

N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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**Demographics (3 points)**

<b>Date &amp; Time of Admission</b> 0022 on 03/01/2021	<b>Patient Initials</b> C.M.J.	<b>Age</b> 25 years old	<b>Gender</b> Female
<b>Race/Ethnicity</b> Caucasian	<b>Occupation</b> Retail at target	<b>Marital Status</b> Single	<b>Allergies</b> NKA
<b>Code Status</b> Full	<b>Height</b> 5'2"	<b>Weight</b> 198 pounds	<b>Father of Baby Involved</b> Yes

**Medical History (5 Points)**

**Prenatal History:** The client is a 25-year-old female who has a gravida of one, a para of one, a term of one, a preterm of zero, an AB of zero, and one living. The client delivered a healthy baby boy for her first pregnancy at forty-one weeks and zero days gestation on 03/01/2021. The client had no complications during her pregnancy and has had no previous pregnancies.

**Past Medical History:** The client has a past medical history of allergic rhinitis, hypoglycemia, depression, anxiety, and a trichomonas infection.

**Past Surgical History:** The client has no past surgical history.

**Family History:** The client's paternal grandmother has diabetes and the maternal grandmother has cancer.

**Social History (tobacco/alcohol/drugs):** The client reports being an occasional former cigar and marijuana smoker. The client reports that she stopped when she found out she was pregnant. The client denies any use of alcohol or other illicit drug use.

**Living Situation:** The client lives at home with her boyfriend.

**Education Level:** The client has completed high school and is attending law school.

**Admission Assessment**

**Chief Complaint (2 points):** Induction of labor

**Presentation to Labor & Delivery (10 points):** On March 1<sup>st</sup>, a 25 y/o Caucasian, single, female came to the hospital with her boyfriend to be seen for an induction of labor. The client was forty-one weeks and zero days gestation. The client had an estimated delivery date of 02/24/2021. The client had an uncomplicated obstetrical history and reported no contractions or vaginal bleeding. The client also had a good range of motion and the fetal movement was noted as normal.

### **Diagnosis**

**Primary Diagnosis on Admission (2 points):** Induction of labor

**Secondary Diagnosis (if applicable):** N/A

### **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:**

Labor is divided into four stages: dilation, expulsive, placental, and restorative (Ricci et al., 2020). The first stage, known as dilation, is divided into two phases, the latent phase and the active phase, because it takes the longest (Ricci et al., 2020). During the first stage, the fetal membranes typically rupture (Ricci et al., 2020). The latent phase begins with the start of true dilations and ends when rapid cervical dilation happens (Ricci et al., 2020). The latent phase can last up to twenty hours in a new mother and up to fourteen hours in a mother who has had previous children (Ricci et al., 2020). During the latent phase, the cervix will slowly dilate to six centimeters (Ricci et al., 2020). Contractions are described as mild during palpation and will usually happen every five to ten minutes and last thirty to forty-five seconds (Ricci et al., 2020). The contraction's intensity is assessed by pressing down on the client's fundus during a contraction to see if it can be dented by the nurse's finger (Ricci et al., 2020). The cervical

effacement will be from zero to forty percent (Ricci et al., 2020). Women also usually remain talkative during this phase and say that the contractions are similar to the feeling of menstrual cramps (Ricci et al., 2020). The active phase will begin when the cervical dilation rate increases and end when the cervix is completely dilated (Ricci et al., 2020). Active labor with increased cervical dilation will increase at a rate of 1.2 to 1.5 centimeters per hour (Ricci et al., 2020). The fetus will move farther into the client's pelvis (Ricci et al., 2020). The contractions will be described as moderate to strong by palpation and now be every two to five minutes and last forty-five to sixty seconds (Ricci et al., 2020). The cervical effacement will be from forty to one-hundred percent (Ricci et al., 2020). The client's discomfort intensifies, becoming more intense and focused (Ricci et al., 2020). The client will limit interactions with everyone in the room (Ricci et al., 2020). The client and her partner may even begin to use relaxation and breathing techniques to cope with the contractions (Ricci et al., 2020). My client was in stage one for ten hours and fourteen minutes. The client had received an epidural. The client remained talkative with minimal complaints of pain.

The second stage of labor will begin when the cervix is completely dilated and ends with the birth of the newborn (Ricci et al., 2020). This stage involves moving the fetus through the birth canal and out of the client's body (Ricci et al., 2020). The contractions will be described as strong by palpation and will occur every two to three minutes lasting sixty to ninety seconds (Ricci et al., 2020). The length of the second stage of labor shows to be affected by parity, delayed pushing, use of epidural analgesia, maternal body mass index, birth weight pelvis shape, occiput posterior position, and fetal station at complete dilation (Ricci et al., 2020). If the second stage of labor has a longer duration it is said to be associated with adverse maternal outcomes (Ricci et al., 2020). These outcomes could include a higher rate of puerperal infection, third- and

