

N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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**Demographics (3 points)**

<b>Date &amp; Time of Admission</b> 3/24/21, 0600	<b>Patient Initials</b> C.H.	<b>Age</b> 32	<b>Gender</b> Female
<b>Race/Ethnicity</b> Hispanic	<b>Occupation</b> Unemployed	<b>Marital Status</b> Married	<b>Allergies</b> NKA
<b>Code Status</b> Full Code	<b>Height</b> 165 cm	<b>Weight</b> 81 kg	<b>Father of Baby Involved</b> Yes; father is present at bedside.

**Medical History (5 Points)**

**Prenatal History:** C.H.'s GTPAL designation is 22001. Her previous pregnancy was free from complications, and she delivered vaginally without incident.

**Past Medical History:** C.H. has a history of exercise-induced asthma.

**Past Surgical History:** This patient has no prior surgical history.

**Family History:** No significant family history is noted.

**Social History (tobacco/alcohol/drugs):** The patient denies any use of tobacco, alcohol, or illicit drugs.

**Living Situation:** The patient lives at home with her husband and previous child.

**Education Level:** C.H. has completed some high school. Based on C.H.'s interaction with this nurse, it is unclear whether her education level represents a practical barrier to learning. This nurse recommends taking care during patient teaching to encourage C.H. to ask clarifying questions and using techniques like teaching back to assess understanding.

**Admission Assessment**

**Chief Complaint (2 points):** Labor

**Presentation to Labor & Delivery (10 points):**.

C.H. is a 32-year-old female who presents to the labor & delivery unit at 0600 for active labor. The patient is a full-code and has no known drug allergies. She is at 39- and 5/7-weeks gestation with a GTPAL designation of 22001. Upon encounter with this nurse at 0720, her contractions are four minutes apart with a duration of 50 seconds. Shortly after admission, Dr. Sittner performed an artificial rupture of membranes. This nurse noted a moderate amount of meconium-stained amniotic fluid. Fetal heart rate monitoring was initially reassuring, but continued monitoring revealed late decelerations. A subsequent pelvic examination by this nurse revealed umbilical cord prolapse. An assisting nurse performed manual elevation of the presenting part from the umbilical cord. C.H. was started on oxygen at 10 L by non-rebreather mask, given 0.25 mg terbutaline subcutaneously, and prepared for emergency delivery by cesarean section. She additionally received a dose of nalbuphine 10mg IV at 0725 for contraction-related pain. This nurse notified surgical staff, anesthesia, and the neonatal ICU. C.H.'s most recent vital signs are BP 136/82 mmHg, HR 91 beats per minute, RR 16 respirations per minute, T 99 degrees Fahrenheit, and O2 saturation 100% on 10L/non-rebreather mask. She has an 18-gauge IV placed in her right forearm and is presently receiving lactated Ringer's at 125 mL per hour.

### **Diagnosis**

**Primary Diagnosis on Admission (2 points):** 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:**

The first stage of labor is the longest and may be broadly described as lasting from the initial true contraction to full cervical dilation (Ricci et al., 2021). The stage is further divided into two phases; latent and active (Ricci et al., 2021). The latent phase is characterized by cervical dilation of up to 6 cm and effacement of up to 40% (Ricci et al., 2021). Contractions during the latent phase are irregular, mild to moderate in intensity, and last 30-45 seconds (Holman et al., 2019). According to Ricci et al. (2021) the frequency of contractions during the latent phase is every 5 to 10 minutes. However, Holman et al. (2019) assert that contractions in the latent phase occur every 5 to 30 minutes. After the latent phase comes the active phase of the first stage of labor (Holman et al., 2019). The active phase is characterized by cervical dilation of between 6 and 10 cm and cervical effacement between 40 to 100% (Ricci et al., 2021). Contractions are regular and intensity is moderate to strong (Holman et al., 2019, Ricci et al., 2021). During the first stage of labor, the nurse should encourage voiding every 2 hours and monitor fetal heart rate (Holman et al., 2021). The nurse can promote client comfort by assisting with position changes, encouraging deep breathing and relaxation, and providing pharmacological pain relief if ordered (Holman et al., 2021). Based on C.H.'s contractions, which were 50 seconds in duration and 4 minutes apart, she is in the active phase of the first stage of labor.

The second stage of labor begins after full dilation of 10 cm is achieved and ends with the birth of the newborn (Ricci et al., 2021). According to Ricci et al. (2021) there are two phases:

the pelvic phase and the perineal phase. The former can be simplified as the period lasting until the fetus has descended, and the latter refers to the period following fetal descent wherein active pushing has commenced (Ricci et al., 2021). Cervical dilation and effacement are complete during the second stage (Ricci et al., 2021; Holman et al., 2019). Contractions are strong in intensity and occur every 2 to 3 minutes or less (Ricci et al., 2021). Ricci et al. (2021) assert that contractions in this stage last 60 to 90 seconds. According to Holman et al. (2019), during this stage the nurse can expect to observe signs such as an increase in bloody show, increased pushing efforts by the mother, and the shaking of extremities. The nurse can promote client comfort during the second stage of labor by assisting the client into a position that allows them to push effectively, promoting rest between contractions, and utilizing non-pharmacological pain interventions like cold compresses (Holman et al., 2019).

The third stage of labor refers to the period between the delivery of the fetus and the delivery of the placenta (Holman et al., 2019). While this stage normally occurs in less than 10 minutes, it may take as long as 30 minutes in some clients (Ricci et al., 2021). During this stage, the nurse should be acutely aware that it is primarily during this stage of labor that postpartum hemorrhage occurs (Ricci et al., 2021). Accordingly, the nurse should anticipate administering uterotonic drugs as prescribed and performing fundal massage after the placenta is expelled (Ricci et al., 2021). As with the prior two stages, the third stage of labor may also be divided in to two phases: placental separation and placental expulsion (Ricci et al., 2021). During this stage, the nurse should instruct the client to push beginning when placental separation initiates and until the placenta is expelled (Holman et al., 2019). The nurse can promote comfort during the third stage of labor by providing gentle peri care and offering an ice pack for the client to place on the perineum (Holman et al., 2019).

