N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 4/1/2017	**Patient Initials** LS	**Age** 28 years old	**Gender** Female
Race/Ethnicity Does not specify	**Occupation** Waitress	**Marital Status** Not married - in a relationship	**Allergies** Diltiazem, Penicillin
Code Status	**Height** 172.7 cm (5'8")	**Weight** 129.7 kg (286 lbs)	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: LS was diagnosed with Gestational diabetes at 28 weeks and her 3 hour glucose tolerance test measured 190, as well as cholelithiasis at around 26 weeks of pregnancy.

Past Medical History: LS has a history of cholelithiasis.

Past Surgical History: N/A

Family History: N/A

Social History (tobacco/alcohol/drugs): N/A

Living Situation: At home with her significant other (BG).

Education Level: N/A

Admission Assessment

Chief Complaint (2 points): Consistent contractions (preterm labor)

Presentation to Labor & Delivery (10 points):

LS, a 28-year-old woman who presented to the labor and delivery unit 4/1/17 admitted for preterm labor. LS was put on an external fetal monitor upon admission. The fetal heart rate showed some accelerations. Her vaginal exam exhibits that her cervix is dilated at 2 cm, effaced at 80%, and intact membranes at +2 station. LS stated that the contractions she is experiencing began several hours before admission and thought that they were Braxton Hicks contractions. LS

was transferred to the antepartum unit for nonstress tests and was monitored for 24 hours. She experienced spontaneous rupture of membranes 12 hours after admission while she was in the bathroom. She was transferred to the labor and delivery unit where the fetal monitor showed moderate variability. She was 5 cm dilated, 100% effaced, and the presenting part was at +1 station. The baby was delivered on 4/4/17 at 0828 and was sent to NICU after stimulation and positive pressure ventilation.

Diagnosis

Primary Diagnosis on Admission (2 points): Preterm labor/active labor

Secondary Diagnosis (if applicable): Gestational diabetes

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:
History of Labor

LS was admitted to the labor and delivery unit on 4/1/17 for preterm Labor. A vaginal examination showed that LS was 2 cm dilated, 80% effaced, and an intact membrane was at +2 station. She was transferred to the antepartum unit when the contractions subsided after 24 hours of monitoring. Twelve hours after being admitted into the antepartum unit, LS had a spontaneous rupture of membranes and started to have more contractions at 05:10. LS was transferred to the Labor and delivery where a vaginal examination confirmed that she was 5 cm dilated, 100% effaced, and the fetal presenting part was at +1 station.

The current stage of Labor

LS is now in the puerperium, also know as the 4th stage of Labor.

Expected findings/Signs and symptoms

Expected findings, signs, and symptoms of the 4th stage of Labor may include lochia (scant to heavy bleeding), mild to moderate cramping of the uterus, tender breasts (due to lactation), increased urinary frequency, as well as decreased peristalsis, decreased fundal height, and lacerations in the perineum area (Ricci et al., 2017). LS's blood loss was estimated at 350 mL. Normal blood loss for a vaginal delivery is between 250-500 mL of blood (Ricci et al., 2017). LS was also instructed on how to use a breast pump. Upon examination, the fundus was a u/u, which simply means that the head of the fundus is at her umbilicus level (Ricci et al., 2017). The fundal height is expected to decrease by 1-2 cm per day (Ricci et al., 2017).

How is the stage identified?

The puerperium stage is the 4th stage of Labor. A mother in postpartum is considered to be in the 4th stage of Labor after she has delivered the infant and the placenta (Ricci et al., 2017). LS delivered the placenta at 08:35 on 4/4/17, approximately 7 minutes after the delivery of the infant.

Typical nursing interventions

Typical nursing interventions may include the administration of prescribed analgesic medications and uterotonic medications (Hinkle & Cheever, 2018). A nurse may also perform fundal massages to encourage the proper discharge of uterine contents and prevent bleeding (Hinkle & Cheever, 2018).). Additionally, a nurse may educate the mother on proper ways to breastfeed and positional changes (Ricci et al., 2017). The nurse administered 40 units of Pitocin after the placenta was delivered to help prevent further bleeding. The nurse also instructed LS on how to use a breast pump properly.

