N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 10/18/20 1015	**Patient Initials** MC	**Age** 26	**Gender** Female
Race/Ethnicity White	**Occupation** Student/Mom	**Marital Status** Married	**Allergies** Lexapro
Code Status Full Code	**Height** 177.8	**Weight** 149.7 kg	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: Normal check-ups prenatally. No other prenatal care. G1P0. 40 weeks gestation.

Past Medical History: Asthma, Anxiety

Past Surgical History: None

Family History: None

Social History (tobacco/alcohol/drugs): Denies Use

Living Situation: She lives at home with her husband.

Education Level: She is currently in college.

Admission Assessment

Chief Complaint (2 points): She is complaining of back pain.

Presentation to Labor & Delivery (10 points):. The patient came into the hospital complaining of contractions. Her contractions were about 5 minutes apart and were lasting about 30-60 seconds. She said they started regulating at around 0830. She complained of severe back pain and stated, "It feels like knives in my back." She said movement aggravates them while they are going on. Breathing techniques help relieve the pain slightly. She rated her pain a 6 out of 10 upon admission. She did not try any other treatments; she just came to the hospital.

Diagnosis

Primary Diagnosis on Admission (2 points): In Labor- spontaneous labor of the 40-week gestational mother

Secondary Diagnosis (if applicable):. None

Stage of Labor

Stage of Labor Write Up, APA format (20 points) This should include the progression of cervical effacement & dilation as well as pain management techniques:

The client came into the hospital on October 19th, 2020, complaining of regular strong contractions that lasted 30-60 seconds and were 5 minutes apart. She was complaining of sharp pains in her back and abdomen. Upon vaginal examination, they determined she was 4 centimeters dilated. During this time, the client was considered to be in the first stage of labor in the latent phase (Ricci et al., 2017). Other symptoms of this stage include cramps, lower abdominal pressure, indigestion, diarrhea, and blood-tinged mucous vaginal discharge, also known as bloody show.

On October 21st, 2020, the patient was still in labor. Upon vaginal examination, the client was 6 centimeters dilated at 0530. She was complaining of contractions in her back that felt like knives. She was in distress, crying, screaming, and was extremely fatigued. At 0830, the patient measured 6.5cm dilated. She rated her contractions and pain at a 9 out of 10. The patient was in the first stage of labor in the active phase (Ricci et al., 2017). Other symptoms of the active phase include stronger contractions, leg cramps, urge to push, your water may break, and nausea (Mayo Clinic, 2020). The active phase is identified by being dilated 6 to 10 centimeters (Mayo Clinic, 2020).

During the first stage of labor in the active phase, the patient may experience a higher heart rate and a higher respiratory rate. Her blood pressure and oxygen level should stay stable. There is a chance that blood pressure and oxygen could drop slightly. Blood pressure would drop because of blood and fluid loss, and the oxygen could drop if the mother is holding her breath during a contraction. Depending on if the mother has lost blood during this time, her blood levels could be low. This patient did lose a small amount of blood during her laboring, so her red blood cells, hemoglobin, and hematocrit are low. Upon admission, the patient's red blood cell count is 3.9, the hematocrit is 34.4, and the hemoglobin is 11.7.

To treat the low blood levels, you may give a patient a blood product to replace what was lost. This would include an infusion of packed red blood cells (Ricci et al., 2017). If a patient's blood pressure drops drastically, or her fluid volume level gets dangerously low, they will be given intravenous fluids. This could be a normal saline solution or 0.9% fluid (Ricci et al., 2017). If the patient's oxygen level gets, low concentrated oxygen will be given to the patient via a nasal cannula or simple face mask (Ricci et al., 2017). During this labor stage, you want to keep the patient as comfortable as possible by using analgesics, positioning, massage, and pressure techniques. You could also use meditation, guided imagery, or distraction techniques.

Progression to the transition stage could include dilation of 10 centimeters and 100% effacement. The baby could also descend into the birth canal and be in station 0. Station 0 means the baby's head is lined up with the ischial spines in the birthing canal. The mother will the urge to push and be extremely irritable and possibly feel hopeless (Ricci et al., 2017).

Stage of Labor References (2) (APA):

Mayo Clinic. (2020). *Stages of labor and birth: Baby, it's time!* Labor and delivery, postpartum care. https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/stages-of-labor/art-20046545

Ricci, S., Kyle, T., Carmen, S. (2017). *Maternity and pediatric nursing* (3rd ed.) Lippincott, Williams & Wilkins.

