N/A** **Temperature: N/A** **Turgor:N/A** **Rashes:N/A** **Bruises: N/A** **Wounds/Incision: N/A** **Braden Score: 22** **Drains present: Y☐ N X☐** **Type: N/A**	**Pt is Caucasian in color. Skin is fair. Normal elasticity warm to touch. Post delivery small abrasion to right side of labia. Gauze applied to area not stitches required. No other open areas or lacerations. Ice pack applied. Vaginal area and fundus assessed every 15 minutes. Patient states that she is just tired after delivery and pain is only at a 2. Ibuprofen offered for discomfort and given. No rashes normal skin turgor. Hair is brown in color. Braden Scale 22**
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is or normal shape with no apparent deviations. Hair is brown. Ears have no drainage or discomfort, tympanic membrane pearly gray. PEERLA within normal limits. Pt eyes show no discharge. No deviation of the septum, turbinates equal bilaterally. No rhinorrhea. No complaints of congestion or nose bleeds. Oral mucosa is pink and moist with no discharge. Patient's teeth are complete.**

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CARDIOVASCULAR (1points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N X** **EdemaY ☐ N X** **Location of Edema: N/A**	.**Placement auscultated x5 for heart sounds. Pt has normal S1 and S2 no abnormalities, no murmurs, no thrills. Pt has normal cardiac rhythm with Regular cap refill<3,no edema noted. Pt is not monitored by heart monitor. Radial pulses and pedal pulse 2+ bilaterally. Negative for any vein distention.**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N X** **Breath Sounds: Location, character**	. .**Pt has Normal lung sounds No Crackles No rhonchi , Pt shows no signs of distress. No accessory muscle use during breathing. No deviations. Pt has no signs of discomfort. Patient currently on room air. Pt states she feels good (except for minor vaginal discomfort) and does not need oxygen at this time.**
GASTROINTESTINAL (5 points): **Diet at home: regular** **Current Diet --regular** **Height: 5' 6"** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:**	.**Pt current regular diet. Pt does not smoker. Pt denies alcohol use and does not us drugs. Patient has opted for a natural birth. No abnormal distention. Bowel sounds in all four quadrants. No tenderness. No masses. No ostomy. No nasogastric tubes. No wounds. Pt has no signs of distress no diarrhea, no constipation, no bloating or irritability. Pt states last bowel movement was yesterday. Abdomen is soft and able to be assessed. U2 fundus. Pt complaining of some discomfort of the vaginal area following birth. Patient having fundus assessed and massaged every fifteen minutes. Patient has moderate bleeding and redness of the vaginal area 1 hour post delivery. No drains or discoloration to the area. Encouraged movement and activity to help reduce pain. Breathing techniques mentioned to help with pain level and tolerance. Ice pack applied and pad in place in peri area. Patient's uterus is above the umbilicus.**

Drains: **Wounds:** **Fundal Height & Position:**	
GENITOURINARY (5 Points): **Bleeding: Moderate** **Color:Rubor** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N X** **Inspection of genitals:** **Catheter: Y ☐ N X** **Type:** **Size:** **Rupture of Membranes:** **Time:1410** **Color: clear** **Amount: WDL** **Odor: none** **Episiotomy/lacerations: Abrasion only**	**Pt uses bathroom patient states her Urine has been clear no odor. Patient denies pain during urination. No irregularities -minor bleeding noted on pad. No catheter.** **Genitals are red and swollen due to recent birth. The rupture of membranes was at 1410. No odor and clear fluid. Amount was within normal limits.** **Small abrasion noted after delivery to right labia. Post delivery fifteen minute fundus assessments and massage if needed. No catheter at this time.**
MUSCULOSKELETAL (2 points): **ADL Assistance: YX N ☐** **Fall Risk: Y X N☐** **Fall Score: 28** **Activity/Mobility Status:** **Independent (up ad lib)☐** **Needs assistance with equipment ☐** **Needs support to stand and walk X**	**Pt exhibits normal active ROM bilaterally walks independently with no assistance. Patient is currently using breathing techniques to help with the pain and discomfort before during and after labor. Pt encouraged that movement and activity will help increase circulation and decrease pain. Pt is currently doing skin to skin with baby to encourage bonding. Pt is also currently breastfeeding.**
NEUROLOGICAL (1 points):	**Pt is sitting up in bed orientated time 3 w/newborn**

