N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 3/8/21 0733	Patient Initials EB	Age 32 y/o	Gender Female
Race/Ethnicity Caucasian	Occupation Bartender	Marital Status Single	Allergies NKA
Code Status Full Code	Height 5'6" (167.6 cm)	Weight 201 lbs. (91.2 kg)	Father of Baby Involved Father present at hospital

Medical History (5 Points)

Prenatal History: The client's first prenatal visit occurred on 8/19/20.

G-5, T-2, P-0, A-2, L-2.

The first child's birth was successful at 40 weeks, the second fetus was lost through spontaneous abortion and was removed through dilation and curettage, the third fetus experienced a therapeutic abortion, and the 4th child was carried to 38 weeks and delivered successfully.

Past Medical History: The client suffers from asthma, anemia, depression, and ovarian cysts.

Past Surgical History: The client has undergone a ovarian cystectomy (2013), and a dilation and curettage (2013).

Family History: The client's mother suffered from hepatitis C, and the client's father has no known history.

Social History (tobacco/alcohol/drugs): The client states that she smoked one cigarette a day, rarely drinks alcohol outside of the pregnancy, and never uses drugs.

Living Situation: The client currently lives at home with her children. The father of the current child does not reside in the same house.

Education Level: The client has completed some college but does not currently have a degree.

Admission Assessment

Chief Complaint (2 points): No complaint upon admission, the client is not suffering from contractions, rupture of membrane, or vaginal bleeding.

Presentation to Labor & Delivery (10 points): The client is scheduled to be induced to promote labor. The client does not suffer from contractions, vaginal bleeding, rupture of membranes, or pain.

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:

At the time of admission, the client is not dilated and is being admitted for induction of labor. At 1400, the client was 2 cm dilated and 60% effaced. At 2 cm dilated, the client is in the first stage, latent phase of labor (Ricci et al., 2021). At 1700, the client progressed to 3 cm dilated and 70% effaced. The client is still in the latent phase of labor but starting to progress towards the active phase. During the latent phase, the client has not experienced feelings of anxiousness or hopelessness yet. The client changed positions often and continued to walk around when she felt comfortable. These are some actions the mother can do to advance towards the next stages (Bhargava, 2020). Throughout the clinical time, she was feeling very optimistic and unbothered by the contractions. During this time, the

client received 30 units of oxytocin. Throughout this stage of labor, the client also received acetaminophen when she reported pain from 1-3 and fentanyl when she reported her pain above a 4/10. According to the client, she was experiencing little to no pain between 1400 and 1700. Her pain did increase around 1700 but was moderate and mildly uncomfortable. Contractions during this period fluctuated mildly but remained inconsistent and occurred every 5-10 minutes. At 1800, the client's contractions became more regular and occurred every 3-5 minutes. At the end of clinical, the cervical dilation and effacement had no been updated per the chart. The client stated that she was becoming nervous but had a good attitude about her delivery.

Stage of Labor References (2) (APA):

Bhargava, H. D. (2020, August 17). *Stages of Labor & Types of Childbirth Delivery*. WebMD. https://www.webmd.com/baby/guide/pregnancy-stages-labor#1-2.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing*. 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	3.63	3.56	3.56	
Hgb	11-16	9.8	9.9	9.9	This client's low Hgb levels are caused by their anemia (Hinkle & Cheever, 2018).
Hct	34-47%	30.6%	29.7%	29.7%	This client's low Hct levels are caused by their anemia (Hinkle & Cheever, 2018).
Platelets	140-400	169	182	182	
WBC	4-11	10.92	10.23	10.23	
Neutrophils	1.6-7.7	9.1	7.86	7.89	High neutrophils are

					typically caused by bacterial infections (Capriotti & Frizzell, 2016).
Lymphocytes	**1-4.9**	**1.82**	**1.38**	**1.38**	
Monocytes	**0-1.1**	**0.78**	**0.79**	**0.79**	
Eosinophils	**0-0.5**	**0.08**	**0.05**	**0.05**	
Bands	**0-0.9**	**0.11**	**0.13**	**0.13**	

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**	**O**	**O**	**O**	
Rh Factor	**+/-**	**+**	**+**	**+**	
Serology (RPR/VDRL)	**Non-Reactive**	**Non-Reactive**	**Non-Reactive**	**Non-Reactive**	
Rubella Titer	**<7=Insufficient vaccination/ non-exposure**	**1.67**	**N/A**	**N/A**	**This client's rubella titer is low due to the client not obtaining a rubella vaccine before the prenatal visit.**
HIV	**Non- reactive**	**Negative**	**Negative**	**Negative**	
HbSAG	**Non- reactive**	**Negative**	**Negative**	**Negative**	
Group Beta Strep Swab	**Negative**	**Negative**	**Negative**	**Negative**	
Glucose at 28 Weeks	**<140**	**112**	**N/A**	**N/A**	
MSAFP (If Applicable)	**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
Covid-19	**Negative**	**Negative**	**Negative**	**Negative**	

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)	**N/A**	**N/A**	**N/A**	**N/A**	

Lab Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. F.A. Davis Company.