fourth-degree perineal lacerations, and postpartum hemorrhaging (Ricci et al., 2020). During the second stage of labor, the client will feel more in control and less irritable and agitated because the client will be focused on pushing (Ricci et al., 2020). The client will usually feel the urge to push during this stage when the fetus is in direct contact with the pelvic floor (Ricci et al., 2020). During the second stage, active pushing is described as when the client feels rectal pressure by the fetal presenting part and physiologically feels the urge to push (Ricci et al., 2020). The perineum will begin to bulge, and there is an increase in the amount of blood (Ricci et al., 2020). The fetal head will begin to show as the vaginal opening during contractions and disappear between the contractions (Ricci et al., 2020). When the fetal head no longer disappears between contractions, it is known as crowning (Ricci et al., 2020). The fetal will rotate as it is maneuvering its way out of the vaginal opening (Ricci et al., 2020). The second stage can last up to three hours in a first-time mom and up to two hours in a mom who has had previous children (Ricci et al., 2020). The second stage of labor can also be done by spontaneous pushing or directed pushing (Ricci et al., 2020). Spontaneous pushing is a natural urge to push that comes and goes throughout a contraction (Ricci et al., 2020). Directed pushing is when the nurse instructs the client to hold their breath to the count of ten, inhale again, push again, and repeat up to three times during a contraction (Ricci et al., 2020). My client was complete and entered stage two at 1015. The client was in the second stage of labor for three hours and fifty minutes. The client described her contractions during this stage as moderate and feeling mostly pressure. The client did have an epidural and noted that her right side of the body was numb, and the left side was not quite numb. During the client's second stage, we practiced slowed breathing techniques with her in between contractions. The client had an increased bloody show, and you could see the perineum bulging. Once the client was crowned, it did not take long for her to push the

newborn out. The client did have labial and vaginal lacerations. The client started pushing at 1304 and used the direct pushing method by holding her breath until the count of ten, inhaling again, pushing again, and repeating two more times during each contraction. The nurse helped the client use different pushing techniques such as having the client grab her legs and pull them into her chest with her elbows up and outward, and by pulling a tied towel while the nurse pulled away from her. The client delivered a healthy seven-pound baby boy at 1405, and the dad cut the baby's umbilical cord one minute later.

The third stage of labor will begin once the newborn is born and end with placenta's separation and birth (Ricci et al., 2020). Once the newborn is born, they should be immediately placed on the client's abdomen for skin-to-skin contact, promoting the newborns transition from intrauterine to extrauterine life (Ricci et al., 2020). The third stage of labor consists of placental separation and placental expulsion (Ricci et al., 2020). The third stage of labor's biggest risk is severe bleeding which can kill women within hours if it is not taken care of immediately (Ricci et al., 2020). Postpartum hemorrhage can be prevented by active management such as a uterotonic agent after birth, the placenta's expulsion with controlled traction of the cord, and uterine fundal massage after placental expulsion Ricci et al., 2020). The placental separation will begin to happen after the birth of the newborn, and the uterus will continue to contract strongly but can now retract, causing the placenta to pull away from the uterine wall (Ricci et al., 2020). When the uterus rises upward, the umbilical cord lengthens, a sudden trickle of blood is released from the vaginal opening, and the uterus changes its shape to globular are all signs of separating, indicating that the placenta is ready to be delivered (Ricci et al., 2020). The contractions will still be present after the separation of the placenta from the uterine wall (Ricci et al., 2020). The contractions will cause the placenta to be delivered between two and thirty minutes (Ricci et al.,

2020). After the placenta is delivered, the uterus needs to be massaged until it is firm so that the blood vessels in the uterus constrict (Ricci et al., 2020). The constriction will help minimize the risk of the client hemorrhaging (Ricci et al., 2020). The normal amount of blood loss in the third stage is five-hundred millimeters for a vaginal delivery and up to one-thousand millimeters for a cesarean birth (Ricci et al., 2020). Anything over one-thousand millimeters is considered to be severe bleeding (Ricci et al., 2020). My client was in the third stage for seven minutes with two hundred and fifty-five millimeters of blood loss. The placenta was delivered at 1412. The nurse massaged the fundus after the delivery of the placenta until the uterine became firm. After the delivery of the placenta, the client also had to be stitched up due to her labial and vaginal tearing. The client stated that the third stage was more painful and uncomfortable than her child's actual labor. The newborn was put directly on the client's abdomen after birth for the skin-to-skin contact and then was taken briefly for his assessment.

The fourth stage of labor begins with the placental delivery and ends with the mother's physiological and stabilization (Ricci et al., 2020). The fourth stage can last one to four hours (Ricci et al., 2020). The client will usually feel a sense of peace and excitement (Ricci et al., 2020). The client will be wide awake and talkative (Ricci et al., 2020). The attachment process will begin with the mother inspecting and desiring to cuddle and breastfeed the newborn (Ricci et al., 2020). The client's fundus should be well contracted and firm at this point (Ricci et al., 2020). The fundus is located at the midline between the umbilicus and the symphysis, slowly rising to the umbilicus level within the first hour after birth (Ricci et al., 2020). The lochia is the red vaginal discharge after birth mixed with small clots and moderate flow (Ricci et al., 2020). The fourth stage's focus is monitoring of the mother to help prevent any complications such as hemorrhaging, bladder distention, or venous thrombosis (Ricci et al., 2020). The mother is

usually starving and thirsty during the fourth stage, resulting in her requesting food and drinks (Ricci et al., 2020). The client's bladder is also hypotonic, causing the client to not know when she has a full bladder (Ricci et al., 2020). Lastly, during the fourth stage, the client's vital signs, the amount and consistency of the lochia, and the uterine fundus will need to be monitored every fifteen minutes for the first hour (Ricci et al., 2020). My client was excited and relieved. My client inspected her baby and was so happy to point out everything he had that looked similar to his dad's such as his nose, chin, and hair. The nurse helped the baby stay skin-to-skin with the mother and helped initiate breastfeeding. The newborn took a couple of minutes to figure it out but latched on perfectly afterward. The client also noted how she was starving and could not wait to order food. Shortly after the breastfeeding the client was sent to the postpartum floor, to complete the fourth stage of labor.

