N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission	Patient Initials	Age	Gender
6/10/21 2313	A.B.	25	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Nurse	Married	Peanut- anaphylaxis Varicella live vaccine- rash Mucinex Amoxicillin
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full Code	5'3"	91.6 kg	Yes

Medical History (5 Points)

Prenatal History: G1 T0 P0 A0 L0. No complications noted.

Past Medical History: History of asthma, foot fracture, allergic rhinitis, eye issues concerning refraction and accommodation.

Past Surgical History: No surgical history.

Family History: Father has hypertension. Mother has heart disease and hypertension.

Social History (tobacco/alcohol/drugs): Patient states she drank alcohol socially before pregnancy. Is currently not drinking alcohol. She doesn't use recreational drugs or smoke cigarettes.

Living Situation: Lives in a home with her husband.

Education Level: Completed a nursing degree.

Admission Assessment

Chief Complaint (2 points): Patient is in labor. No specific complaints at this time.

Presentation to Labor & Delivery (10 points): Onset: Patient stated she started noticing regular contractions and pressure late Wednesday evening. Location: Patient states she feels

pressure in her pelvis. Duration: Patient's contractions continue to become stronger and regular since Wednesday evening. Characteristics: Before the epidural patient stated that contractions were very painful. After the epidural she states her contractions are not painful. Says "It just feels like he is kicking." Associated manifestations: The client states that nothing really brings the pain on. Relieving factors: The client stated that breathing through the contractions and having her husband's support made her feel better. The patient received an epidural around 1600 and reported her pain at about a 5 out of 10 during contractions.

Diagnosis

Primary Diagnosis on Admission (2 points): The primary diagnosis is 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:
Stage of Labor References (2) (APA):

The patient is currently in the first stage of labor. The first stage of labor is usually the longest and can take up to twelve hours for a first-time mother (Ricci et al., 2017). The first stage of labor is made up of three phases. These phases include the latent phase, the active phase, and the transition phase. Upon arriving in the labor and delivery unit, the patient was in the latent phase of the first stage of labor. She progressed to the active phase throughout the afternoon.

The patient's signs in the latent phase of labor include irregular contractions and occurring every five to thirty minutes. The contractions are often rated as mild to moderate, lasting thirty to forty-five seconds. The patient typically appears talkative, eager, and excited. The cervix is dilated between one to three centimeters and is up to forty percent effaced. During the active phase of the first stage of labor, the contractions begin to become more regular and

occur every three to five minutes. They are more painful and range from moderate to strong. The contractions occur every three to five minutes and usually last forty to seventy seconds. During this stage of labor, common emotions include feeling helpless, anxious, and restless (Ricci et al., 2017). During the active phase, the cervix dilates from four to seven centimeters (American Pregnancy Association, 2020). The effacement is between forty to eighty percent (Ricci et al., 2017). During the most current assessment, the patient was five centimeters dilated and eighty percent effaced.

The patient's vital signs were stable. It is not uncommon for the blood pressure, heart rate, and respiration rate to increase. Her temperature was also being monitored every four hours since her membranes hadn't been ruptured yet. All labs are being monitored. Her blood type is A positive; therefore, Rhogam is not indicated. The patient's complete blood count lab test was completed. All ranges were within normal limits except a slight increase in the white blood cell count to 12.90 and a neutrophil count of 8.94, which is to be expected and not problematic at this point.

Many nursing interventions can be done for a laboring patient in the active phase of labor. The patient was experiencing pain and discomfort. We performed some nursing interventions by providing a calm and quiet space, working through breathing techniques, and helping reposition the patient often (Ricci et al., 2017). An epidural was placed by the CRNA, and ropivacaine was administered for pain control. The patient had an IV placed in her left hand. We made sure that it was secure, clean, and dry. The patient received lactated ringers’ solution at 125 ml/hour to keep the line patent and prevent dehydration.

The patient is progressing to the transition stage of the first phase of labor. In this stage, the cervix dilates from eight to ten centimeters, and the effacement is one hundred percent. The

contractions will be very strong, last forty-five to ninety seconds, and occur every two to three minutes (American Pregnancy Association, 2020). During this stage, the patient may feel tired, out of control, and have increased bloody show. The next stage of labor is the second stage that lasts from the cervix dilating to ten centimeters to the infant's birth. During this stage, the mother has frequent contractions and feels the urge to push. During this time, the nurse should be assessing the vital signs and fetal heart rate.

References

American Pregnancy Association. (2020). *First stage of labor*. https://americanpregnancy.org/healthy-pregnancy/labor-and-birth/first-stage-of-labor-893/.