Although the fourth stage of labor is frequently not considered part of true labor, it does represent the transition in to the postpartum phase (Ricci et al., 2021). The period refers to the first few hours after birth, and is marked by maternal stabilization and beginning to form attachment between the dyad (Ricci et al., 2021). During this stage the nurse should monitor maternal vital signs every 15 minutes for the first 2 hours, every 4 hours for the first 8 hours, and then at least once every 8 hours (Holman et al., 2019). Furthermore, the nurse should perform fundal massage to maintain uterine tone, assess the fundus and lochia every 15 minutes, assess the episiotomy if present, and promote bonding between the dyad (Holman et al., 2019).

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

Holman, H. C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., McMichael, M. G., & Barlow, M. S. (2019). *RN maternal newborn nursing review module* (11<sup>th</sup> ed.).

Assessment Technologies Institute, LLC.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4<sup>th</sup> 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 (x10 <sup>6</sup> /mcL)	4.2-5.4 (Pagana et al., 2021).	3.5	4	5.1	Dilutional anemia associated with pregnancy can result in a decreased RBC count (Ricci et al.,

					2021).
<b>Hgb (g/dL)</b>	12-16 (Pagana et al., 2021).	15	12.7	13	n/a
<b>Hct (%)</b>	36-47 (Pagana et al., 2021).	37	38.1	38	n/a
<b>Platelets (x10<sup>9</sup>/L)</b>	150-400 (Pagana et al., 2021).	180	178	177	n/a
<b>WBC (x10<sup>9</sup>/L)</b>	5-10 (Pagana et al., 2021)	9	11	10.2	Pregnancy and labor may be associated with elevated WBC levels (Pagana et al., 2021).
<b>Neutrophils (%)</b>	55-70 (Pagana et al., 2021).	n/a	n/a	n/a	This test was not performed on C.H.
<b>Lymphocytes (%)</b>	20-40 (Pagana et al., 2021).	n/a	n/a	n/a	This test was not performed on C.H.
<b>Monocytes (%)</b>	2-8 (Pagana et al., 2021).	n/a	n/a	n/a	This test was not performed on C.H.
<b>Eosinophils (%)</b>	1-4 (Pagana et al., 2021)	n/a	n/a	n/a	This test was not performed on C.H.
<b>Bands (%)</b>	3-5 (GlobalRPh, 2017).	n/a	n/a	n/a	This test was not performed on C.H.

**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>	A, B, AB, or O. (Pagana et al., 2021).	O	O	O	n/a
<b>Rh Factor</b>	Positive or Negative (Pagana et	Positive	Positive	Positive	n/a

	al., 2021).				
<b>Serology (RPR/VDRL)</b>	Reactive or nonreactive (Pagana et al., 2021).	nonreactive	nonreactive	n/a	n/a
<b>Rubella Titer</b>	Immune or non-immune (Pagana et al., 2021).	immune	immune	n/a	n/a
<b>HIV</b>	Reactive or nonreactive (Pagana et al., 2021).	Nonreactive	Nonreactive	n/a	n/a
<b>HbSAG</b>	Positive or Negative (Pagana et al., 2021).	Negative	Negative	n/a	n/a
<b>Group Beta Strep Swab</b>	Positive or Negative (Pagana et al., 2021).	Negative	Negative	n/a	n/a
<b>Glucose at 28 Weeks (mg/dL)</b>	<140 on 2-hr glucose tolerance test (Pagana et al., 2021).	110	n/a	n/a	n/a
<b>MSAFP (If Applicable) (ng/mL)</b>	<40 (Pagana et al., 2021).	n/a	n/a	n/a	This test was not performed on C.H.

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


**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 protein/creatinine ratio (if applicable) (mg protein/mg creatinine)</b>	<0.18 (Mayo Clinic Laboratories, 2021).	n/a	n/a	n/a	This test was not performed on C.H.

**Lab Reference (1) (APA):**

GlobalRPh. (2017). *Laboratory values*. <https://globalrph.com/laboratory-values/>

Mayo Clinic Laboratories. (2021). *Protein:creatinine ratio, random, urine*.

<https://www.mayocliniclabs.com/test-catalog/Clinical+and+Interpretive/601551>

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2021). *Mosby's diagnostic & laboratory test reference* (15<sup>th</sup> ed.). Elsevier.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4<sup>th</sup> ed.). Wolters Kluwer.

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

<b>Component of EFHM Tracing</b>	<b>Your Assessment</b>
<b>What is the Baseline (BPM) EFH?</b>	<p>The baseline fetal heart rate is 140 beats per minute (BPM) with moderate variability. A fetal heart rate of 140 BPM falls within an expected normal range of 110-160 BPM (Ricci et al., 2021). A finding of moderate variability is an indicator of appropriate fetal neurological development and oxygenation (Ricci et al., 2021).</p>
<p><b>Are there accelerations?</b></p> <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> <p><b>What is the variability?</b></p>	<p>This student notes three accelerations of 10 BPM with moderate variability on the fetal heart rate monitoring strip. The observed accelerations lasted 15-20 seconds each. These findings are consistent with category I criteria and are reassuring (Ricci et al., 2021). Accelerations are indicative of fetal movement and may be interpreted as a sign of fetal well-being (Ricci et al., 2021). According to Ricci et al. (2021) intervention is unnecessary for accelerations.</p>
<p><b>Are there decelerations? If so, describe them and explain the following: What do these mean?</b></p> <ul style="list-style-type: none"> <li>o <b>Did the nurse perform any</b></li> </ul>	<p>While initial findings were reassuring, this nurse noted a single late deceleration of 15 BPM lasting 55 seconds. Following this observation, the nurse was unable to discriminate between fetal and</p>