#### **Stage of Labor References (2) (APA):**

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and Pediatric Nursing* (4th ed.). LWW.

Mayo Clinic. (2020, February 6). *Stages of Labor and Birth: Baby, it's time!*

<https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/stages-of-labor/art-20046545>

#### **Laboratory Data (15 points)**

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

<b>Lab</b>	<b>Normal Range</b>	<b>Prenatal Value</b>	<b>Admission Value</b>	<b>Today's Value</b>	<b>Reason for Abnormal Value</b>
<b>RBC</b>	3.50 – 5.20	4.07	3.81	N/A	N/A
<b>Hgb</b>	11.0 –	12.2	11.5	N/A	N/A

	16.0				
<b>Hct</b>	34.0 – 47.0	37.9	34.4	N/A	N/A
<b>Platelets</b>	140,000 – 400,000	229,000	267,000	N/A	N/A
<b>WBC</b>	4.00 – 11.00	10.65	14.66	N/A	The patient’s white blood cell count was elevated due to the amount of stress on the patient’s body during pregnancy (Ricci et al., 2020)
<b>Neutrophils</b>	1.70 – 7.00	6.2	11.99	N/A	These values indicate an infection and could also be due to the increased level of white blood cells in the patient’s body (Capriotti & Frizzell, 2016).
<b>Lymphocytes</b>	0.90 – 2.90	2.4	12.0	N/A	These values are consistent with the patient’s increased white blood cell count (Capriotti & Frizzell, 2016).
<b>Monocytes</b>	0.30 – 0.90	0.74	4.5	N/A	The patient’s monocytes are likely elevated because of the inflammatory response due to the pregnancy (Capriotti & Frizzell, 2016).
<b>Eosinophils</b>	0.05 – 0.50	0.3	0.2	N/A	N/A
<b>Bands</b>	0.00 – 0.30	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	Value on Admission	Today’s Value	Reason for Abnormal
<b>Blood Type</b>	AB+, AB-, A+, A-, B+, B-, O+, O-	O+	O+	O+	N/A

<b>Rh Factor</b>	Rh+, Rh-	Rh+	N/A	N/A	N/A
<b>Serology (RPR/VDRL)</b>	Negative	Nonreactive	N/A	N/A	N/A
<b>Rubella Titer</b>	7 IU/mL or less no significant level detectable, 8-9 IU/mL equivocal, 10 IU/mL or greater positive	5.6	N/A	N/A	N/A
<b>HIV</b>	Negative	Nonreactive	N/A	N/A	N/A
<b>HbSAG</b>	Negative	Nonreactive	N/A	N/A	N/A
<b>Group Beta Strep Swab</b>	Negative	Nonreactive	N/A	N/A	N/A
<b>Glucose at 28 Weeks</b>	< 140	83	N/A	N/A	N/A
<b>MSAFP (If Applicable)</b>	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
<b>COVID-19</b>	Negative	Not detected	N/A	N/A	N/A
<b>Uric acid</b>	2.6 – 6.0	N/A	4.9	N/A	N/A
<b>LD (LDH)</b>	84 – 246	N/A	227	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
<b>Urine</b>	Ratio	N/A	0.4	N/A	This test is used to

<b>protein/creatinine ratio (if applicable)</b>	reference range not established per random urine specimen			access for excess protein in the urine, to help evaluate and monitor kidney function, and to detect kidney function. This client’s findings were normal and as expected. It did not show any abnormal findings.
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**Lab Reference (1) (APA):**

The normal ranges for the above tests were per Carle’s epic system.

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and Pediatric Nursing* (4th ed.). LWW.

Capriotti, T., & Frizzell, J. P. (2016). *Human Pathophysiology*. F.A. Davis Company.

**Electronic Fetal Heart Monitoring (16 points)**

<b>Component of EFHM Tracing</b>	<b>Your Assessment</b>
<b>What is the Baseline (BPM) EFH?</b>	The normal fetal heart rate is between 110 and 160 beats per minute. The baseline for this client was 155.
<b>Are there accelerations?</b> <ul style="list-style-type: none"> <li>• <b>If so, describe them and explain what these mean (for example: how high do they go and how long do they last?)</b></li> </ul> <b>What is the variability?</b>	Accelerations are short-term rises in the fetal heart rate that are 15 beats by 15 seconds. Accelerations are perfectly normal and healthy. This client did experience accelerations. The accelerations were 15 beats by 15 seconds.  The client’s variability was noted as moderate.
<b>Are there decelerations? If so, describe them and explain the following: What do these mean?</b> <ul style="list-style-type: none"> <li>o <b>Did the nurse perform any interventions with these?</b></li> </ul>	Decelerations are temporary drops in the fetal heart rate. There are three different types of decelerations known as early decelerations, late decelerations, and variable decelerations. The client had a couple of variable decelerations which is not good and is caused by umbilical cord compression. Variable decelerations are when the fetal heart rate decrease is greater than or equal to 15 beats per minute and last for longer than or equal to 15 seconds, but less than two minutes from the onset to the return of the baseline. The nurse

<p><b>o Did these interventions benefit the patient or fetus?</b></p>	<p>helped the client move around and change positions to try and help relieve the cord compression. The movements helped and the fetal heart rate when back to normal.</p>
<p><b>Describe the contractions:</b>  <b>Frequency:</b>  <b>Length:</b>  <b>Strength:</b>  <b>Patient's Response:</b></p>	<p>The client's frequency was between 2 and 2 ½ minutes                  The client's length was between 60 and 70 seconds.                  The client's strength was between 80 and 85 mmHg.                  The client started pushing at 1304 and delivered at 1405. The client did really well with pushing during her contractions. The client started out really strong but began to get tired towards the end. The client was encouraged by the staff and her boyfriend to keep pushing and that she was doing great. The client had an epidural and did not report much pain.</p>

**EFM reference (1) (APA format):**

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and Pediatric Nursing* (4th ed.). LWW.