Stage of Labor References (2) (APA):

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

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

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	3.5-5.2	N/A	4.16	N/A	Normal lab value
Hgb	11-16	N/A	12.9	N/A	Normal lab value
Hct	34-47	N/A	37.9	N/A	Normal lab value
Platelets	140-400	N/A	178	N/A	Normal lab value
WBC	4-11	N/A	9.08	N/A	Normal lab value
Neutrophils	45.3-79%	N/A	N/A	N/A	Normal lab value
Lymphocytes	11.8-45.9%	N/A	N/A	N/A	Normal lab value
Monocytes	4.4-12.0%	N/A	4.8	N/A	Normal lab value
Eosinophils	0.0-6.3%	N/A	0.2	N/A	Normal lab value
Bands	0.0-5.0%	N/A	N/A	N/A	Normal lab value

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	O+	O+	O+	O+	Normal lab value
Rh Factor	+	+	+	+	Normal lab value
Serology (RPR/VDRL)	Negative	Negative	Negative	Negative	Normal lab value
Rubella Titer	>10/	>500	>500	>500	A rubella titer value of >10

	Immune				indicates that the patient is immune (Hinkle & Cheever, 2018).
HIV	Negative	Negative	Negative	Negative	Normal lab value
HbSAG	Negative	Negative	Negative	Negative	Normal lab value
Group Beta Strep Swab	Negative	N/A	Positive	Positive	A positive culture of GBS indicates that the patient has an increased number of GBS, which is not harmful to the mother but can be harmful to the infant (Ricci et al., 2017).
Glucose at 28 Weeks	<140	190	110	99	LS was diagnosed with Gestational diabetes at week 28 of her pregnancy explaining the prenatal value (Ricci et al., 2017). She is doing a carb count diet to manage her Gestational diabetes.
MSAFP (If Applicable)	0.5-2.0	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

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)	<3.5	N/A	N/A	N/A	N/A

Lab Reference (APA):

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

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

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	The fetal baseline heart rate was 150 bpm.
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?)**	There were a few accelerations in fetal heart rate with variability ranging from minimal (0-6 bpm above baseline) to mild (6-25 bpm above baseline) across the 4 strips that were provided. These accelerations are expected findings and are normal (Ricci et al.,

What is the variability?	2017). The fetal heart rate accelerations indicate that the baby is receiving enough oxygen (Ricci et al., 2017).
Are there decelerations? If so, describe them and 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?**	The strips show late decelerations with minimal (0-6 bpm below baseline) to mild (6-25 bpm below baseline) variability. Decelerations indicate that the baby is not receiving enough oxygen causing constriction of the blood vessels (Ricci et al., 2017). The nurse turned LS to her left side and put on an oxygen mask at a rate of 3L. This intervention benefits the fetus because it improves blood flow to the uterus (Ricci et al., 2017). Turning LS on her left side also benefits her because it decreases the likelihood of developing maternal hypotension (Ricci et al., 2017).
Describe the contractions: **Frequency:** **Length:** **Strength:** **Patient's Response:**	<u>Strip 1</u> Frequency: ~4 minutes Length: 50 seconds Strength: 5-10 mm Hg Response: LS thought that these are Braxton Hicks contractions. <u>Strip 2</u> Frequency: ~3.5 minutes Length: 70 seconds Strength: 40-80 mm Hg Response: LS is moving into active labor. She cannot relax between contractions and she is anxious.

	Strip 3 Frequency: ~1.5 minutes Length: 60-80 seconds Strength: 30-40 mm Hg Response: LS is experiencing an increase in pain and had asked for an epidural. Strip 4 Frequency: ~1-1.5 minutes Length: 60-70 seconds Strength: 10-30 mm Hg Response: LS is frantic and reported of having built up pressure in her bottom.