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing*. Wolters Kluwer.

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	**The fetus' baseline heart rate is 135-140 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?)** **What is the variability?**	**The accelerations present are 15 beats by 15 seconds with moderate variability.**
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?**	**There are no decelerations present at the time of assessment. Any decelerations that the client experiences should be identified immediately and the proper interventions should be applied as soon as possible.**
Describe the contractions: **Frequency:** **Length:** **Strength:** **Patient's Response:**	**The client's contractions occurred every 3-5 minutes and lasted about 60-70 seconds. The strength of these contractions is mild and the patient described the contractions as "not too bad, yet." The client showed no outright signs of discomfort.**

EFM reference (1) (APA format): Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing*. Wolters Kluwer.

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

Home Medications (2 required)

Brand/Generic	**Tylenol/ acetaminophen**	**Ferrous sulfate**	**Vistaril/ hydroxyzine**		
Dose	**650 mg**	**27 mg**	**50 mg**		
Frequency	**PRN**	**Once daily**	**PRN**		
Route	**Oral**	**Oral**	**Oral**		
Classification	**Antipyretic**	**Antianemic**	**Anxiolytic**		
Mechanism of Action	**Inhibits cyclooxygenase which blocks prostaglandin production that causes inflammatory response.**	**Acts to normalize RBC production by binding with hemoglobin.**	**Competes with histamine for H1 receptor site.**		
Reason Client Taking	**This medication was ordered for the client to stop any pain the client may be experiencing.**	**This client is taking ferrous sulfate to decrease anemia of the blood.**	**To treat the client's anxiety.**		
Contraindications (2)	**This medication should not be given to clients with hepatic**	**This medication should not be used in clients with hemolytic anemias.**	**This medication should not be given to client's who**		

	impairment or severe liver disease. **This medication should not be given to clients with hepatic impairment or severe liver disease.**	**This medication should not be used in clients with hemochromatosis.**	**are breastfeeding.** **This medication should not be given to clients who suffer from a prolonged QT interval.**		
Side Effects/Adverse Reactions (2)	**Common side effects include hepatotoxicity and hypotension.**	**Common side effects include hypotension and angioedema.**	**Common side effects include seizures and torsades de pointes.**		
Nursing Considerations (2)	**Use cautiously in patients with hepatic impairment.** **Monitor renal function in clients who use acetaminophen for long periods.**	**Give iron with a full glass of water or juice.** **Iron should be given 1 hour before or 2 hours after meals.**	**Use cautiously in clients with electrolyte imbalance.** **Do not give this medicine subcutaneously as this can cause tissue necrosis.**		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Liver function tests should be evaluated before use in clients with hepatic impairment.**	**A complete blood count should be tested before prescribing ferrous sulfate.**	**N/A**		
Client Teaching needs (2)	**Teach client how to identify signs of hepatotoxicity.** **Instruct client the importance of taking the appropriate dose of this**	**Instruct patient not to chew any form of iron tablets unless the chewable form.** **Inform patient that antacids should not be taken 1 hour**	**Instruct client to avoid alcohol while taking this medication.** **Caution client regarding the drowsiness effects this**		

	medication.	**before or 2 hours after taking the iron tablet.**	**medication can cause.**		

Hospital Medications (5 required)

Brand/Generic	**Tylenol/ acetaminophen**	**Abstral/ fentanyl**	**Zofran/ ondansetron**	**Anergan/ promethazine**	**Pepcid/ famotidine**
Dose	**650 mg**	**50 mcg**	**4 mg**	**12.5 mg**	**20 mg**
Frequency	**PRN**	**Q2H PRN**	**Once daily**	**Q4H PRN**	**Q12H PRN**
Route	**Oral**	**I.V.**	**I.V.**	**I.V.**	**Oral**
Classification	**Antipyretic**	**Opioid analgesic**	**Antiemetic**	**Antiemetic / antihistamine**	**Anti-ulcer agent**
Mechanism of Action	**Inhibits cyclooxygenase which blocks prostaglandin production that causes inflammatory response.**	**Alters response to pain by binding to opioid receptor in CNS.**	**Blocks serotonin receptors at the vagal nerve.**	**Competes with histamine for H1 receptor site.**	**Reduces HCl formation in the GI tract.**
Reason Client Taking	**This medication was ordered for the client to stop any pain the client may**	**This medication was ordered for this client to reduce pain.**	**This medication was ordered for this client to reduce nausea and vomiting.**	**This medication was ordered to reduce the clients' nausea and vomiting.**	**This medication was given to prevent GERD.**