<p><b>interventions with these?</b></p> <ul style="list-style-type: none"> <li>o <b>Did these interventions benefit the patient or fetus?</b></li> </ul>	<p>maternal heart rate on the monitor output. Late decelerations are indicative of fetal hypoxia (Ricci et al., 2021). After observing the late deceleration, the nurse performed a pelvic examination which revealed umbilical cord prolapse. The observation of a late deceleration on the fetal monitor was likely a manifestation of the umbilical cord prolapse. Upon discovery of the prolapse, the nursing staff initiated several interventions. First, one nurse manually lifted the presenting part of the fetus from the umbilical cord. Second, this nurse administered oxygen at 10 L by non-rebreather mask to C.H. Third, the nurse assisted C.H. into the Trendelenburg position. Fourth, the nurse administered terbutaline 0.25 mg subcutaneously to C.H. in accordance with provider orders. Finally, nursing staff prepared C.H. for emergency delivery by cesarean section per provider instructions.</p> <p>This nurse observed that following administration of oxygen to C.H., her oxygen saturation increased from 97% to 100%. This nurse did not observe any appreciable change to the fetal heart rate monitoring strip following any of the interventions performed.</p> <p>However, the nurse’s instructor advised him that it is possible that the fetal heart rate monitor was picking up the maternal heart rate rather than fetal heart rate.</p>
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<p><b>Describe the contractions:</b>  <b>Frequency:</b> 4 minutes  <b>Length:</b> 50 seconds  <b>Strength:</b> 50 mm Hg  <b>Patient's Response:</b>                  "Groans"</p>	<p>At the time of this nurse's encounter with C.H., her contractions were 50 seconds in duration and occurred every 4 minutes. The frequency and length of C.H.'s contractions are consistent with the active phase of the first stage of labor (Ricci et al., 2021). Per electronic fetal heart rate monitor, the strength of C.H.'s contractions is 50 mm Hg. This nurse notes that during C.H.'s contractions she makes a groan. When the nurse asks, C.H. elaborates that she experiences 2/10 pain on the numeric scale with contractions and localizes the pain to her back, pelvis, and lower abdomen.</p>
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**EFM reference (1) (APA format):**

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4<sup>th</sup> ed.). Wolters Kluwer.

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

**Home Medications (2 required)**

<b>Brand/Generic</b>	Ventolin HFA/ albuterol sulfate	One A Day Prenatal Gummies/ prenatal vitamin	n/a	n/a	n/a
<b>Dose</b>	2 puffs	2 gummies			
<b>Frequency</b>	Q4-6 hours PRN	Daily			
<b>Route</b>	Inhaled	PO			
<b>Classification</b>	Chemical: Beta-2- adrenergic agonist  Therapeutic:	Vitamin/mineral supplement			

	bronchodilator  (Jones & Bartlett Learning, 2019)		
<b>Mechanism of Action</b>	This drug binds the beta-2-adrenergic receptors of bronchial cell membranes which stimulates the conversion of ATP to cAMP, lowers intracellular calcium levels, and increases intracellular cAMP levels. As a result, histamine release is inhibited and bronchial smooth-muscle cells are relaxed.  (Jones & Bartlett Learning, 2019).	Prenatal vitamins supplement vitamins, minerals, and fatty acids to prevent deficiencies before, during, or after pregnancy (WebMD, n.d.). While specific formulations may vary, prenatal vitamins commonly contain vitamins A, D, E, and K as well folic acid and iron (University of Michigan, n.d.; WebMD, n.d.).	
<b>Reason Client Taking</b>	C.H. has a history of exercise-induced asthma.	Ensuring adequate nutrition including the intake of critical vitamins and minerals such as folic acid, iron, and calcium is essential for the wellness of fetus and mother (Holman et al., 2019).	
<b>Contraindications (2)</b>	<ul style="list-style-type: none"> <li>- Hypersensitivity to albuterol or its components.</li> <li>- No other contraindications are noted, but this drug may increase the risk of hypokalemia if used with potassium-lowering drugs.</li> </ul> (Jones & Bartlett Learning, 2019)	<ul style="list-style-type: none"> <li>- Simultaneous use of a similar vitamin product can lead to vitamin overdose (University of Michigan, n.d.).</li> <li>- This drug should not be used by patients with iron overload disorders such as hemochromatosis (WebMD, n.d.).</li> </ul>	
<b>Side Effects/Adverse Reactions (2)</b>	<ul style="list-style-type: none"> <li>- Arrhythmias</li> <li>- Bronchospasm</li> </ul> (Jones & Bartlett Learning, 2019).	<ul style="list-style-type: none"> <li>- GI upset</li> <li>- Headache</li> </ul> (University of Michigan, n.d.).	
<b>Nursing Considerations (2)</b>	<ul style="list-style-type: none"> <li>- This drug is most effective when pressurized inhalations are delivered during the second half of inspiration.</li> <li>- The nurse should be aware that</li> </ul>	<ul style="list-style-type: none"> <li>- Overdose of vitamins A, D, E, or K can have serious or life-threatening side effects and cause fetal harm (University of Michigan, n.d.)</li> <li>- Vitamins should</li> </ul>	

	<p>prolonged is associated with the development of tolerance to albuterol.</p> <p>(Jones &amp; Bartlett Learning, 2019).</p>	<p>be stored in their original packaging at room temperature and protected from moisture or heat (University of Michigan, n.d.)</p>	
<p><b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b></p>	<p>Because this drug is associated with transient hypokalemia, potassium levels should be monitored before and throughout therapy. Furthermore, the patient should be assessed for any history of conditions that may be worsened by albuterol use. These include cardiac disorders, hypertension, diabetes mellitus, hyperthyroidism, or seizure disorders.</p> <p>(Jones &amp; Bartlett Learning, 2019).</p>	<p>The nurse should monitor for signs of overdose which may include stomach pain, vomiting, diarrhea, constipation, loss of appetite, hair loss, peeling skin, paresthesias around the mouth, weight loss, severe headache, muscle or joint pain, severe back pain, hematuria, pallor, ecchymosis, and inappropriate bleeding (University of Michigan, n.d.).</p>	
<p><b>Client Teaching needs (2)</b></p>	<ul style="list-style-type: none"> <li>- The patient should be taught to shake the canister before use and to verify function by spraying it to check for a fine mist in accordance with manufacturer instructions.</li> <li>- The patient should be instructed to wash their mouth-piece once a week and allow it to air dry.</li> </ul> <p>(Jones &amp; Bartlett Learning, 2019).</p>	<ul style="list-style-type: none"> <li>- The patient should be advised to take a missed dose as soon as they can, but to skip a missed rather than taking two doses at once if it is almost time for their next dose (University of Michigan, n.d.).</li> <li>- The client should be advised to review their medications with their provider before starting and while taking a prenatal vitamin, particularly diuretics, blood pressure medications, tretinoin or isotretinoin, trimethoprim and sulfamethoxazole, and NSAID drugs (University of Michigan, n.d.).</li> </ul>	