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	4.28-5.56	4.47	3.9	N/A	The red blood cells are low because they are apart of the blood, and she lost blood during labor. Blood loss can result in low red blood cells (Ricci et al., 2017).
Hgb	13-17	13.5	11.7	N/A	The hemoglobin is low because they are a part of the blood, and she lost blood during labor. Blood loss can result in low hemoglobin (Ricci et al., 2017).
Hct	38.1-48.9	39.1	34.4	N/A	The hematocrit is low because they are a part of the blood, and she lost blood during labor. Blood loss can result in low hematocrit (Ricci et al., 2017).
Platelets	149-393	220	199	N/A	
WBC	4-11.7	7.6	7.9	N/A	
Neutrophils	45.3-79	74.7	78.7	N/A	
Lymphocytes	11.8-45.9	19.3	13.5	N/A	
Monocytes	4.4-12.9	5.9	6.4	N/A	
Eosinophils	0-6.3	0	0.6	N/A	

Bands	0-6	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	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	A, B, AB, O	AB	AB	AB	
Rh Factor	+/-	+	+	+	
Serology (RPR/VDRL)	Negative	Negative	Negative	N/A	
Rubella Titer	Negative	NON	NON	N/A	The patient has to receive the MMR as soon as she delivers. She was not immune to rubella.
HIV	Negative	N/A	N/A	N/A	
HbSAG	Negative	N/A	N/A	N/A	
Group Beta Strep Swab	Negative	N/A	N/A	N/A	
Glucose at 28 Weeks	70 - 100	84	93	N/A	
MSAFP (If Applicable)	0.5-2.0	N/A	N/A	N/A	

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

Lab Test	Normal Range	Prenatal Value	Value on Admission	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
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

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

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

Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Explanation of Findings
Urine protein/creatinine ratio (if applicable)	<0.2	0.17	0.18	N/A	

Lab Reference (APA):

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	160
Are there accelerations? • **If so, describe them and explain what these mean (for example: how high do they go and how long do they last?)** **What is the variability?**	No
Are there decelerations? If so, describe them and	No

explain the following: What do these mean? o **Did the nurse perform any interventions with these?** o **Did these interventions benefit the patient or fetus?**	
Describe the contractions: **Frequency:** **Length:** **Strength:** **Patient's Response:**	During our care, the contractions were happening every 2-3 minutes. The contractions lasted 60-90 seconds. She rated the contractions as causing a 9 out of 10 pain level. The strength was measured at an 80 mmHg. The patient was screaming and crying during her contractions.

EFM reference (APA format):

Current Medications (7 points, 1 point per completed med)
7 <u>different</u> medications must be completed

Home Medications (2 required)

Brand/Generic	**Fer-Iron ferrous sulfate**	**Folvite folic acid**	**Singular montelukast**	**Effexor XR venlafaxine**	**Vitamin D Vital-D**
Dose	325 mg	0.5 mg	10 mg	150 mg	100 mg
Frequency	Daily	Daily	Daily	Daily	Daily
Route	PO	PO	PO	PO	PO
Classification	Antianemic	Antianemic Vitamins	Bronchodilators	Antidepressant Antianxiety	Vitamin supplement
Mechanism of Action	An essential mineral found in hemoglobin, myoglobin, and many enzymes. It enters the	Required for protein synthesis and red blood cell function.	Antagonizes the effects of leukotrienes, which mediate the following: airway edema,	Inhibits serotonin and norepinephrine reuptake in the CNS.	The vitamin is digested and absorbed in the small intestines then stored in the fat cells.

	bloodstream and is transported to the reticuloendothelial system (liver, spleen, bone marrow), where it becomes part of iron stores.	This medication stimulates the production of red blood cells, white blood cells, and platelets. Necessary for normal fetal development.	smooth muscle constriction, altered cellular activity. The result is a decreased inflammatory process, which is part of asthma and allergic rhinitis.		
Reason Client Taking	Low RBCs	Low RBCs & Prenatal Vitamin	Asthma	Anxiety	To supplement her calcium during pregnancy
Contraindications (2)	Anemia not due to iron deficiency & Hemochroma-osis	Uncorrected pernicious, aplastic, or normocytic anemias & Undiagnosed anemias.	Hypersensitivity & acute attacks of asthma.	Hypersensitivity & Cardiovascular disease	- high levels of vitamin d - high levels of calcium
Side Effects/Adverse Reactions (2)	Dark Stools & Syncope	Rash & Difficulty Sleeping	Suicidal thoughts & Rash	Abnormal dreams & Sexual Dysfunction	- weakness -fatigue
Nursing Considerations (2)	Assess bowel function for constipation or diarrhea. Assess nutritional status and dietary history to determine possible causes of anemia and the need for patient teaching.	Assess patients for signs of megaloblastic anemia before and periodically throughout therapy. Assess for symptoms of an adverse reaction.	Assess lung sounds and respiratory function before and periodically during treatment. Monitor closely for changes in behavior that could indicate the emergence or worsening of depression or	Assess mental status and mood changes. Monitor BP before and periodically during therapy.	- only give if the body is in need - monitor for hypercalcemic events