	be experiencing.				
Contraindications (2)	**This medication should not be given to clients with hepatic impairment or severe liver disease.** **This medication should not be given to clients with hepatic impairment or severe liver disease.**	**This should not be given to clients with significant respirator depression.** **This medication should not be given to clients with an upper airway obstruction.**	**This medication should not be given to clients who have congenital long QT syndrome.** **This medication should not be given to clients who are currently taking apomorphine.**	**This medication should not be given to clients who suffer from angle-closure glaucoma.** **This medication should not be given to clients who suffer from bone marrow depression.**	**This medication should not be given to clients with hypersensitivity to famotidine.** **This medication should not be given to clients with hypersensitivity to H2 receptor antagonists.**
Side Effects/Adverse Reactions (2)	**Common side effects include hepatotoxicity and hypotension.**	**Common side effects include hypotension and respiratory depression.**	**Common side effects include hypotension and serotonin syndrome.**	**Common side effects include neuroleptic malignant syndrome and hypotension.**	**Common side effects include bronchospasms and laryngeal edema.**
Nursing Considerations (2)	**Use cautiously in patients with hepatic impairment.** **Monitor renal**	**Use extreme caution in clients with COPD or other airway diseases.**	**Hypokalemia and hypomagnesemia should be corrected before administering this medication.**	**Give I.V. injection at no more than 25 mg/min.** **Monitor for signs of hypotensio**	**Shake oral suspension for 5-10 seconds before administration.** **Be aware**

	function in clients who use acetaminophen for long periods.	**Monitor clients' respirator status closely throughout treatment.**	**Monitor client closely for hypersensitivity to ondansetron.**	**n or neuroleptic malignant syndrome.**	**that chewable tablets should not be given to clients with phenylketonuria.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Liver function tests should be evaluated before use in clients with hepatic impairment.**	**Client should be asked their pain rating before receiving this medication.**	**The client should be experiencing nausea or vomiting before administering this medication.**	**The nurse should assess the client's blood pressure before administering this medication.**	**N/A**
Client Teaching needs (2)	**Teach client how to identify signs of hepatotoxicity.** **Instruct client the importance of taking the appropriate dose of this medication.**	**Instruct client not to take more than prescribed as this can lead to fatal effects.** **Instruct client to avoid alcohol and other CNS depressants while taking this medication.**	**Instruct client to seek medical attention if problems persist or worsen.** **Instruct client to use calibrated container when taking the oral liquid version of this drug.**	**Instruct client to avoid alcohol while taking this medication.** **Instruct client to use a calibrated measuring device when taking medication at home.**	**Instruct client to store this medication at room temperature.** **Instruct client to avoid alcohol while taking this medication.**

Medications Reference (1) (APA): Jones & Bartlett Learning. (2020). *2020 Nurse's drug handbook.*

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The patient is alert and oriented.** **The client shows no signs of distress.** **The client is well groomed, and appearance is normal.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score: 20** **Drains present: Y☐ N ☒** **Type:**	**The client's skin is pink, moist, and warm to the touch.** **The client's skin turgor is <3 seconds.** **The client has no rashes, bruises, or wounds.**
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**The patient's head and neck are symmetrical.** **No tracheal deviation present.** **Ears have no drainage or discharge. Tympanic membrane is pearly grey with no signs of inflammation.** **The sclera's are white without jaundice.** **No subconjunctival hemorrhages are present.** **The client's turbinates are visible with no**

	signs of inflammation. **No septal deviation present.** **Dentition is good and all teeth are intact.** **Mucosa of the mouth is pink and moist without inflammation.**
CARDIOVASCULAR (1 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): Normal sinus** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☒** **Location of Edema:**	**S1 and S2 present.** **No murmurs or extra beats present.** **Peripheral pulses are 3+ at all extremities.** **Capillary refill <3 seconds.** **No edema present.**
RESPIRATORY (1 points): . **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Breath sounds are audible bilaterally in all lobes.** **The breath sounds are clear throughout.**
GASTROINTESTINAL (5 points): **Diet at Home:** **Current Diet:** **Height: 167.6 cm** **Weight: 91.2 kg** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	**The client is currently following a high iron diet.** **Bowel sounds are normoactive in all four quadrants.** **Client states last bowel movement was the morning of admission before they left the house.**
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine: 900 cc in past 12 hours.** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **Rupture of Membranes:**	**The client's urine is yellow without blood, cloudiness, or sediment.** **The client is voiding regularly without pain or discomfort.** **Rupture of membranes has not occurred at the time of clinical.**