**Hospital Medications (5 required)**

<b>Brand/Generic</b>	Lactated Ringer's Solution	Nubain/ nalbuphine hydrochloride	Brethaire/ Terbutaline sulfate	Zofran/ ondansetron hydrochloride	Pitocin/ oxytocin
<b>Dose</b>	125 mL/hr	10 mg	0.25 mg	4 mg	30u/500 mL
<b>Frequency</b>	Continuous	Q1-2H PRN	Once	Q6H	Continuous
<b>Route</b>	IV	IV Piggyback	Subcutaneous	IV	IV
<b>Classification</b>	Alkalinizing agents (RxList, 2021).	Chemical Class: Phenanthrene derivative  Therapeutic class: Analgesic.  (Jones & Bartlett Learning, 2019)	Chemical class: sympathomimetic amine  Therapeutic class: bronchodilator  (Jones & Bartlett Learning, 2019)	Chemical class: carbazole  Therapeutic class: antiemetic  (Jones & Bartlett Learning, 2019)	Chemical class: exogenous hormone  Therapeutic class: oxytocics  (Nursing 2019 drug handbook, 2019)

<p><b>Mechanism of Action</b></p>	<p>This solution provides calories, electrolytes, and hydration. Dextrose in ringers lactate provides calories. Furthermore, dextrose may reduce the loss of protein and nitrogen, promote glycogen storage, and mitigate ketosis in sufficient doses. Sodium is the major extracellular cation and is critical for the regulation of fluid distribution, balance, and osmotic pressure. Potassium is the major intracellular ion, is used during carbohydrate and protein metabolism, and plays a regulatory role in nerve conduction and muscle contraction. Calcium is used in the formation of bones, is involved in the blood clotting mechanism, and important to the regulation of cardiac and neuromuscular activity. Sodium lactate is racemic; the levo form is converted to bicarbonate in the liver while the dextro form is converted to glycogen.</p> <p>(RxList, 2021).</p>	<p>This drug alters the perception of and emotional response to pain by binding kappa and mu-opiate receptors in the spinal cord and central nervous system.</p> <p>(Jones &amp; Bartlett Learning, 2019).</p>	<p>This drug relaxes bronchial smooth muscles by increasing the synthesis of cAMP via stimulation of beta-2-adrenergic receptors of the lungs. Through the same mechanism, terbutaline relaxes the smooth muscles of the uterus.</p> <p>(Jones &amp; Bartlett Learning, 2019; Medscape, n.d.)</p>	<p>This medication prevents serotonin release to reduce nausea and vomiting by blocking serotonin receptors in the chemoreceptor trigger zone and peripheral vagal nerve terminals of the intestine.</p> <p>(Jones &amp; Bartlett Learning, 2019)</p>	<p>This drug causes selective stimulation of uterine and mammary gland smooth muscle.</p> <p>(Nursing 2019 drug handbook, 2019).</p>
<p><b>Reason Client Taking</b></p>	<p>Fluid volume maintenance</p>	<p>C.H. takes this drug for the management of pain on an as needed basis.</p>	<p>C.H. was given this drug to reduce and prevent uterine contraction.</p>	<p>C.H. is taking this drug to treat nausea and vomiting.</p>	<p>C.H. was given this drug to stimulate labor.</p>
<p><b>Contraindications (2)</b></p>	<ul style="list-style-type: none"> <li>- Hypersensitivity to corn products (RxList, 2021).</li> <li>- Severe metabolic acidosis or alkalosis, severe liver disease or anoxic</li> </ul>	<ul style="list-style-type: none"> <li>- Hypersensitive to nalbuphine or its components.</li> <li>- No other contraindications are listed, however this drug should be used cautiously</li> </ul>	<ul style="list-style-type: none"> <li>- Hypersensitivity to terbutaline or other sympathomimetic amines.</li> <li>- No other contraindications are listed, however when used with beta blockers</li> </ul>	<ul style="list-style-type: none"> <li>- Congenital long QT syndrome.</li> <li>- Concomitant use of apomorphine.</li> </ul> <p>(Jones &amp; Bartlett Learning, 2019)</p>	<ul style="list-style-type: none"> <li>- This drug is contraindicated during fetal distress when delivery is not imminent, in prematurity, in obstetric emergencies, or in patients with severe</li> </ul>

	states that affect lactate metabolism (RxList, 2021).	in clients using drugs known to cause CNS depression and is considered incompatible with diazepam or pentobarbital.  (Jones & Bartlett Learning, 2019)	this drug may increase risk of bronchospasm.  (Jones & Bartlett Learning, 2019)		toxemia or hypertonic uterine patterns.  - This drug is contraindicated when vaginal delivery is not advised such as with placenta previa, cephalopelvic disproportion, or transverse fetal lie.  (Nursing 2019 drug handbook, 2019)
<b>Side Effects/Adverse Reactions (2)</b>	- Hyperkalemia - Hypermagnesemia  (RxList, 2021).	- Confusion - Dyspnea  (Jones & Bartlett Learning, 2019)	- Anxiety - Chest pain  (Jones & Bartlett Learning, 2019)	- Abdominal pain - Agitation  (Jones & Bartlett Learning, 2019)	- afibrinohememia - Abruptio placentae  (Nursing 2019 drug handbook, 2019)
<b>Nursing Considerations (2)</b>	- This medication should be administered in the largest available peripheral vein using a small-bore needle. - The nurse should take care to monitor for infection, phlebitis, extravasation, and hypervolemia.  (RxList, 2021).	- Resuscitation equipment and naloxone should be readily available when using this drug. - This drug should be given slowly by IV; a 10 mg dose should be given over 3 to 5 minutes into a free-flowing line with a compatible infusion solution such as lactated ringers solution	- This drug should be used cautiously in patients with a history of cardiovascular disease. In these patients, heart rate, rhythm, and blood pressure should be regularly monitored. - When used subcutaneously, inject into the lateral deltoid area.  (Jones & Bartlett Learning, 2019)	- The nurse should be aware that ondansetron can mask symptoms of gastric distension after abdominal surgery. - The nurse should monitor the patient closely for signs of serotonin syndrome including agitation, chills, confusion	- This drug should be given only by piggyback infusion so that it may be stopped without interrupting IV line. - The drug should be discontinued immediately if uterine hyperactivity or fetal distress occurs.  (Nursing 2019 drug handbook, 2019)