MAEW: Y X N☐ **PERLA: Y X N☐** **Strength Equal: Y X N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation: X3** **Mental Status: normal** **Speech:clear** **Sensory:intact** **LOC:N/A** **DTRs:WNL**	**and is breastfeeding, Pt has very little discomfort since the delivery. Pt states pain is at a 2 post delivery. Pt states she is glad she did the natural birth. Pt speaks clear good English with normal tone. PT MAEW for current age and condition. Strength is bilateral and equal. Pt follows commands with no restrictions. Pt has no signs of neurological deficit. Reflexes are normal and responsive when demonstrated bilaterally.**
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data(Think about home environment, family structure, and available family support):**	**.High School education, family every involved and supportive, pt states she is very spiritual. One daughter that is 5 at this time. Husband is involved but mother and grandmother has elected to be with her throughout the birthing experience and are at bedside with patient at this time. Patient will be returning home with newborn and grandparents will be helping throughout the recovery period.**
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date:7/18/2019** **Time: 1617** **Type (vaginal/cesarean):vaginal** **Quantitative Blood Loss: 200** **Male or Female** **Apgars:7 and 9** **Weight:3395 (7lbs 8 ounces)** **Feeding Method:football hold/breastfeeding**	**Patient was in 1st stage of labor when I arrived. Pt was dilated to 4. Within 2 hours the baby had descended down into 7cm and +1 station. The patient proceeded to develop further along even after the bolus was stopped at 1509 and the Oxytocin stopped at 1510. Patient continued to develop on her own to 8cm and +2 station. Patient continued to progress to 10 cm and 100 percent effaced and fully dilated. Patient received sacral pressure to offset the pain of the labor process. 1552 second stage of the labor of pushing began – baby in vertex posterior position. Patient delivered at 1617 a baby girl.**

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal 7/18	**73**	**115/67**	**16**	**97.3**	**97**
Labor/Delivery	**67**	**81/48**	**20**	**97.0**	**96**
Postpartum	**N/A -pt still in recovery**	**N/A**	**N/A**	**N/A**	**N/A**

Vital Sign Trends: Blood pressure can increase during labor and delivery due to stress, pain and inflammation factors. Blood pressure fluctuations can also be attributed to an increase due to contractions which can increase stroke volume and heart rate. The patient blood pressure will eventually return to a pre-pregnancy state after the delivery of the fetus. The changes reflect the fact the mother is no longer feeding and carrying the fetus in her uterus. This transition signifies the body changing to return to the normal blood levels similar to the pre-pregnancy state. The patient did well after the delivery of the fetus vitals signs remained within normal limits. Patient and baby are both calm and responding well to skin to skin contact and bonding with successful breastfeeding as well.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1645	**2**	**Vaginal**	**Throbbing/ Painful when moving**	**Throbbing/ cramping**	**Ibuprofen**
1700	**0**	**Vaginal**	**No pain at this time**	**No throbbing or pain at this time**	**Breathing techniques**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:18 gauge **Location of IV:right fore arm** **Date on IV:7/18/2019** **Patency of IV: Patent** **Signs of erythema, drainage, etc.:no signs of drainage or erythema** **IV dressing assessment: intact**	**No current issues with IV such as redness or irritation/ stationary in placement (intact-WNL)** **Oxytocin infusion recontinued after delivery at this time (only for a certain amount of time) /IV site patent**

Intake and Output (2 points)

Intake (in mL) 120ml (ice chips)	Output (in mL) (was not yet documented)expect for 200 quantitative blood loss

Interventions (12 points)

Teaching Topics (6 points)

Teaching points on post partum hemorrhage would be a priority for the patient. Signs and symptoms are important for patients to recognize for early prevention of complications. As a nurse I would explain the colors and amounts that should be normal considerations after birth to points within the next few weeks. As the body changes and hormones shift changes can occur with the bleeding eventually getting lighter to eventually stop. Patients need to understand the limits of activity to avoid hemorrhage or bleeding outcomes. Information regarding sexual activities should also be discussed to understand the risk factors of pregnancy and possible bleeding with intercourse. Birth control teaching should be discussed and most recommendations are to avoid vaginal sexual intercourse for at least 6 weeks.