EFM reference (APA format):

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

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

Home Medications (2 required)

Brand/Generic	Prenatal multivitamin				
Dose	0.8 (1 tab)				
Frequency	Daily				
Route	PO				
Classification	Vitamin				

Mechanism of Action	Supports metabolic functions, protein synthesis, and DNA synthesis.				
Reason Client Taking	Vitamin deficiencies during pregnancy				
Contraindications (2)	Wilson's disease; undiagnosed anemias				
Side Effects/Adverse Reactions (2)	nausea, vomiting; constipation				
Nursing Considerations (2)	Severe iron toxicity may occur; perform a medication reconciliation to make sure the patient is not taking medications that will interact with the multivitamin and its components.				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor the patient for hypervitaminosis - increased vitamins in serum blood test.				
Client Teaching needs (2)	Take your multivitamin with a full glass of water; store at room temperature away from moisture and heat.				

Hospital Medications (5 required)

Brand/Generic	Lactated Ringers	Pitocin **oxytocin**	Oxygen		
Dose	1000 mL	40 units	3L		
Frequency	100 mL/hr; bolus	Once	Once		
Route	IV	IV rider	Mask; inhalation		
Classification	IV fluids	Uterotonic	Supplemental gas		
Mechanism of Action	Replaces fluids and electrolytes.	Hormone used to induce labor or increase the strength of uterine contractions to control bleeding.	Increases oxygen circulation to the fetus during labor and delivery.		
Reason Client	To replace lost fluids	To control bleeding	To ensure that the fetus is		

Taking	during labor and delivery.	after the delivery of her infant and placenta.	receiving an adequate amount of oxygen during contractions.		
Contraindications (2)	Hypersensitivity to sodium lactate; separate infusion when administering ceftriaxone.	Hypersensitivity to the medication; genital infection	High risk for seizures; high fever		
Side Effects/Adverse Reactions (2)	Sodium retention; fluid retention.	Tachy or bradycardia; nausea, vomiting	Toxicity; irritated skin		
Nursing Considerations (2)	Use caution in patients with renal impairment; use caution in patients on diuretics.	Caution in decreased fetal heart rate; use caution because it may cause severe CNS damage in neonates	Caution in patients with sinus damage; monitor patient for vision changes		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor for hyperkalemia and hypervolemia.	Monitor the patient's and the fetus' baseline heart rate.	Monitor the patient's oxygen saturation		
Client Teaching needs (2)	Use potassium sparing diuretics; report any symptoms of hypervolemia.	Report an increase in heart rate; report signs and symptoms of infection due to increased bleeding.	Report any vision changes, report any earache.		

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *Nurses drug handbook.*

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	LS was awake and oriented to person, place, time, and situation (x4). LS responded to the questions asked appropriately. She looked well nourished and in a good mood. Very easy to talk to and cooperative.

INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Braden Score: 23 (not a skin risk) Her skin was appropriate color for race, intact, warm, and dry to touch with good skin turgor. There were no rashes, bruises, or wounds noted or reported by the patient. No drains are present.
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head is normocephalic and midline with no deviations. The neck is short with trachea in midline. The patient exhibited PERRLA and the six cardinal fields of gaze. The tympanic membrane is pearly, grey in color, and intact bilaterally. There was no drainage in the patient's ears. Her nose showed no deviated septum. Her nose showed equal turbinates, bilaterally. The skin around her nose is intact and shows no signs of breakdown caused by the oxygen mask. The oral mucosa is pink, moist, and intact with teeth present. Tongue was pink in color. No abnormalities noted.
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:**	S1 and S2 were heard with normal rate and rhythm. Pedal pulses were strong and graded at 2+, bilaterally. Her capillary refill was less than 3 seconds. No murmurs, edema, or JVD noted.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The patient's respirations were unlabored at 16 breaths/min with no signs of accessory muscle use.All lung fields are clear to auscultation. The patient's chest moved with each respiration with no chest wall deformities observed. Her O2 sat was noted at 98% on 3L via oxygen mask at the time of assessment. The patient had no productive cough.
GASTROINTESTINAL (5 points): **Diet at Home:**	Ht: 68" Wt: 286 lbs