**Current Medications (7 points, 1 point per completed med)**

**\*7 different medications must be completed\***

**Home Medications (2 required)**

<b>Brand/Generic</b>	Diphenhydramine hydrochloride (Benadryl)	Prenatal gummy
<b>Dose</b>	50mg capsule	Two gummies
<b>Frequency</b>	PRN	q.d.
<b>Route</b>	Oral	Oral
<b>Classification</b>	Antianaphylactic adjunct, antidyskinetic, antiemetic, antihistamine	Multivitamin, mineral, and fatty acid product
<b>Mechanism of Action</b>	Binds to central and peripheral H1 receptors, competing with histamine for these sites and preventing it from reaching its side of action. By blocking histamine, diphenhydramine produces antihistamine effects, inhibiting GI, respiratory, and vascular smooth	Vitamins, minerals, and fatty acids are important building blocks of the body and help keep you in good health. This is used to treat or prevent vitamin deficiency, before, during, and after pregnancy.

	<p>muscle contraction; decreasing capillary permeability, which reduces flares, itching, and wheals; and decreasing lacrimal and salivary gland secretions. Diphenhydramine produces antidyskinetic effects, possibly by inhibiting acetylcholine in the central nervous system. It also produces antitussive effects by directly suppressing the cough center in the medulla oblongata in the brain.</p> <p>Diphenhydramine's antiemetic and antivertigo effects may be related to its ability to bind the central nervous system muscarinic receptors and depress vestibular stimulation and labyrinthine function. Its sedative effects are related to its central nervous system depressant action.</p>	
<b>Reason Client Taking</b>	This medication is being given to help the client sleep and treat hypersensitivity reactions to her seasonal allergic rhinitis as needed.	This medication is being taken to prevent vitamin deficiency before, during, and after pregnancy.
<b>Contraindications (2)</b>	Breastfeeding; hypersensitivity to diphenhydramine	High amounts of calcium in the urine or blood; decreased kidney function
<b>Side Effects/Adverse Reactions (2)</b>	Arrhythmias; thrombocytopenia	Constipation; severe dizziness
<b>Nursing Considerations (2)</b>	<p>Expect to give parenteral form of diphenhydramine only when oral ingestion is not possible.</p> <p>Expect to discontinue drug at least 72 hours before skin tests for allergic because drug may inhibit cutaneous histamine response, thus producing false negative results.</p>	Monitor the health status of the mother and fetus, provide emotional support, and teaches the pregnant woman and her family about physiological and psychological changes during pregnancy, fetal development, labor and childbirth, and care for the newborn.
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	<p>Assess for any history of allergies to antihistamines.</p> <p>Perform a physical examination to establish a baseline data for assessing</p>	<p>Asses the client's allergic reactions prior to administration.</p> <p>Assess the client's lab values to ensure that the client's vitamin and mineral labs</p>

	<p>the effectiveness of the drug. Administer the drug on an empty stomach to increase absorption so double check with the client to see when they ate last. Assess the client’s vital signs prior to administration.</p>	<p>are not extremely high Perform a physical assessment</p>
<b>Client Teaching needs (2)</b>	<p>Instruct the client to take diphenhydramine at least 30 minutes before exposure to situations that may cause motion sickness. Advise the client to avoid taking OTC drugs that contain diphenhydramine to prevent additive effects.</p>	<p>This medication is best taken on an empty stomach 1 hour before or 2 hours after meals. Do not lie down for at least ten minutes after taking this medication.</p>

**Hospital Medications (5 required)**

<b>Brand/Generic</b>	Ibuprofen	Acetaminophen (Tylenol)	Famotidine (Pepcid)	Ephedrine sulfate	Ropivacaine (Naropin)
<b>Dose</b>	600mg	650mg	20mg	50mg/mL	5mg/mL
<b>Frequency</b>	One time dose	q.4.h. PRN	One time dose	One time dose	One time dose
<b>Route</b>	Oral	Oral	Intravenous	Intravenously	Epidurally
<b>Classification</b>	Analgesic, anti-inflammatory, antipyretic	Nonsalicylate, para-aminophenol derivative, antipyretic, nonopioid analgesic	Antiulcer agent	Alpha/beta adrenergic agonists	Sodium channel blocker; local anesthetics
<b>Mechanism of Action</b>	It blocks the activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral	In normal digestion, parietal cells in the gastric epithelium secrete hydrogen (H+) ions, which combine with chloride ions	Direct and indirect sympathomimetic amine. Ephedrine activates adrenergic A and B receptors as well as	The drug substance is a white crystalline powder. It causes reversible inhibition of sodium ion influx, and