Time: **Color:** **Amount:** **Odor:** **Episiotomy/Lacerations:**	
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 15** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	**The client has full mobility.** **The client has full range of motion.**
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **Deep Tendon Reflexes:**	**Client shows no signs of mental or neurological impairment.** **Grip strength is equal bilaterally.** **The client is oriented to surroundings, time, and reason for being at the hospital.** **Client does not slur speech, enunciates all words well.** **Deep tendon reflexes are present bilaterally, 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):**	**Client states that she uses her smoking as a coping mechanism for stressors.** **Client states that she is a Christian but does not attend church on a regular basis.** **Client's family lacks in structure.**
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	**Delivery has not occurred for this client at the time of clinical.**

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**103**	**120/65**	**20**	**98.2**	**Not recorded**
Admission to Labor/Delivery	**114**	**127/71**	**20**	**98.6**	**100%**
During your care	**114**	**118/83**	**20**	**98.5**	**100%**

Vital Sign Trends: The client's pulse has increased, and their blood pressure, respirations, temperature, and oxygen saturation has remained relatively the same since the prenatal visit.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0805	**Numeric**	**Abdomen**	**0**	**N/A**	**N/A**
1404	**Numeric**	**Abdomen**	**5**	**Cramping, radiating**	**The client was given fentanyl to reduce pain.**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV: Right forearm** **Date on IV: 3/8/21 0840** **Patency of IV: IV is intact** **Signs of erythema, drainage, etc.: N/A** **IV dressing assessment: Intact, clean.**	Lactated Ringers @ 125 mL/ hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1404: 250 cc	**1203: 700 cc** **1405: 200 cc**

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.
Administering pain medications (T)	**PRN**	**The client was provided pain medication to help relieve any pain she might be experiencing.**
Replacement of fetal heart monitor (N)	**PRN**	**The client's FHM moved out of place occasionally. Proper placement of the FHM is important to identify accelerations and decelerations in the fetus' heart rhythm.**

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

Nursing Diagnosis (2 pt each)	Rationale (1 pt each)	Intervention/Rationale(2 per dx) (1 pt each)	Evaluation (1 pt each)

Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	Explain why the nursing diagnosis was chosen	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.	• 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 chemically stimulated contractions as evidenced by client's report of pain and client's reaction to contractions.	**This nursing diagnosis was chosen because the client is experiencing mild to moderate pain with the contractions.**	**1. Administer pain medication.** **Rationale** **Administering pain medication will relieve the pain the client experiences with every contraction.** **2. Encourage client to perform breathing exercises.** **Rationale** **Performing breathing exercises can distract the client from the pain they are experiencing.**	**The client's pain decreased with the use of medication and breathing exercises.**
2. Anxiety related to labor as evidenced by client's mental apprehension to progress into later stages of labor.	**This nursing diagnosis was chosen because while the client was experiencing little to no anxiety at the start of the clinical rotation, she did begin to feel nervous towards the end of the time spent at the hospital.**	**1. Encourage the client to verbalize feelings about their experience.** **Rationale** **Allowing the client to speak about their feelings can relieve stress during the stages of labor.** **2.** Encourage client to perform breathing exercises. **Rationale** **Encouraging the client to perform breathing exercises allows a distraction from the anxiety. The breathing exercises also act as a**	**The client experienced little to no anxiety during the first stage of labor and the start of the second stage of labor.**

		relaxation technique which can lower anxiety.	
3. Lack of knowledge related to client's induction as evidenced by questions about the induction process.	**The client has not been induced in the past. The client has deficient knowledge about labor induction and may ask questions about the process.**	**1. Assess the client's knowledge about induction of labor.** **Rationale** **Assessing the client's knowledge about labor allows the nurse to know what information the client already has and allows the nurse to provide proper education about the process.** **2. Allow the client to ask any questions that they may have about the process of induction, including pharmacological questions and how long the process should take.** **Rationale** **Addressing any questions the client has about the process allows the nurse to provide the client with education while relieving stress the client may have.**	**The client's questions about the process were answered and she felt comfortable with the procedure.**
4. Lack of knowledge related to medications received during hospital stay as evidenced by questions about medication.	**Upon arrival, the client had many questions regarding some of the medications she was receiving.**	**1. Provide proper education regarding all medications the client receives.** **Rationale** **Providing proper education to the client can allow them to understand the medications they are receiving and reduce any unnecessary stress during labor.** **2. Provide the client with**	**The client's questions were answered regarding the medication she was receiving during her admission.**

		documentation regarding information about the medications. **Rationale** **Documentation about medications can provide more in depth and specific answers the nurse might not be able to provide.**	

Other References (APA)