		<p>or normal saline.</p> <p>(Jones &amp; Bartlett Learning, 2019)</p>		<p>n, diaphoresis, diarrhea, fever, hyperactive reflexes, poor coordination, restlessness, shaking, uncontrolled excitement, tremor, and twitching.</p> <p>(Jones &amp; Bartlett Learning, 2019)</p>	
<p><b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b></p>	<p>Because this drug can affect fluid balance, electrolyte levels, and acid-base balance, the nurse should check the client's blood chemistry and assess for fluid overload before and during therapy.</p> <p>(RxList, 2021).</p>	<p>Because this drug can cause CNS and respiratory depression, the nurse should assess respiratory status and perform a neurologic examination prior to administration.</p> <p>(Jones &amp; Bartlett Learning, 2019)</p>	<p>Because this drug can affect cardiovascular and respiratory function, before and during use the nurse should assess:</p> <ol style="list-style-type: none"> <li>1) Respiratory rate and depth, oxygen saturation, and activity tolerance.</li> <li>2) Heart rate, rhythm, and blood pressure.</li> </ol> <p>(Jones &amp; Bartlett Learning, 2019)</p>	<p>The patient should be assessed for electrolyte imbalances, decreased bowel activity, and cardiac arrhythmias.</p> <p>(Jones &amp; Bartlett Learning, 2019)</p>	<p>- Because this drug can cause uterine hyperactivity and fetal distress, electronic fetal heart rate monitoring should be performed before and during therapy.</p> <p>- The nurse should monitor fluid intake and output due to the drug's antidiuretic effects. Furthermore, heart rate, blood pressure, intrauterine pressure, fetal heart rate, and character of blood loss if present should be monitored before and every 15 minutes during therapy.</p> <p>(Nursing</p>

					2019 drug handbook, 2019)
<p><b>Client Teaching needs (2)</b></p>	<ul style="list-style-type: none"> <li>- The client should be advised to immediately report tingling in the extremities, altered reflexes, confusion, or weakness. These symptoms may indicate potassium intoxication.</li> <li>- The patient should be advised that ringer’s lactate is a pregnancy category C drug; it is not established whether this drug can cause fetal harm or affect reproductive capacity.</li> </ul> <p>(RxList, 2021)</p>	<ul style="list-style-type: none"> <li>- The patient should be advised to avoid hazardous activities until the CNS effects of this drug on them are known.</li> <li>- The patient should be advised that this medication can cloud judgment. Accordingly, the client should avoid making important decisions when receiving this drug.</li> </ul> <p>(Jones &amp; Bartlett Learning, 2019)</p>	<ul style="list-style-type: none"> <li>- The client should be advised that they may experience nervousness or tremors when taking this drug. They should be informed that these are transient effects.</li> <li>- The patient should not consume caffeine while using this medication.</li> </ul> <p>(Jones &amp; Bartlett Learning, 2019)</p>	<ul style="list-style-type: none"> <li>- Advise patients to immediately report any new rash, which may be a sign of hypersensitivity reaction.</li> <li>- Advise the patient that transient blindness is a potential adverse reaction of ondansetron and that it will resolve between several minutes and 48 hours of onset.</li> </ul> <p>(Jones &amp; Bartlett Learning, 2019)</p>	<ul style="list-style-type: none"> <li>- The nurse should educate the client and their family about why this drug is being used and how it is administered.</li> <li>- The patient should be advised to immediately report site irritation, nausea, bleeding, blurred vision, difficulty speaking, wheezing, itching, or swelling to the nurse. These may indicate hypersensitivity.</li> </ul> <p>(Nursing 2019 drug handbook, 2019)</p>

**Medications Reference (1) (APA):**

Holman, H. C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., McMichael, M.

G., & Barlow, M. S. (2019). *RN maternal newborn nursing review module* (11<sup>th</sup> ed.).

Assessment Technologies Institute, LLC.

Jones & Bartlett Learning. (2019). *2019 nurse’s drug handbook* (18<sup>th</sup> ed.). Jones & Bartlett

Learning, LLC.

Medscape. (n.d.). *Terbutaline (Rx)*. <https://reference.medscape.com/drug/brethine-terbutaline-343135#10>

*Nursing 2019 drug handbook*. (2019). Wolters Kluwer.

RxList (2021, March 1). *Lactated ringers*. <https://www.rxlist.com/lactated-ringers-drug.htm>

University of Michigan. (n.d.). *Prenatal multivitamins*. <https://www.uofmhealth.org/health-library/d03148a1>

WebMD. (n.d.). *Prenatal*. <https://www.webmd.com/drugs/2/drug-164355/prenatal-gummy-oral/details>

### Assessment

#### Physical Exam (18 points)

<p><b>GENERAL (0.5 point):</b>  <b>Alertness:</b> Alert  <b>Orientation:</b> Place, person, time, &amp; situation.  <b>Distress:</b> C.H. is physically uncomfortable and concerned about the well-being of her baby.  <b>Overall appearance:</b> Aside from her evident distress, C.H. appears physically healthy.</p>	<p>C.H. is A/O x4 and appears physically healthy. She does seem distressed due to her labor pain and concerns about her baby’s safety; repeatedly asks “Is my baby okay?”</p>
<p><b>INTEGUMENTARY (2 points):</b>  <b>Skin color:</b> light brown  <b>Character:</b> clean, dry, and intact.</p>	<p>C.H.’s skin is light-brown in color and is within normal limits for her ethnicity. The skin is warm to the touch, dry, and intact. C.H.’s skin turgor is</p>