1. Pt to monitor signs and symptoms of bleeding/ Pt to report any excessive unusual amounts of bleeding or clots to provider report any unusual signs of fever, rash, dizziness, or chills

2. Pt to increase movement daily within in normal limitations including scheduling of adequate rest periods/ Pt to increase walking ability as tolerated to increase circulation without dizziness, excessive bleeding or fatigue. Pt to report to provider any weakness or pain associated with walking or movement.

Nursing Interventions (6 points)

The following were also interventions that were implemented during the birthing process while was helpful to the progression of the delivery of the fetus. The bouncing ball was used in the beginning to help the baby proceed into a better position and help the cervix dilate. The mother was able to stay focused with breathing which allowed for the cervix to ripen and progress into the stages of labor. Positioning and counter pressure was used to help the patient adjust to the further dilation of the cervix without major discomfort. These interventions helped the patient gain better focus and control of her breathing techniques which helped the fetus remain at a comfortable baseline without any decelerations. During this process the patient was very willing and mobile she also understood the process of the course of the delivery. Patient had elected a natural birth these interventions were helpful throughout the stages of labor.

Nursing Interventions: Patient repositioning –for comfort measures-peanut ball and round ball used for comfort measures and helping the baby get lower into position –counter pressure applied to relieve discomfort

Medical Treatments: Assessing for pain and giving ibuprofen if needed for pain relief -

Encouraging walking and (proper positioning) ice for discomfort and swelling

Monitor blood loss and weigh pads –observe for clots - Assessing fundus/fundus massage if needed / --- Monitor vitals

<u>Nursing Diagnosis (15 points)</u>

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)** Include a short rationale as to why you chose this intervention & cite the reference appropriately	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Nursing Diagnosis - Impaired Tissue Integrity related to dehiscence as evidence by vaginal abrasion from vaginal delivery.	**Due to the vaginal abrasion pt may be at risk for a dehiscence due to the impaired tissue integrity.**	**1. Cleansing & assessing the wound monitor for changes in tissue integrity (Swearington, P. 2018).** **2. Assess temp. pulse, respirations, pain characteristics 2-4 hours to monitor for signs of infection or tissue integrity (Swearington, P. 2018).**	**Family was very positive and interacting with the nurse in a positive manner** **Pt Goal for Patient to Use Spray bottle after going to the bathroom** **Pt abrasion to heal without signs or symptoms of infection.** ***Client was very happy with natural delivery, client was responding well to recommendations for future ambulation- Client was doing skin to skin with baby at this time of education. Goal-Pt to have minimal to no bleeding & Pt education goal to recognize& report any signs and symptoms of abnormal bleeding & report them immediately to the provider**
1. Nursing Diagnosis Acute Pain related to post delivery uterine contractions as evidence by report of 0-3 pain on a scale of 1- 10.	**Due to pain from delivery and with increasing daily activity**	**1. Monitor patient for a verbal report & behavioral signs of pain q 2 hours/Encourage repositioning and walking to increase circulation and reduce pain/Assess**	**Patient was doing well after delivery moderate bleeding nursing assessment and fundus massage (massage if needed). Patient had very low scale amount of pain stated a 2 if that. Patient feeling good and happy the**

		fundus for firmness to help reduce bleeding associated with pain/ massage fundus is needed for bleeding (Swearington, P. 2018). **2. Teach & assist patient appropriate breathing & relaxation techniques/ medication if needed with reference to the use of the pain scale (Swearington, P. 2018).**	**baby is out. Patient responded well to the Oxytocin and her body actually was dilating on its own when the Oxytocin was paused. Mom and baby resting baby has been breastfeeding. Ibuprofen for pain was given & ice pack applied to peri area.**