Current Diet: **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	Last BM: N/A LS is on diabetic diet eating at about 2,200 calories per day. Her abdomen was soft and nondistended with hypoactive bowel sounds in the all four quadrants after auscultating for 3 minutes. The abdomen was round and moved with respirations. There was no organomegaly noted. No distention, incision, scar, drain, or wound noted. No feeding tubes in use. No mass palpated. No discomfort reported.
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:**	Upon assessment, the patient's urine was clear and yellow in the toilet. The amount was not measured. No distention of the bladder noted. The patient did not report any changes in voiding or dysuria. Patient was not on dialysis or had a catheter. LS had spontaneous rupture of membranes on 4/4/17 at 05:10. The color was clear, large amount, and no odor. No episiotomy or lacerations noted.
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☐**	Fall Score: 0 (Not a fall risk) The patient was able to perform active range of motion in both upper and lower extremities, bilaterally. She exhibited equal strength in all four extremities. The patient is up and ad lib. The patient requires no assistive device. There was no joint swelling noted. No discomforts reported.
NEUROLOGICAL (1 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -**	LS speaks English as her primary language and responded appropriately for her age. She is alert and oriented x4. The patient moved all extremities well (MAEW). PERRLA was noted.

Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **Deep Tendon Reflexes:**	LS's strength is equal bilaterally in all four extremities. Her mental status is appropriate for her age. Sensory and judgement are intact. No change in LOC noted. Deep tendon reflex intact.
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):**	LS was calm and cooperative. LS did not mention any religion. Her boyfriend, BG, is her support person. She stated that she is happy with her life. Her developmental level is appropriate for age. Her close family lives at least an hour away.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	LS delivered her baby boy on 4/4/17 at 08:28 by vaginal delivery. Baby boy weighed in at 2,013 grams and 18 inches long. Her estimated blood loss was 350 mL. His APGAR scores are as follows: - 1 minute: 6 - 5 minute: 8 LS is interested in breastfeeding but has not gone through the breastfeeding class like she had planned. She was instructed on how to use a breast pump for now. Baby boy is currently in the NICU.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	98	132/85	16	98.4	100%
Admission to Labor/Delivery	110	110/65	16	97.6	97%
During your care	104	124/75	16	99	98%

Vital Sign Trends: LS vital signs were stable throughout her admission. She had an increase in heart rate during labor and delivery and it is now consistently decreasing. Her temperature is slightly elevated and a CBC has been ordered to rule out any possible infections.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0500	0-10	Uterus	4/10	Cramping/ contractions	Position changes
0600	0/10	Uterus	8/10	Cramping/ contractions	Epidural

****There were no pain values on the case study. These values are made up according to the description of the discomfort of the patient.****

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:**	20 gauge, right AC dated 4/1/17 The IV is patent with no signs of erythema or drainage. The dressing is dry, clean, and intact. Fluids: - 4/1/17 LR 100 mL/hr - 4/4/17 LR 1000 mL bolus - 4/4/17 LR/Pitocin 1000 mL @500 mL/hr - 4/4/17 LR/Pitocin decreased to 125 mL/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
4/4/17 - 1000 mL (IV LR)	Was no measured

Time of care: 0600-1200 (4/4/17)

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.**
Cold towel on her forehead (N)	During labor and delivery	The cold towel on her forehead acts as a distraction from the stresses of labor and delivering her baby (Ricci et al., 2017).
Turning LS to her left side (N)	During labor	Turning LS to her left side allows for better circulation for the fetus and for LS herself and improving comfort (Ricci et al., 2017).
Epidural (T)	During labor when her pain intensified	The epidural was given to lessen the pain that LS was experiencing during labor after she had asked to receive one (Ricci et al., 2017).

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."