<p><b>Temperature:</b> warm  <b>Turgor:</b> elastic  <b>Rashes:</b> n/a  <b>Bruises:</b> n/a  <b>Wounds/Incision:</b> n/a                  Braden Score: <b>21</b>  <b>Drains present:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b></p>	<p>elastic and her skin is free from rashes, bruising, or wounds. No rashes are present. The client's Braden Score is 21, which corresponds to an average risk.</p>
<p><b>HEENT (0.5 point):</b>  <b>Head/Neck:</b> normocephalic, trachea-midline, lymph nodes are non-palpable, thyroid is non-palpable. Oral mucosa is moist and intact. Tonsils are graded 2+.  <b>Ears:</b> Tympanic membranes are visible, intact, and pearly-grey in color bilaterally.  <b>Eyes:</b> PERRLA. EOMI. Conjunctiva are pink with no inflammation or drainage.  <b>Nose:</b> Septum is midline. No epistaxis or visible turbinates.  <b>Teeth:</b> Dentition is intact and off-white in color.</p>	<p>C.H.'s head is normocephalic. The client's trachea is midline and her lymph nodes and thyroid gland are non-palpable. No jugular venous distension is noted. The oral mucosa is moist and intact. Tonsils are graded 2+.</p> <p>The client's tympanic membranes are visible, intact, and pearly-grey bilaterally. PERRLA and EOMI. The conjunctiva are pink with no inflammation or drainage noted bilaterally.</p> <p>The nasal septum is midline. No epistaxis is noted.</p> <p>The client's dentition is complete, intact, and off-white in color.</p>
<p><b>CARDIOVASCULAR (1 point):</b>  <b>Heart sounds:</b> S1S2  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b> Regular  <b>Peripheral Pulses:</b> +2 bilaterally, upper and lower extremities.  <b>Capillary refill:</b> &lt;3 seconds bilaterally  <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> n/a</p>	<p>Auscultation of C.H.'s heart reveals a regular rate and rhythm. S1 and S2 are heard with no murmur auscultated. The client has 2+ radial pulses bilaterally and 2+ pedal pulses bilaterally. Capillary refill is &lt;3 seconds bilaterally. No jugular venous distension or edema is noted.</p>
<p><b>RESPIRATORY (1 points):</b>  <b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Breath Sounds:</b> Clear throughout all lobes, posterior and anterior.</p>	<p>Respirations are even and regular with a rate of 18 respirations per minute. C.H. denies any dyspnea. Lung sounds are clear throughout all lobes posteriorly, anteriorly, and bilaterally. No cough is noted.</p>
<p><b>GASTROINTESTINAL (5 points):</b>  <b>Diet at Home:</b> Regular  <b>Current Diet:</b> Ice chips only  <b>Height:</b> 165 cm  <b>Weight:</b> 81 kg</p>	<p>The client has been on a regular diet at home, but is presently NPO apart from ice-chips and sips of water permitted for dry mouth. Her height is 165 cm and weight is 81 kg. C.H. has active bowel sounds in all four quadrants with clicks and</p>

<p><b>Auscultation Bowel sounds:</b> Active in all four quadrants.  <b>Last BM:</b> 3/23/21  <b>Palpation: Pain, Mass etc.:</b> Denies pain on palpation. Fetal landmarks are palpable during Leopold’s maneuvers.  <b>Inspection:</b>  <b>Distention:</b> Abdomen appears distended.  <b>Incisions:</b> n/a  <b>Scars:</b> n/a  <b>Drains:</b> n/a  <b>Wounds:</b> n/a</p>	<p>borborygmi auscultated in each quadrant. She reports her last bowel movement was on the evening of 3/23/21.</p> <p>Inspection of the abdomen reveals a distended appearance with a visible linea nigra. No incisions, scars, drains, or wounds are present. C.H. denies pain on abdominal palpation. No masses are palpated. Leopold’s maneuvers reveal that the fetus is in the vertex position with a longitudinal lie. Fundal height is at the level of C.H.’s xiphoid process.</p>
<p><b>GENITOURINARY (5 Points):</b>  <b>Bleeding:</b> No bleeding noted.  <b>Color:</b> Urination not observed.  <b>Character:</b> Urination not observed.  <b>Quantity of urine:</b> Doppler reveals 208 mL of urine in bladder.  <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> n/a  <b>Size:</b> n/a  <b>Rupture of Membranes:</b> AROM  <b>Time:</b> 0630  <b>Color:</b> meconium-stained  <b>Amount:</b> moderate  <b>Odor:</b> no  <b>Episiotomy/Lacerations:</b> N/A</p>	<p>The nurse did not observe C.H. urinate during our encounter. However, doppler scan reveals 208 mL of urine present in the bladder. C.H. states she last urinated earlier this morning and denies any pain associated with doing so. No catheter is present.</p> <p>The client’s perineum is intact. C.H. had an artificial rupture of membranes, performed by Dr. Sittner, at 0630. Following the rupture of membranes, a moderate amount of meconium-stained amniotic fluid was noted.</p> <p>Pelvic examination at the time of encounter reveals umbilical cord prolapse.</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> 15  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib)</b> <input type="checkbox"/>  <b>Needs assistance with equipment</b>  <b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p>At the time of encounter, C.H. is on bed rest with bathroom privileges. She can bear weight independently but ambulates with supervision. The nurse assists C.H. with her IV while she ambulates. Muscular strength is 5/5 in bilateral upper and lower extremities. C.H.’s Morse Fall Scale score is 15, which corresponds to a low fall risk.</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> Place, person, situation, and time.</p>	<p>C.H. is A/O x4. PERRLA and EOMI. The client demonstrates bilaterally equal strength in her upper and lower extremities. The nurse notes no sensory deficits. The client speaks in clear and coherent English. Deep tendon reflexes are 2+ with no clonus noted.</p>