Other References (APA):

Swearington, P. (2018). ***All-In-One Nursing Care Planning Resource.*** **[S.I.]: MOSBY. St.Louis, Missouri: Mosby, Inc.**

Sorenson, M., Quinn, L., Klein, D. (2019). ***Pathophysiology: concepts of human disease.*** **Hoboken, NJ: Pearson, Education, Inc**

Ricci, S., Carman, S. and Kyle, T. (2017). ***Maternity and pediatric nursing*****. 3rd ed. Philadelphia: Wolters Kluwer.**

N305 Care Plan Grading Rubric: LaborStudent Name:

Demographics	3 points	1.5 points	0 points	Points
Demographics • Date of admission • Patient initials • Age • Gender • Race/Ethnicity • Occupation • Marital Status • Father of baby involvement • Allergies • Code Status • Height • Weight	Includes complete information regarding the patient. Each section is filled out appropriately with correct labeling.	Two or more of the key components are not filled in correctly.	5 or more of the key components are not filled in correctly and therefore no points were awarded for this section	
Medical History	**5 points**	**2.5 points**	**0 points**	**Points**
Prenatal History **Past Medical History** • All previous medical diagnosis should be listed **Past Surgical History** • All previous surgeries should be listed **Family History** • Considering paternal and maternal **Social History** • Smoking (packs per day, for how may year) • Alcohol (how much alcohol consumed and for how many years) • Drugs (how often and drug of choice) **Living situation** **Education level**	Includes each section completed correctly with a detailed list of pertinent medical history, surgical history, family history and social history. If patient is unable to give a detailed history, look in the EMR and chart.	1 or moreof the key components is missing detailed information.	More than two of the key components are not filled in correctly	

• If applicable to learning barriers				

Admission Assessment -Chief Complaint	2 points	1 point	0 points	Points
Chief complaint • Identifiable with a couple words of what the patient came in complaining of	Chief complaint is correctly identified.	Chief complaint not completely understood.	No chief complaint listed.	
Admission Assessment- History	**10 points**	**6-10 points**	**0-5 points**	**Points**
Presentation to Labor & Delivery • Information is identified in regards to why the patient came to the hospital • Utilization of OLD CARTS as appropriate • Written in a paragraph form with no less than 5 sentences • Information was not copied directly from the chart and no evidence of plagiarism • Information specifically stated by the patient using their own words is in quotations • Plagiarism will receive a 0	Every key component of the admission history is filled in correctly with information. It is written in a paragraph form, in the student's own words. There is no evidence of plagiarism identified. This is developed in a paragraph format with no less than 5 sentences.	Two or more of the key components are missing in the admission history. The admission history is lacking important information to help determine what has happened to the patient.	4 or more components are missing in the admission history. Paragraph is not well developed and it is difficult to understand what the patient is seeking care for. There is evidence of plagiarism noted in the HPI.	
Primary Diagnosis	**2 points**	**1 points**	**0 points**	**Points**
Primary Diagnosis • The main reason the patient was admitted	All key components are filled in correctly.	One of the key components is missing or not	Student did not complete this section and there is concern	

Secondary Diagnosis • If the patient has more than one reason they are being admitted	The student was able to identify the correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.	understood correctly.	for lack of understanding the diagnosis.		