			suicidal thoughts.		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor hemoglobin, hematocrit, and reticulocyte values before and every three weeks during the first two months of therapy and periodically after that. Monitor serum ferritin and iron levels to assess the effectiveness of treatment.	Monitor plasma folic acid levels, hemoglobin, hematocrit, and reticulocyte count before and periodically during therapy. May cause low serum concentrations of other B complex vitamins when given in high continuous doses.	Monitor for an increase in AST and ALT concentrations.	Monitor CBC with differential and platelet count periodically during therapy. May cause anemia, leukocytosis, leukopenia, thrombocytopenia, basophilia, and eosinophilia. Monitor for an increase in serum alkaline phosphatase, bilirubin, AST, ALT, BUN, creatinine, and cholesterol.	- vitamin d levels -calcium level
Client Teaching needs (2)	Explain the purpose of iron therapy for the patient. Advise the patient that stools may become dark green or black.	Folic acid in early pregnancy is necessary to prevent neural tube defects. Explain that folic acid may make the urine more intensely yellow.	Instruct the patient to take medication daily in the evening or at least 2 hours before exercise, even if not experiencing asthma symptoms. Instruct the patient not to discontinue or reduce other asthma medications without consulting a health care professional.	Instruct patient to notify health care professional if signs of allergy occur. May cause drowsiness or dizziness, caution the patient to avoid driving or other activities requiring alertness until the drug's response is known.	- monitor for signs and symptoms of hypercalcemia - educate about how vitamin d helps absorb calcium

Hospital Medications (5 required)

Brand/Generic	**Tylenol acetaminophen**	**Hemabate carboprost**	**Colace Docusate sodium**	**Fentanyl Duragesic**	**Zofran Ondansetron**
Dose	650 mg	250 mg	100 mg	10 ml/hour	4 mg
Frequency	Q4hr	Q15min	Daily	Continuous	Continuous
Route	PO	IM	PO	Epidural	IV
Classification	Analgesic	Prostaglandin	Laxative	Analgesic	Antiemetic
Mechanism of Action	"The analgesic effects are believed to be due to activation of descending serotonergic inhibitory pathways in the CNS. Interactions with other nociceptive systems may be involved as well" (Wolters Kluwer, 2020).	It is a synthetic prostaglandin. It binds the prostaglandin E2 receptor, causing myometrial contractions, causing the induction of labor or the placenta's expulsion. Prostaglandins occur naturally in the body and act at several sites in the body, including the womb (uterus).	"Reduces surface tension of the oil-water interface of the stool resulting in enhanced incorporation of water and fat allowing for stool softening" Wolters Kluwer, 2020).	"Binds to opioid receptor sites in the CNS, altering the perception of and emotional response to pain by inhibiting ascending pain pathways" (Wolters Kluwer, 2020).	"Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine. This action reduces nausea and vomiting by preventing serotonin release in the small intestine and by blocking signals to the CNS. Ondansetron may also bind to other serotonin receptors and to mu-opioid receptors" (Jones & Bartlett, 2019).
Reason Client Taking	Pain	Bleeding	Constipation	Pain	Nausea
Contraindications (2)	Hypersensitivity Taking other	Fetus in utero that should not be aborted	Do not use if vomiting Do not use if	Asthma Myasthenia gravis	- use of apomorphine - long QT

	medications that have acetaminophen in them	No bleeding	there is unexplained abdominal pain		syndrome
Side Effects/Adverse Reactions (2)	Skin rash Increased serum glucose	Abdominal cramping Abnormal clotting	Throat irritation Diarrhea	Confusion Slurred speech	- agitation -weakness
Nursing Considerations (2)	Monitor hepatic function Monitor pain level	Monitor amount of bleeding Monitor contraction intensity	Do not administer if the patient has diarrhea Do not administer if the patient reports stomach pains	Monitor mother for adverse effects of medication Monitor respiratory status	-Correct hypokalemia before use -monitor for hypersensitivity
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Pain level Hepatic function	Pain level Fluid/blood output	Output amount/ characteristics Last bowel movement date	Pain level Respiratory rate	-potassium -magnesium
Client Teaching needs (2)	Report not being able to pass urine Monitor for any signs of hypersensitivity	Report excessive bleeding immediately If the cramping becomes too intense, report to the provider	Do not take for longer than seven days Do not take if you are experiencing any GI issues	If the difficulty of breathing occurs, alert someone immediately If pain is uncontrolled, tell a healthcare professional	-if experiencing worsening symptoms, seek medical care - report rash to provider