	<p>cause local pain, swelling, and vasodilation. By inhibiting prostaglandins, this NSAID reduces inflammatory symptoms and relieves pain. Ibuprofen’s antipyretic action probably stems from its effects on the hypothalamus, which increases peripheral blood flow, causing vasodilation and encouraging This medication is being given to relieve mild to moderate pain as an adjunct to opioid analgesics. heat dissipation.</p>	<p>nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2.</p>	<p>(Cl-) to form hydrochloric acid (HCl), as shown before left. However, HCl can inflame, ulcerate, and perforate gastric and intestinal mucosa normally protected by mucus. Famotidine, an H2 – receptor antagonists, reduces HCl formation by preventing histamine from binding with H2 receptors on the surface of parietal cells. By doing so, the drug helps prevent peptic ulcers from forming and helps heal existing ones.</p>	<p>inhibiting norepinephrine reuptake, and increasing the release of norepinephrine from vesicles in the nerve cells.</p>	<p>thereby blocks impulse conduction in nerve fibers. This action is potentiated by dose-dependent inhibition of potassium channels.</p>
<p><b>Reason Client Taking</b></p>	<p>This medication is being given to relieve mild to moderate pain as an adjunct to opioid analgesics.</p>	<p>The client is taking this medication to relieve mild to moderate pain during pregnancy.</p>	<p>This medication is being taken to treat GERD.</p>	<p>This medication was given with ropivacaine to help prevent maternal hypotension and restore</p>	<p>This medication was given as a local anesthetic for pain management during labor and delivery.</p>

				uterine perfusion pressure to avoid intrapartum fetal asphyxia while the client was under local anesthesia.	
<b>Contraindications (2)</b>	Hypersensitivity to ibuprofen, its components, or other fever reducers or pain relievers; asthma	Severe hepatic impairment, severe active liver disease	Hypersensitivity to famotidine, other H2 receptors antagonists, or their components	Hypertension; abnormal heart rhythm	Platelet abnormalities; infection or inflammation at the injection site.
<b>Side Effects/Adverse Reactions (2)</b>	Hemorrhage, bleeding	Hypotension, hepatotoxicity	Leukopenia, aplastic anemia	Palpitations, tachycardia	Excessive plasma levels, numbness or tingling feeling
<b>Nursing Considerations (2)</b>	<ol style="list-style-type: none"> <li>1. Use ibuprofen with extreme caution because it increases the risk of having GI bleeding and ulcerations.</li> <li>2. Assess the patient's skin regularly for signs of rash or other hypersensitivity reaction.</li> </ol>	<ol style="list-style-type: none"> <li>1. Use acetaminophen cautiously in clients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment.</li> <li>2. Acetaminophen can cause hepatotoxicity,</li> </ol>	<ol style="list-style-type: none"> <li>1. Give the IV injection over 2 minutes or dilute in 100 mL of D5W and infuse over 15 to 30 minutes.</li> <li>2. Shake the oral suspension for 5 to 10 seconds before administration.</li> </ol>	<ol style="list-style-type: none"> <li>1. Monitor the client's cardiovascular and respiratory status frequently after administration.</li> <li>2. Check blood pressure steadily during the first 5 minutes and then every three to five minutes until stabilized after administration.</li> </ol>	<ol style="list-style-type: none"> <li>1. Monitor the client's cardiovascular and respiratory status throughout the treatment period.</li> <li>2. Frequently assess the client's vital signs and pain level after administration.</li> </ol>

		so liver function tests need to be ordered and monitored.			
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	Obtain the patient’s drug history to determine possible drug interactions and allergies. Assess the patient’s vital signs and pain level prior to administering. Assess the patient’s cardio, respiratory, and GI status prior to administering. Try to have the patient eat something prior to administration to avoid GI upset.	Assessing the patient’s vital signs and pain level prior to administering the acetaminophen. Prior to administering acetaminophen, you should check the patient’s liver function test results, prothrombin time, INR, and BUN. Obtain the patient’s drug history to determine possible drug interactions and allergies.	Assess the client’s vital signs prior to administration. Perform a physical assessment. Identify if the client has any allergic reactions to this medication. Make sure the client has not taken any other acid-reducing products recently.	Establish the client’s baseline vital signs before administration. Perform a physical assessment prior to administration. Monitor I & O ratio pattern before, during, and after. Encourage the client to void before medication administration.	Perform physical assessment prior to administration. Assess the client’s CBC count prior to administration. Assess the client’s baseline vital signs including a pain assessment prior to administration. Make sure the client has an IV line inserted.
<b>Client Teaching needs (2)</b>	Urge patient to avoid alcohol, aspirin, and other corticosteroids while taking ibuprofen, unless prescribed.  Advise patients to report flu-like symptoms, rash,	Caution patient to not exceed the recommended dosage or take other drugs containing acetaminophen at the same time because of the risk of liver damage.	Caution patient to avoid alcohol and smoking during famotidine therapy because they irritate the stomach and can delay ulcer healing.	Do not breastfeed while taking this medication and do not take any OTC drugs without the approval of the physician.  Instruct the	Inform the client to let the nurse know if she develops numbness over a large portion of her body or any other reactions especially regarding the

	signs of GI bleeding, swelling, vision changes, and weight gain.	Teach the patient to recognize signs of hepatotoxicity, such as bleeding, easy bruising, and malaise, which commonly occurs with chronic overdose.	Advise the client to notify the nurse if she develops pain, has trouble swallowing, or if she has blood vomit or black stools.	client to notify the nurse of any adverse effects immediately and to not get out of bed without the nurse’s help.	cardiovascular and respiratory system.  Instruct the client to not get out of bed without help from someone else after administration.
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**Medications Reference (1) (APA):**

Jones & Bartlett Learning. (2019). *2019 Nurse’s drug handbook*.