Stage of Labor	20 points	14-10 points	9-5 points	4-0 points	Points
Stage of Labor • Professionally written essay in APA format outlined all aspects of the stage of labor the client is in during the student's care • information is well written and no less than 1 page • Signs/symptoms of the stage • Expected findings related to the stage such as vital signs and laboratory findings • How the stage of labor is identified • Typical nursing interventions and treatments for the stage of labor • Assessment findings that would suggest the client is progressing to another stage • Listed clinical data that correlates to this particular client • Plagiarism results in a zero in this section • 2 APA references, essay is	All key components were addressed and student had a good understanding of the expectations listed. Stage of labor was thorough with a direct correlation of how this related to the client and their stage of labor was performed.	One or two key components were missing such as signs and symptoms, expected findings, correlation and treatment. Student was able to describe the stage of labor.	Three or more components were missing throughout the paper. Unable to determine if the student had a good understanding of the stage of labor and the direct correlation to the client	Section is incomplete with several key factors missing. Student did not have a good understanding of the stage of labor and how it correlated to the client. Section was not in APA format with minimum of 2 references (0 points will be given)	

written in correct APA format.					

Laboratory Data	15 points	5-14 points	4-0 points	Points
Normal Values • Should be obtained from the chart when possible as labs vary some. If not possible use laboratory guide. • Normal values should be listed for all laboratory data. **Laboratory Data** • Admission Values • Most recent Values (the day you saw the patient) • Prenatal Values **Rational for abnormalvalues** • Written in complete sentences with APA citations • Explanation of the laboratory abnormality in this client • For example, elevated WBC in patient with pneumonia is on antibiotics. • Minimum of 1 APA reference, no reference will result in zero points for this section	All key components have been addressed and the student shows an understanding of the laboratory norms and abnormalities. Student had 1 reference listed and is able to correlate abnormal laboratory findings to the client's particular disease process.	1 or more of the client's labs were not reported completely with normal values or patient results. Lab correlation did not completely demonstrate student's understanding of correlation.	Student did not have an understanding of laboratory values and the abnormalities. More than 2 labs were excluded. Student did not discuss the abnormal findings in APA format with a minimum of 1 reference.	
Electronic Fetal Heart Monitoring	**20 points**	**19-10 points**	**0-10 points**	**Points**
Components of EFHM: • Baseline • Accelerations • Variability	All key components have been addressed and	One or more of the key components is missing, yet the	Student did not have an understanding of EFHM and the	

• Decelerations • Contractions: frequency, duration, intensity • Correlation of EFHM to the client's diagnosis and condition. • Interventions performed • Normal values/expected values are listed • Minimum of 1 APA reference, no reference will result in zero points for this section	the student shows an understanding of the norms and abnormalities. Student had 1 reference listed and is able to correlate abnormal findings to the client's particular disease process.	student is able to demonstrate an understanding of the diagnostic testing and is able to correlate the abnormal findings to the disease process.	abnormalities. Student did not have an APA reference listed.	

Current Medications	10 points	1-9 points	0 points	Points
Current Medications • Requirements of 5 inpatient hospital medications and 2 home medications—these must be 7 DIFFERENT medications • Each medication must have brand/generic name • Dosage, frequency, route given, class of drug and the action of the drug • Reason client taking • 2 contraindications must be listed o Must be pertinent to your patient • 2 side effects or adverse effects • 2 nursing considerations • Key nursing assessment(s)/lab(s) prior to	All key components were listed for each of the 7 medications, along with the most common side effects, contraindications and client teachings. Student had 1 APA citation listed.	1 point will be lost for each medication with incomplete information.	There was noted lack of effort on the student's part to complete this section or there was no APA citation listed.	

administration o Example: Assessing client's HR prior to administering a beta-blocker o Example: Reviewing client's PLT count prior to administering a low-molecular weight heparin • 2 client teaching needs • Minimum of 1 APA citation, no citation will result in loss of all points in the section					
Physical Assessment	**20 points**	**1-18 points**	**0 points**	**Points**	
• Completion of a head to toe assessment done on the students own and not copied from the client's chart • Fall risk assessment • Braden skin assessment • **No fall risk or Braden scale will result in a zero for the section**	All key components are met including a complete head to toe assessment, fall risk and Braden score.	One or more of the key components is missing from a given section. Each body system is worth points as listed on care plan	More than half of the key components are missing. Therefore, it is presumed that the student does not have a good understanding of the head to toe assessment process.		
Vital Signs	**5 points**		**2.5 points**	**0 points**	**Points**
Vital signs • 3 sets of vital signs are recorded with the appropriate labels attached	All the key components were met for this section (with 2 sets of vital signs) and student has a good understanding of abnormal vital		Only one set of vital signs were completely recorded and one	Student did not complete this section	