Medications Reference (APA):

Drugbank. (2020). Carboprost. https://go.drugbank.com/drugs/DB00429

Wolters Kluwer. (2020). Lexicomp. *Wolters Kluwer Clinical Drug Information, Inc.* [Computer Software]. https://online.lexi.com/lco/action/home

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	This patient is alert and oriented time four. She is in distress due to the contractions, and she looks fatigued. Her overall appearance is appropriate for being in labor with strong and regular contractions.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☒ N ☐** **Type:**	Her skin color was appropriate for her ethnicity. It is moist, intact, and warm to the touch. Her skin is elastic and non-tenting, with no rashes, bruises, or wounds present at the assessment time. She has a Braden score of 19. She is not at risk for skin breakdown. She does have a foley catheter present at this time. The foley is attached to her right leg.
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient was normocephalic with her ears and eyes level and symmetrical. Her nose was midline and intact with a nose ring on the right side. Her extraocular muscles are entire, and eyes follow PERRLA. The patient's teeth are intact. .
CARDIOVASCULAR (1 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	The patient's heart rhythm is normal, with S1 and S2 auscultated. She is slightly tachycardic, with a pulse of 110 beats per minute. There is no murmur present. Her pedal pulses are equal bilaterally and felt at a +3. Her capillary is less than 3 seconds. There is no neck vein distention or edema present.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	She is on room air with an oxygen saturation of 98%. Her breaths are labored at an accelerated rate of 28 breaths per minute. She is not using

	accessory muscles to breathe at this time. Her breath sounds are heard clearly anteriorly and posteriorly in all lobes of both the left and right lungs. Her nail beds are normal for her ethnicity.
GASTROINTESTINAL (5 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	She is on a regular diet with no restrictions at home and currently in the hospital as well. The patient became NPO 1 hour before her cesarean section. She is 177.8 cm tall and weighs 149.7 kg. There are active bowel sounds in all four quadrants. Her last bowel movement was on 10/18/20. Upon palpitation, the fundus was felt at the xiphoid process. Her uterus is distended. Her uterus was midline. There are no incisions, scars, drains, or wounds at this time.
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:** **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Episiotomy/Lacerations:**	She has light, bright, red bleeding. She had a quantity of 3250 mL. She is not experiencing pain with urination. Her genitals were appropriate for her age and gender. She has an 18 French Catheter in place. Her membranes have ruptured on 10/18/20 at 1430. The color was clear, and she states the amount was a lot. There was no exact amount known. There was no odor to the fluid. She had to have a C-Section, so she has a laceration on her lower abdomen post-surgery.
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	She needs assistance with ADLs because she is a fall risk and is in a lot of pain. Her fall score is 12. She is on bed rest and needs support to stand, move, and walk.
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐**	She moves all extremities well and has equal strength, except when her spinal was done due to having a C-Section. During the spinal, the patient

Strength Equal: Y ☐ N ☒ if no - Legs ☒ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **Deep Tendon Reflexes:**	does not have much strength in her lower extremities. Her strength in her legs is graded at a 1. After the spinal wears off, she can MAEW and have equal strength in all four extremities. Her eyes follow PERRLA. She is alert and oriented time 4. Her mental status is appropriate for her mental status and age. Her speech is clear, with breaths in between words due to contractions. She has normal deep tendon reflexes graded as a 2+.
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):**	To cope with stress, she sleeps. Her highest level of education is college, in which she is currently enrolled in. She does not have a preferred religion, and religion is not a large part of the patient's life. She lives at home with her husband.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	Her delivery date was 10/21/20 at 1113. She had a cesarean section. She lost 300 mL of blood during the procedure. She gave birth to a male. His APGAR score was a 9. He weighed 7 pounds and 12 ounces. The baby will be bottle-fed.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	84	116/69	18	97.3 F	98%
Admission to Labor/Delivery	95	121/59	24	97.0 F	98%
During your care	110	115/56	28	97.5 F	98%