RxList. (2018, December 17). *Naropin (Ropivacaine Hcl): Uses, Dosage, Side Effects, Interactions, Warning*. <https://www.rxlist.com/naropin-drug.htm#description>

RxList. (2020, August 10). *Side Effects of Ephedrine (Ephedrine), Warnings, Uses*. <https://www.rxlist.com/ephedrine-side-effects-drug-center.htm#overview>

RxList. (2021, February 25). *Prenatal Gummy oral: Uses, Side Effects, Interactions & Pill Images*. <https://www.rxlist.com/fdb/drugs/164355/prenatal-gummy-oral-drug.htm>

**Assessment**

**Physical Exam (18 points)**

<p><b>GENERAL (0.5 point):</b>  <b>Alertness:</b>  <b>Orientation:</b>  <b>Distress:</b>  <b>Overall appearance:</b></p>	<p>Patient appears pleasant.  A&amp;O x3  Oriented to person, time, place, and current events. Very talkative and cooperative.  Patient appears to have moderate distress which is normal under the client’s circumstances.  Patient appears overall well groomed.</p>
<p><b>INTEGUMENTARY (2 points):</b>  <b>Skin color:</b>  <b>Character:</b>  <b>Temperature:</b>  <b>Turgor:</b></p>	<p>Tan/pink normal for race  Patient appears sweaty and exhausted which is normal for the client’s circumstances.  Warm  Normal turgor 2+</p>

<p><b>Rashes:</b>  <b>Bruises:</b>  <b>Wounds/Incision:</b> .  <b>Braden Score:</b>  <b>Drains present:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b></p>	<p>No rashes noted.                  No bruises noted.                  No wounds or incisions noted on the client's integumentary system.                  Braden score: 20</p>
<p><b>HEENT (0.5 point):</b>  <b>Head/Neck:</b>   <b>Ears:</b>   <b>Eyes:</b>   <b>Nose:</b>   <b>Teeth:</b></p>	<p>Head and neck symmetrical, no bumps or lesions noted. Trachea is midline. Lymph nodes are nonpalpable.                  Ears are free of discharge, no bumps or lesions noted, healthy cerumen, and tympanic membrane is a pearly grey.                  Eyes normal. Upon inspection sclera was white, cornea was clear, conjunctiva was white with no lesions or discharge noted. Normal EOM.                  Septum midline. No drainage or bleeding noted. No deviation or abnormalities and sinuses are not tender.                  Patient has natural teeth on top and bottom. Good dentition overall. No lesions or bumps noted. Mouth is pink and moist.</p>
<p><b>CARDIOVASCULAR (1 point):</b>  <b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>  <b>Capillary refill:</b>  <b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Edema</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Location of Edema:</b></p>	<p>S1 and S2 heart sounds normal, no murmurs or rubs present.                  Pulse is 86 bpm radial.                  Capillary refill is less than 3 seconds.</p>
<p><b>RESPIRATORY (1 points):</b>  <b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Breath Sounds: Location, character</b></p>	<p>Client has normal lung sounds with no rales/crackles, rhonchi, or wheezes present.                  Respirations are nonlabored.</p>
<p><b>GASTROINTESTINAL (5 points):</b>  <b>Diet at Home:</b>  <b>Current Diet:</b>  <b>Height:</b>  <b>Weight:</b>  <b>Auscultation Bowel sounds:</b>  <b>Last BM:</b></p>	<p>Normal eating at home                  Regular diet                  5'2"                  198 lbs.                  Bowel sounds are audible.                  Normoactive in all four quadrants                  03/01/2021</p>

<p><b>Palpation: Pain, Mass etc.:</b>  <b>Inspection:</b>  <b>Distention:</b>  <b>Incisions:</b>  <b>Scars:</b>  <b>Drains:</b>  <b>Wounds:</b></p>	<p>No pain or masses noted on palpation.                  No abnormalities such as distention, incisions, scars, drains, or wounded noted during inspection.</p>
<p><b>GENITOURINARY (5 Points):</b>  <b>Bleeding:</b>   <b>Color:</b>   <b>Character:</b>   <b>Quantity of urine:</b>  <b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Inspection of genitals:</b>  <b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b>  <b>Size:</b>  <b>Rupture of Membranes:</b>  <b>Time:</b>  <b>Color:</b>  <b>Amount:</b>  <b>Odor:</b>  <b>Episiotomy/Lacerations:</b></p>	<p>255mL of blood lost                  Bright red                  The client's bleeding was bright red and was perfectly normal for labor and delivery.                  450 mL of urine                  Genitals were normal looking. There were no lesions, unusual pigmentation, or other skin changes. The patient had no inflammation, edema, or other lesions of the periurethral tissue. There was also no bleeding or abnormal discharge noted.                   0612                  Clear/slight yellowish due to the presence of some meconium                  250mL                  No odor present.                  The client had labial and vaginal lacerations.</p>
<p><b>MUSCULOSKELETAL (2 points):</b>  <b>ADL Assistance:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Fall Risk:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Fall Score:</b>  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib)</b> <input checked="" type="checkbox"/>  <b>Needs assistance with equipment</b> <input type="checkbox"/>  <b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p>The client has no neurovascular deficits noted.                  The client's ROM is good and equal bilaterally.                  The client had no fall risk, so the client had a fall score of zero.</p>
<p><b>NEUROLOGICAL (1 points):</b>  <b>MAEW:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -  <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b></p>	<p>Moves both arms and legs well bilaterally.                  Pupils equal, round, and reactive to light.                   Alert and oriented x3 to person, time, place, and current events.                  Mental status is good.</p>