• Includes a prenatal set, labor/ delivery set, and postpartum set • *If client has not delivered for a postpartum set, student is to list TWO vitals from labor and delivery* • Student highlighted the abnormal vital signs • Student wrote a summary of the vital sign trends	signs.	of the key components were missing.		
Pain Assessment	**2 points**	**1 point**	**0 points**	**Points**
Pain assessment • Pain assessment was addressed and recorded twice throughout the care of this client • It was recorded appropriately and stated what pain scale was used	All the key components were met (2 pain assessments) for this section and student has a good understanding of the pain assessment.	One assessment is incomplete.	Student did not complete this section	

IV Assessment	**2 points**	**1 point**	**0 points**	**Points**
IV assessment • IV assessment performed and it is charted including what size of IV and location of the IV • Noted when the IV was placed • Noting any signs of erythema or drainage • Patency is verified and	All of the key components were addressed. Student demonstrates an understanding of an IV assessment.	One of the key components is missing.	More than 1 aspect of the IV assessment is missing or student did not	

recorded • Fluid type and rate is recorded or Saline lock is noted. • IV dressing assessment is recorded (clean, dry and intact)			complete this section.	
Intake and Output	**2 points**	**1-0 points**		**Points**
Intake • Measured and recorded appropriately—what the patient takes IN • Includes: oral intake, IV fluid intake, etc. **Output** • Measured and recorded appropriately—what the client puts OUT • Includes: urine, stool, drains/tubes, emesis, etc.	All of the key components of the intake and output were addressed. Student demonstrates an understanding of intake and output.	One of the key components of the intake and output is missing. Difficult to determine if the student has a thorough understanding of the intake and output.		
Nursing Care/Interventions	**12 points**	**2-0 points**		**Points**
Nursing Interventions • List the nursing interventions utilized with your client • Includes a rationale as to why the intervention is carried out or should be carried out for the client **Teaching topics** • List 2 priority teaching items • Includes 1 expected outcome	All the key components of the summary of care (2 points) and discharge summary (2 points) were addressed. Student demonstrated an understanding of the nursing care.	One or more of the key components of the nursing care was missing, therefore it was difficult to determine if the student had a thorough understanding of the nursing care.		

for each teaching topic				
Nursing Diagnosis	**15 points**	**5-14 points**	**4-0 points**	**Points**
Nursing Diagnosis • List 2 nursing diagnosis o Include full nursing diagnosis with “related to” and “as evidenced by” components • Appropriate nursing diagnosis • Appropriate rationale for each diagnosis o Explain why the nursing diagnosis was chosen • Minimum of 2 interventions for each diagnosis • Rationale for each intervention is required • Correct priority of the nursing diagnosis • Appropriate evaluation	All key components were addressed. The student demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.	One or more of the nursing diagnosis/rationa l/intervention sections was incomplete or not appropriate to the patient Each section is worth 3 points. Prioritization was not appropriate.	More than 2 of the nursing diagnosis sections were incomplete or inappropriate. Prioritization is dangerously inappropriate.	
Overall APA format	**5 Points**	**1-4 Points**	**0 Points**	**Points**
APA Format • The student used appropriate APA in text citations and listed all appropriate references in APA format. • Professional writing style and grammar was used in all narrative sections.	APA format was completed and appropriate. Grammar was professional and without errors	APA format was used but not correct. Several grammar errors or overall poor writing style was used. Content was difficult to	No APA format. Grammar or writing style did not demonstrate collegiate level writing.	

		understand.		

		Points
- Instructor Comments:	**Total points awarded**	
Description of Expectations	**/150= %**	
Must achieve 116 pt =77%		