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	**Rational (1 pt each)** Explain why the nursing diagnosis was chosen	**Intervention/Rational (2 per dx) (1 pt each)** Interventions should be specific and individualized for his patient. Be sure to include a time interval such as Assess vital signs q 12 hours." List a	**Evaluation (1 pt each)** ● How did the patient/family respond to the nurse's actions? ● Client response, status of goals and outcomes,

		rationale for each intervention and using APA format, cite the source for your rationale.	modifications to plan.
1. Risk for infection related to labor and delivery as evidenced by slightly elevated postpartum temperature and vaginal delivery.	LS postpartum temperature was at 99 F, which is nowhere near her baseline. Lacerations and bleeding also increase the risk for developing an infection.	1. Practice aseptic technique when caring for LS. **Rationale:** We want to use aseptic technique to minimize the risk of infection in postpartum mothers (Hinkle & Cheever, 2018). 2. Reduce causative factors. **Rationale:** We want to minimize the chance of pathogens entering vulnerable areas like lacerations/episiotomy. We want to keep everything as clean and as aseptic as possible (Hinkle & Cheever, 2018).	**Goal:** LS will not show any other signs of infection during her recovery. Care providers are going by aseptic protocols to ensure the safety of LS when providing care.
2. Risk for overweight related to Gestational diabetes as evidenced by Gestational weight of 286 lbs.	LS's pre-pregnant weight was at 260 lbs and she was at 286 lbs during her pregnancy. She is 5'8" which puts her at a high BMI.	1. Educate LS about proper nutrition to reduce her weight and reduce chances of developing postpartum type II diabetes. **Rationale:** Gestational diabetes occurs during pregnancy, if it is not controlled properly, type II diabetes may develop. We can reduce this risk by educating our patients about better food choices (Ricci et al., 2017). 2. Educate LS about developing a proper exercise routine. **Rationale:** Developing a proper exercise routine aids in reducing the risk of developing diabetes through reducing weight by increasing energy expenditure (Hinkle & Cheever, 2018).	**Goal:** LS will be able to identify better food options for herself for losing weight. LS is able to stay compliant with her diet to help her maintain her weight and control her Gestational diabetes. We want LS to be able to develop a healthy exercise routine to help her lose weight.

3 Risk for unstable blood glucose level related to Gestational diabetes as evidenced by prenatal history blood glucose of 190.	L's 3 hour glucose tolerance test was at 190 at 28 weeks of gestation.	1. Develop a diet that aids in controlling blood glucose levels. **Rationale:** We want a diet that is balanced and will not increase blood glucose levels to reduce the risk of developing type II diabete (Hinkle & Cheever, 2018). 2. Educate LS about prevention of Gestational diabetes in the event that she has another pregnancy. **Rationale:** Prevention is always the best intervention. We want to ensure that LS is informed about the risk factors of developing Gestational diabetes that can complicate her health, as well as her baby's health if it is not controlled appropriately (Hinkle & Cheever, 2018).	**Goal:** LS will have a better control of her blood glucose levels. LS has shown the ability to maintain and control her blood glucose at a desired level (70-100). We want her to continue to monitor her blood glucose to decrease the risk of developing diabetes.
4. Caregiver role strain related to newborn baby/new mother as evidenced by family on maternal and paternal side living 1 hour away.	The families of LS and her significant other BG both live at least 1 hour away. They both work to be able to pay for their bills.	1. Identify and help develop coping mechanisms for LS. **Rationale:** Families of LS may not always be available to help her and BG raise their newborn so we want to help them develop healthy coping mechanisms to cope with the stresses (Ricci et al., 2017). 2. Refer the couple to a support group. **Rationale:** Support groups may be able to help new parents develop better strategies and coping mechanisms when taking care of their newborn (Ricci et al., 2017).	**Goal:** LS and BG are able to identify coping strategies that will help them with caregiver role strain. Risk for shaken baby syndrome, neglect, and other parent role strain may cause harm to the newborn. We want to prevent this by informing the new parents about ways they can cope and how they may deal with the stresses of becoming new parents.

Other References (APA)

Carpenito, L. J. (2017). *Handbook of nursing diagnosis*. Philadelphia: Wolters Kluwer.

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

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

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. Elsevier.