<p><b>Mental Status:</b>  <b>Speech:</b>  <b>Sensory:</b>  <b>LOC:</b>  <b>Deep Tendon Reflexes:</b></p>	<p>Speech was clear and precise.                  No glasses or contacts present. Vision seems normal.                  DVT 2+ (average/normal)</p>
<p><b>PSYCHOSOCIAL/CULTURAL (1 points):</b>  <b>Coping method(s):</b>  <b>Developmental level:</b>  <b>Religion &amp; what it means to pt.:</b>  <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b></p>	<p>The client worked throughout her pregnancy. The client mentioned she loved taking warm baths and just relaxing on the couch watching tv while eating all of her pregnancy cravings with her boyfriend.                  The client did not specify a specific religion. The client during labor stated, “Our parents are both amazing and very supportive. This will be our first child and their first grandchild. Everyone is so excited to meet him.” The boyfriend was with the client the entire time and was being very helpful and supportive of her. They were both so excited and talked about how their families were just as supportive and excited. Overall, they seem to have a good home environment with an amazing support system.</p>
<p><b>DELIVERY INFO: (1 point)</b>  <b>Delivery Date:</b>  <b>Time:</b>  <b>Type (vaginal/cesarean):</b>  <b>Quantitative Blood Loss:</b>  <b>Male or Female</b>  <b>Apgars:</b>  <b>Weight:</b>  <b>Feeding Method:</b></p>	<p>The client’s estimated delivery date was 02/24/2021.                  The client delivered on 03/01/2021 at 1405.                  255mL blood loss                  Vaginal delivery                  Male                  1 minute 7; 5 minutes 9                  7 pounds 9 ounces and 21 inches long                  Breastfeeding</p>

**Vital Signs, 3 sets (5 points)**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	94 bpm radial	145/89 right arm	16 bpm	98.2 degrees Fahrenheit	97% room air
Admission to Labor/Delivery	94 bpm radial	122/75 left arm	18 bpm	98.9 degrees Fahrenheit	98% room air
During your care	86 bpm radial	122/83 left arm	18 bpm	99 degrees Fahrenheit	97% room air

**Vital Sign Trends:** The client’s systolic blood pressure was slightly increased during her prenatal visit, but all of the other vital signs are consistent and do not require any additional monitoring.

**Pain Assessment, 2 sets (2 points)**

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
1446	Numeric 0 – 10	Perineal pain	The client rates her pain a 6 on a scale of one to ten.	The client reports her pain as constant and aching.	The client was given pain medications.
1627	Numeric 0 – 10	Perineal pain	The client rated her pain a 4 on a scale of one to ten.	The client reported that her perineal area was sore and achy. The client did have labial and vaginal lacerations that resulted in stitches after birth.	The client was given pain medications.

**IV Assessment (2 Points)**

<b>IV Assessment</b>	<b>Fluid Type/Rate or Saline Lock</b>
<b>Size of IV:</b> <b>Location of IV:</b> <b>Date on IV:</b> <b>Patency of IV:</b> <b>Signs of erythema, drainage, etc.:</b> <b>IV dressing assessment:</b>	18 gauge Anterior right lower forearm 03/01/2021 Patent No signs of erythema or drainage. IV dressing site was intact and looked clean and dry with no redness or swelling present. The client had a one-time dose of lactated ringers at 1000mL/hr.

**Intake and Output (2 points)**

<b>Intake (in mL)</b>	<b>Output (in mL)</b>
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<p>The client did not have anything to eat while I was there.                  The client drank 480mL of water while I was there.                  The client had 1,000mL of lactated ringers through her IV.</p>	<p>The client had a urine output of 450 mL while I was there.</p>
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**Nursing Interventions and Medical Treatments during Labor & Delivery (6 points)**

<b>Nursing Interventions and Medical Treatments (Identify nursing interventions with “N” after you list them, identify medical treatments with “T” after you list them.)</b>	<b>Frequency</b>	<b>Why was this intervention/ treatment provided to this patient? Please give a short rationale.</b>
Administering pain medications (T)	q.4.h. PRN	The client had a vaginal delivery. If the client reports pain acetaminophen or ibuprofen will be administered.
Monitoring maternal vital signs and fetal heart rate (N)	Every 30 minutes to one hour; constantly once pushing starts	This intervention was provided to monitor the mother for any sudden drop or increase in vital signs and to continue to make sure that the client stayed stable. The fetal heart rate is monitored to make sure the baby is doing well and no problems are present.
Promote good breathing techniques (N)	As frequently as possible	This intervention was provided because during labor you want the client to focus on her breathing. Promoting a good breathing technique can help the client relax and decrease her perception of pain.