Vital Sign Trends: The patient's vital signs stayed stable during our care. The patient did become slightly tachycardic during our care and was tachypneic during labor.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numeric	Back	9/10	Stabbing	None
0830	Numeric	Back	9/10	Sharp	Pitocin Stopped

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	The patient has an 18-gauge IV in her left hand that was placed on 10/18. She has a continuous infusion of lactated ringers at the rate of 125mL/hr. It flushes without difficulty and has good blood return. There are no signs of erythema or drainage at the IV site. The dressing is dry and intact.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
2748.2 mL	3250 mL

Nursing Interventions and Medical Treatments during Labor & Delivery (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them, identify medical treatments with "T" after you list them.)	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.
Analgesics prescribed for pain management. (T)	Q4 or PRN	The patient was given this intervention because the labor pains were too much for the patient, and she needs pharmacological help through them.

Different positioning offered to comfort the client. (N)	PRN- offered every 10 minutes	This intervention was given to the patient because she was uncomfortable through labor and needed help in finding a comfortable position during contractions.
Comforting physical touch is given to the patient. (N) Nonpharmacological pain management.	PRN- constant touch by the husband and touch by nurses when checking in	This intervention was given to the patient to comfort the patient and to help relieve her anxiety.

Nursing Diagnosis (30 points)
Must be NANDA approved nursing diagnosis and listed in order of priority
Two of them must be education related i.e. the interventions must be education for the client."

2 points for the correct priority

Nursing Diagnosis (2 pt each) Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rationale (1 pt each)** Explain why the nursing diagnosis was chosen	**Intervention/Rationale(2 per dx) (1 pt each)** Interventions should be specific and individualized for this patient. Be sure to include a time interval such as "Assess vital signs q 12 hours." List a rationale for each intervention and using APA format, cite the source for your rationale.	**Evaluation (1 pt each)** • How did the patient/ family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to cervical dilation and uterine contractions, as evidenced by the client rating her pain as a 9 out of 10.	The patient's pain level is high, which needs to be treated and monitored.	1. Give analgesics as needed Rationale: Analgesics can lower pain levels (Ricci et al., 2017). 2. Teach the patient and husband nonpharmacological pain reduction techniques like breathing exercises and massage. Rationale: Nonpharmacological pain reduction techniques can	The patient wanted the pain medication and tried the nonpharmacological pain reduction techniques that were taught to her.

		lower pain levels along with analgesics (Ricci et al., 2017).	
2. Potential shock related to hypovolemia, as evidenced by the amount of fluid lost during labor and cesarean section.	This was chosen because the patient is losing fluid and blood during the labor and procedure.	1. Administer intravenous fluids as prescribed. Rationale: IV fluids and blood products can be given intravenously to supplement lost blood or fluid (Ricci et al., 2017). 2. Provide the patient with water or a drink of her choice. Rationale: the patient needs to intake fluids as much as possible orally to keep herself hydrated (Ricci et al., 2017).	The patient understood the importance of hydration, complied with the IV fluids, and drank plenty of water.
3. Need for health teaching related to lack of infant knowledge, as evidenced by being first-time parents.	The patient and her partner need to know infant care while taking care of their newborn.	1. Teach the client about basic newborn care, like changing diapers and feeding. Rationale: You need to feed and change the infant regularly to grow and develop accordingly (Ricci et al., 2017). 2. Teach the parents warning signs for infant issues like blue lips, weight loss, or the refusal to eat. Rationale: the parents need to know warning signs of issues to know if they need to bring the infant to the hospital (Ricci et al., 2017).	The parents both received the information well and understood when they need to bring their new baby to the hospital if complications occur.
4. Anxiety related to laboring pain and childbirth, as evidenced by the patient stating she is extremely	The patient is anxious and needs intervention to successfully get through her laboring process and birth without	1. Monitor the patient's anxiety level during labor. Rationale: To know the patient's anxiety level, it must be monitored and understood by questioning her (Ricci et al., 2017). 2. Teach anxiety-reducing activities that she can do	The patient used the anxiety-reducing techniques through labor and said they helped her. She also talked about her anxiety so that the nurse was able to monitor her accurately.

anxious during her labor.	emotional complication.	during labor. Rationale: Anxiety reducing activities can help during labor to calm the patient and improve her mental state (Ricci et al., 2017).	

Other References (APA):

Ricci, S., Kyle, T., Carmen, S. (2017). *Maternity and pediatric nursing* (3rd ed.) Lippincott, Williams & Wilkins.