<p><b>Mental Status:</b> Appropriate and lucid  <b>Speech:</b> Clear  <b>Sensory:</b> No sensory deficits noted. Cranial nerves I-XII are grossly intact.  <b>LOC:</b> Alert  <b>Deep Tendon Reflexes:</b> 2+</p>	
<p><b>PSYCHOSOCIAL/CULTURAL (1 points):</b>  <b>Coping method(s):</b> Talking about problems with spouse.  <b>Developmental level:</b> Appropriate for stated age.  <b>Religion &amp; what it means to pt.:</b> Roman Catholic.  <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b> Client is part of a traditional nuclear family and feels well-supported by her spouse and extended family.</p>	<p>C.H.'s developmental level is appropriate for her stated age. When the nurse asks about her coping methods, she identifies talking about problems with her spouse as useful. C.H. identifies as a devout Roman Catholic and believes she draws strength from her faith. C.H.'s household is a traditional nuclear family; she lives with her husband and previous child. The family describes their relationship with extended family as close, and C.H. feels that her support system is adequate to meet her needs.</p>
<p><b>DELIVERY INFO: (1 point)</b>  <b>Delivery Date:</b> n/a  <b>Time:</b> n/a  <b>Type (vaginal/cesarean):</b> n/a  <b>Quantitative Blood Loss:</b> n/a  <b>Male or Female</b> n/a  <b>Apgars:</b> n/a  <b>Weight:</b> n/a  <b>Feeding Method:</b> n/a</p>	<p>As of the end of our encounter, C.H. patient has not yet delivered. She has been scheduled to deliver via emergency cesarean section.</p>

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
<b>Prenatal</b>	75 beats per minute	125/65 mmHg	18 respirations per minute	98.6 degrees Fahrenheit	100% on room air
<b>Admission to Labor/Delivery</b>	93 beats per minute	135/81 mm Hg	17 respirations	99 degrees Fahrenheit	97% on room air

			per minute		
<b>During your care</b>	91 beats per minute	136/82 mmHg	16 respirations per minute	99 degrees Fahrenheit	100% on oxygen at 10 L via non-rebreather mask.

**Vital Sign Trends:**

Pulse

During all three sets of vitals, C.H.’s pulse is within expected limits. However, the heart rates measured during the admission and student encounter sets are, respectively, +18 and +16 BPM greater than her prenatal pulse. An increase in pulse between 10 and 20 BPM is an expected maternal response to the labor process (Ricci et al., 2021).

Blood Pressure

The blood pressures taken during the admission and student encounter sets are higher, both systolic and diastolic, than the prenatal blood pressure measurement. The differences between the admission blood pressure and student encounter blood pressure are negligible; both systolic and diastolic blood pressure are +1 mm Hg in the student encounter versus the admission set. Increases in cardiac output and blood pressure are expected changes during pregnancy and labor (Ricci et al., 2021).

Respiratory rate

C.H.'s respiratory rate is within the expected range with all three sets of vitals. The respiratory rate decreases by 1 respiration per minute with each set from a high of 18 respirations per minute during the prenatal set to a low of 16 respirations per minute during the student encounter set. The decrease in respirations is potentially explicable by the client's use of PRN nalbuphine during her hospital stay (Jones & Bartlett Learning, 2019).

### Temperature

The temperature in both the admission and student encounter vital sets is 99 degrees Fahrenheit; 0.4 degrees Fahrenheit higher than the prenatal set. A slight increase in temperature is an expected finding during labor (Ricci et al., 2021).

### Oxygen

The client's oxygen saturation was 100% during the prenatal period. During the admission set, oxygen saturation decreased to 97%. C.H.'s oxygen saturation during the student encounter set was 100%. The increase in oxygen saturation between the second in third sets is explicable by the administration of supplementary oxygen.

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

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
<b>0720</b>	Numeric	Back, pelvis, and lower abdomen	2/10	Contraction	The nurse administered nalbuphine 10 mg IV.
<b>0730</b>	Numeric	Back, pelvis, and lower abdomen	2/10	Contraction	The nurse notified C.H.'s provider. The provider did not order any further

					intervention.
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**IV Assessment (2 Points)**

<b>IV Assessment</b>	<b>Fluid Type/Rate or Saline Lock</b>
<b>Size of IV:</b> 18 gauge <b>Location of IV:</b> Right forearm <b>Date on IV:</b> 3/24/21 <b>Patency of IV:</b> Patent <b>Signs of erythema, drainage, etc.:</b> n/a <b>IV dressing assessment:</b> Clean, dry, and intact.	C.H. is receiving lactated ringer’s solution at a rate of 125 mL/hr.

**Intake and Output (2 points)**

<b>Intake (in mL)</b>	<b>Output (in mL)</b>
62.5 mL of lactated ringer’s solution by IV	0 mL

**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>
The nurse performs the Leopold maneuvers (N).	Once.	The nurse performs the Leopold maneuvers to determine fetal presentation, position, and lie (Ricci et al., 2021).
The nurse assists the client in to the Trendelenburg position (N).	Once.	C.H.’s labor has been complicated by umbilical cord prolapse. During umbilical cord prolapse, it is indicated for the nurse to assist the woman to a modified Sims, Trendelenburg, or knee-chest position to attempt to alleviate pressure on the cord (Ricci et al., 2021).
The nurse assesses C.H.’s pain level using the numeric pain	Q30 minutes and PRN.	Pain during labor is a universal experience, and the regular assessment

scale (N).		of pain during labor and childbirth is important to help the client reach a level of pain she finds acceptable (Ricci et al., 2021).
The nurse administers nalbuphine 10 mg IV as ordered (T).	Q1-2 hours PRN	This client reported experiencing pain; nalbuphine is indicated for the management of pain (Jones & Bartlett Learning, 2019).
The nurse administers oxygen at 10L by non-rebreather mask as ordered (T).	PRN for non-reassuring fetal heart rate monitoring results.	The administration of supplemental oxygen is indicated in fetal hypoxia (Ricci et al., 2021).
The nurse administers ondansetron 4 mg IV as ordered (T).	Q4-6 hours PRN	Ondansetron is indicated for the management of nausea and vomiting (Jones & Bartlett Learning, 2019).

References:

Jones & Bartlett Learning. (2019). *2019 nurse’s drug handbook* (18<sup>th</sup> ed.). Jones & Bartlett Learning, LLC.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4<sup>th</sup> ed.). Wolters Kluwer.