**Nursing Diagnosis (30 points)**

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

**Two of the Nursing diagnoses must be education related i.e. the interventions must be education for the client.”**

**2 points for the correct priority**

<b>Nursing Diagnosis (2 pt each)</b>	<b>Rationale (1 pt each)</b>	<b>Intervention/Rationale (2 per dx) (1 pt each)</b>	<b>Evaluation (1 pt each)</b>
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<p>Identify problems that are specific to this patient. Include full nursing diagnosis with “related to” and “as evidenced by” components</p>	<p>Explain why the nursing diagnosis was chosen</p>	<p>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.</p>	<p>• How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.</p>
<p>1. Acute pain related to vaginal delivery as evidenced by verbalizations.</p>	<p>The client had a vaginal delivery. The client verbalized that she was having constant perineal pain with some aching. The client rated her pain a six at 1446 and a four at 1627.</p>	<p>1. Assess the degree of discomfort through verbal and nonverbal cues; note cultural practices on pain response.</p> <p><b>Rationale:</b> Attitudes and reactions to pain are individual and based on past experiences, understanding of physiological changes, and cultural expectations. The client’s level of pain will also determine whether or not to administer pain medication.</p> <p>2. Educate the client on proper relaxation techniques; breathing techniques; and position for comfort as possible.</p> <p><b>Rationale</b> Might help in decreasing anxiety and tension, promote comfort, and enhance sense of well-being. You can also promote a good breathing</p>	<p>The client was cooperative and willing to learn. The client verbally complained of perineal pain while I was there. The client rated her pain a six at 1446 and a four at 1627. The client stated “the pain is constant and achy feeling.” The client’s boyfriend was also there with her. The boyfriend was very cooperative, supportive, and ready to learn with the client. There were not modifications that needed to be made with her plan because the goals were met.</p>

		technique to help the client relax and decrease her perception of pain.	
2. Risk for infection related to traumatized tissues as evidenced by perineal lacerations.	This client had labial and vaginal lacerations during childbirth putting the client at risk for infection due to the breakage of skin in the perineal area.	<ol style="list-style-type: none"> <li>1. Perform perineal care per protocol, using an aseptic technique. Remove any fecal contaminants and change linens as needed.</li> </ol> <p><b>Rationale</b> This will help promote cleanliness and prevent the development of an ascending uterine infection and possibly sepsis.</p> <ol style="list-style-type: none"> <li>2. Educate the client on how to care for her perineal area after birth</li> </ol> <p><b>Rationale</b> The client had labial and vaginal tearing during birth resulting in perineal stitches. The client will need to know how to care for her perineal area to prevent infections and keep the stitches clean and intact.</p>	The client and her boyfriend were cooperative and willing to learn. They were educated on what signs and symptoms to look for in an infection. The client was also taught how to properly wash her perineal area with the incisions. The client voiced that she understood and said that she would ask if she had any other questions. The perineal care and removal of any fecal contaminants or dirty linens were changes as needed throughout the birthing process. No modifications need to be made with the client's plan because the goals were met.
3. Inadequate information related to breastfeeding as evidenced by verbalization of concerns.	This is the client's first baby. The client has never breastfed before. Therefore, the client lacks knowledge related to	<ol style="list-style-type: none"> <li>1. Assist the patient by helping the infant grasp the nipple correctly and advise the mother to expose the nipple to air between feedings.</li> </ol> <p><b>Rationale</b> The mother has never breastfed before, so it is</p>	The client and her boyfriend were very cooperative. They were willing to learn and the client was very excited to try breastfeeding along with getting that emotional connection with the baby. The newborn took a couple

	breastfeeding.	<p>important to educate and assist the client until she gets comfortable doing it on her own.</p> <p>2. Advise the mother to expose the nipple to air between feedings and to apply aloe vera or vitamin E to help heal the tissue.</p> <p><b>Rationale</b> The patient needs to be educated on this because if the client keeps her nipples wet after breastfeeding it will cause soreness and the infant will not be able grip the entire areola properly.</p>	<p>of minutes trying to get the hang of catching on, but they both did really well for the first time. No modifications need to be made with the client’s plan because the goals were being met.</p>
<p>4. Deficient knowledge related to childbirth as evidenced by first time parents.</p>	<p>This was the client’s first baby. This was also the father’s first baby. Therefore, it is important to educate the client and the father about the childbirth process and basic needs of caring for a child to help better prepare them.</p>	<p>1. Assess the client’s baseline knowledge and expectations during pregnancy. Provide the client with the information about the procedures and normal progression of labor.</p> <p><b>Rationale</b> This will help guide in establishing learning needs and set priorities. Prenatal education can also facilitate labor and delivery process, assist the client in maintaining control during labor, help promote a positive attitude, and may decrease reliance on medication.</p> <p>2. Educate the client on</p>	<p>The client and her boyfriend were excited to learn. They were very cooperative and listened to everything that was being said. The nurse went over the expectations and procedures, so they knew what to expect. The nurse also went over the basic needs to help make them feel more prepared and less anxious. The client and boyfriend asked any questions they had and the nurse answered them to the best of her ability. No modifications need to be made with the client’s plan because the</p>

		<p>the basic needs of caring for a child such as feeding, bathing, a consistent schedule, and safety.</p> <p><b>Rationale</b> The client is a first-time mom with minimal knowledge relating to caring for a child. This education will help the client to feel more prepared and less overwhelmed at the thought of being a new mom.</p>	<p>goals were being met.</p>
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**Other References (APA)**

Martin, P. B. (2019, May 31). *36 Labor Stages, Induced and Augmented Labor Nursing Care Plans*. Nurseslabs. <https://nurseslabs.com/labor-stages-labor-induced-nursing-care-plan/#a6>