**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>
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	<ul style="list-style-type: none"> <li>• How did the patient/ family respond to the nurse’s actions?</li> <li>• Client response, status of goals and outcomes, modifications to</li> </ul>

		APA format, cite the source for your rationale.	plan.
<p><b>1.</b> Acute pain related to labor as evidenced by patient groaning during contractions.</p>	<p>This diagnosis was ranked first because acute pain represents an actual and immediate problem for this patient.</p> <p>Pain is regarded as a universal experience in labor (Ricci et al., 2021).</p>	<p>1. The nurse will assess C.H.'s pain level using the numeric scale q 30 minutes and as needed.</p> <p><b>Rationale:</b> The patient is the most reliable source of information regarding their pain and the assessment of pain is considered the first step in planning for pain management (Gulanick &amp; Myers, 2017).</p> <p>2.The nurse will administer nalbuphine 10 mg IV q 1-2 hours PRN as ordered for pain.</p> <p><b>Rationale:</b> Nalbuphine is indicated for the treatment of acute pain when alternatives are inadequate or not tolerated (Jones &amp; Bartlett Learning, 2019).</p>	<p>C.H. was able to use the numeric pain scale. She rated her pain as 2/10, and when asked if she would like medication for her pain she responded that she would. During this student's encounter with C.H., he administered a dose of nalbuphine 10 mg in accordance with provider orders. However, between the time the dose was administered and the end of our encounter, only 10 minutes had elapsed and it is unclear if the intervention will be effective.</p> <p><u>Goal:</u> The client will maintain a level of pain she finds tolerable during her hospital stay, as defined by her using the numeric scale.</p> <p>The goal associated with this diagnosis is currently in progress. While it is known that C.H. finds a pain level of 2/10 on the numeric scale unacceptable, it is not yet known what level on the numeric scale she does find acceptable. Furthermore, it is unknown if the administration of nalbuphine 10 mg is adequate to bring her to</p>

			a level she finds tolerable.
<p>2. Risk for electrolyte imbalance related to treatment regimen as evidenced by observation that patient is receiving ringers lactate 125 mL/hr intravenously.</p>	<p>This diagnosis was ranked second because it is a potential problem rather than an actual problem.</p> <p>A potential adverse effect of ringers lactate solution is electrolyte imbalance (RxList, 2021).</p>	<p>1. The nurse will monitor serum electrolyte levels each shift as ordered. <b>Rationale:</b> Early detection of electrolyte imbalances allows for the timely implementation of measures to prevent or correct them (Gulanick &amp; Myers, 2017).</p> <p>2. The nurse will monitor the client's dietary intake of food and fluid each shift. <b>Rationale:</b> Fluid and food intake can directly influence electrolyte balance (Gulanick &amp; Myers, 2017).</p>	<p>C.H. tolerated the nurse's interventions well during our encounter. This shift, she consumed only 30 cc of ice chips. She is yet to have a blood chemistry panel drawn.</p> <p><u>Goal:</u> The client will maintain serum electrolyte levels within their respective expected ranges during their hospital stay.</p> <p>The client goal is in progress. At this time, the client has not yet had a blood chemistry panel performed. Thus, the nurse is unable to assess results for electrolyte imbalances. The nurse will ask the provider to consider ordering a BMP.</p>
<p>3. Fear related to obstetric emergency as evidenced by patient expressing concern for the safety of her baby.</p>	<p>This diagnosis was ranked third. While fear is not an immediate homeostatic threat, the experience of fear is uncomfortable and may hinder effective communication and teaching</p>	<p>1. Assess the patient's coping mechanisms to deal with their fears. <b>Rationale:</b> Assessing current coping mechanisms allows the nurse to determine the client's need for effective management strategies (Gulanick &amp; Myers, 2017).</p> <p>2. The nurse will instruct the client in the use of breathing modifications to</p>	<p>The ideal response for this client would be for C.H. to identify the methods she presently uses to deal with fear. Furthermore, C.H. would ideally be able to learn and use breathing modifications to control her feelings of fear.</p> <p>The goal for this diagnosis is for the client to express a</p>

	<p>(Gulanick &amp; Myers, 2017).</p>	<p>alleviate fear.  <b>Rationale:</b> Controlled and rhythmic breathing is associated with relaxation and feelings of control (Gulanick &amp; Myers, 2017).</p>	<p>reduction in her level of fear.                       The goal is in progress. By the end of our encounter, this nurse had not yet instructed C.H. on breathing modification.</p>
<p>4. Deficient knowledge related to surgical procedure as evidenced by client asking “Will my husband come with me?” and expressing that they have questions about the procedure.</p>	<p>The nurse should verify that the client has an accurate understanding of the surgical procedure as this is necessary for informed consent. Moreover, understanding what to expect may help mitigate uncertainty or anxiety. (Gulanick &amp; Myers, 2017).</p>	<p>1. The nurse will explain and reinforce the surgeon’s explanations of the proposed surgical procedure.  <b>Rationale:</b> An accurate understanding of the procedure is requisite to informed consent. While it is the surgeon’s responsibility to obtain informed consent, the nurse may reinforce explanations and serves as the patient’s advocate in obtaining additional information from the surgical team (Gulanick &amp; Myers, 2017).                       2. The nurse will provide information about family waiting rooms and how family members can receive updates during the procedure.  <b>Rationale:</b> The nurse should ensure family members know where they may wait during the procedure and inform them about how they may obtain information during the procedure. If necessary, the nurse should arrange for interpreters (Gulanick &amp; Myers, 2017).</p>	<p>C.H. and her family tolerated the nurse’s interventions well. C.H. required only reiteration of the surgeon’s instructions before voicing comfort with the procedure. C.H.’s husband verbalized an understanding of where the surgical waiting room is, and that he could expect periodic updates during the procedure.                       Goal: The client and her family will express comfort with the surgical procedure and associated protocols prior to surgery.                       The goal is complete. Both C.H. and her husband have verbalized understanding of the teaching offered and expressed comfort proceeding as planned.</p>

**Other References (APA)**

Gulanick, M., & Myers, J. L. (2017). *Nursing care plans: Diagnoses, interventions, & outcomes* (9<sup>th</sup> ed.). Elsevier.

Jones & Bartlett Learning. (2019). *2019 nurse's drug handbook* (18<sup>th</sup> ed.). Jones & Bartlett Learning, LLC.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4<sup>th</sup> ed.). Wolters Kluwer.

RxList (2021, March 1). *Lactated ringers*. <https://www.rxlist.com/lactated-ringers-drug.htm>