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

Laboratory Data (15 points)

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

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80-5.20	N/A	N/A	4.10	N/A
Hgb	12.0-15.8	N/A	N/A	12.7	N/A
Hct	36.0-47.0	N/A	N/A	38.2	N/A
Platelets	140-44-	N/A	N/A	177	N/A
WBC	4.0-12.0	N/A	N/A	12.90	Increase in WBC consistent with normal labor process. (Ricci et al., 2017).
Neutrophils	1.60-7.70	N/A	N/A	8.94	Increase in neutrophils consistent with normal labor process. (Ricci et al., 2017).
Lymphocytes	18.0-42.0	N/A	N/A	12.4	Decrease in lymphocytes consistent with normal labor

					process. (Ricci et al., 2017).
Monocytes	4.0-12.0	N/A	N/A	6.4	N/A
Eosinophils	0.0-5.0	N/A	N/A	1.8	N/A
Bands	0.0-1.0	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
Blood Type	A, B, AB, or O	A	A	A	N/A
Rh Factor	Positive or negative	Positive	Positive	Positive	N/A
Serology (RPR/VDRL)	Reactive or non-reactive	Non-reactive	N/A	N/A	N/A
Rubella Titer	>11.00	57.60 Immune	N/A	N/A	N/A
HIV	Negative or positive	Negative	N/A	N/A	N/A
HbSAG	Non-reactive or reactive	Non-reactive	N/A	N/A	N/A
Group Beta Strep Swab	Negative or positive	Negative	N/A	N/A	N/A
Glucose at 28 Weeks	<140	129 mg/dL	N/A	N/A	N/A
MSAFP (If Applicable)	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
Magnesium	1.6-2.6 mg/dL	N/A	N/A	1.9	N/A
Uric acid	2.6-6.0 mg/dL	N/A	N/A	5.3	N/A
LD	84-246	N/A	N/A	190	N/A

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

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

Lab Reference (1) (APA):

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

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	The baseline (BPM) is 135, which is within the normal range of 110-160 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?**	Accelerations are present. The fetal heart rate jumped up from the baseline to 150-155 and remained elevated for 15 seconds. Moderate variability is present. The fluctuations stay within 6-25 bpm, this is a good sign that indicates that the fetus is receiving a good oxygen supply and is well developed (Ricci et al., 2017).
Are there decelerations? If so, describe them and explain the following: What do these mean? o **Did the nurse perform any interventions with these?** o **Did these interventions benefit the patient or fetus?**	The patient has early, variable, and some late decelerations. Early decelerations mirror the mother's contraction. The deceleration is caused by head compression. Late decelerations occur after the contraction peaks and are correlated with placental insuffiency. Variable decelerations are usually seen when the cord is being compressed. One nursing intervention that the nurse performed was changing the patient's position in bed from supine to lying on her side. Another intervention was giving lactated ringers solution. The patient did benefit from the interventions. There was a reduction in

	late decelerations.
Describe the contractions: **Frequency:** **Length:** **Strength:** **Patient's Response:**	The contractions are occurring in a regular pattern. They are occurring every 2 to 3.5 minutes They are lasting 70 to 100 seconds. Moderate strength. The patient has an epidural and is handling the pressure well. She states that she feels uncomfortable, but the pain is very manageable with the epidural.

EFM reference (1) (APA format):

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

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

Home Medications (2 required)

Brand/Generic	**Proair HFA/ albuterol sulfate**	**Flovent HFA/ fluticasone**			
Dose	90 mcg	110 mcg			
Frequency	2 puffs every 4 hours prn	2 puffs every day			
Route	Inhalation aerosol	Inhalation aerosol			
Classification	Bronchodilator	Antiasthmatic, anti-inflammatory			
Mechanism of Action	Relaxes the muscles of the bronchus and inhibits the release of histamine by binding with receptors on the cell membrane.	Inhibits many cells that are responsible for the inflammatory response of asthma such as WBCs, histamines, and cytokines.			
Reason Client Taking	To treat bronchospasms due to an obstructed airway.	To prevent asthma attacks.			
Contraindications (2)	Hypersensitivity to albuterol.	Untreated nasal mucus infection. Hypersensitivity to fluticasone or milk protein.			
Side Effects/Adverse Reactions (2)	Altered taste. Pulmonary edema.	Agitation. Insomnia.			
Nursing Considerations (2)	Assess patients that have diabetes, hypertension, cardiac	Monitor and use cautiously in patients that have a bacterial or viral			

	disorders, or seizures because albuterol can make these conditions worse. Awareness that tolerance can develop.	infection. Monitor patient closely when starting this medication especially with a milk protein allergy.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor potassium levels because albuterol can cause hypokalemia. Vital signs and respiratory status should be assessed frequently.	A CBC should be done to rule out any underlying infection. Respiratory status should be monitored closely.			
Client Teaching needs (2)	Instruct patient to wash the inhaler mouthpiece once a week. Advise not to take more than the prescribed dose because it can become less effective.	Get a refill of the medication when the counter says 020. Dispose of the inhaler when the counter reads 000. When starting this medication, the patient should start noticing relief after two days, but it may take up to two weeks for full effect.			

Hospital Medications (5 required)

Brand/Generic	**Tylenol/ acetaminophen**	**Zofran/ ondansetron**	**Pepcid/ famotidine**	**Ambien/ zolpidem**	**Lazanda/ fentanyl**
Dose	500 mg	4 mg	20 mg	5 mg	50 mcg
Frequency	Every 4 hours prn	Daily prn	Every 12 hours prn	Once at bedtime prn	Every 2 hours as needed
Route	Oral	IV	Oral	Oral	IV
Classification	Antipyretic, nonopioid analgesic	Antiemetic	Antiulcer agent, gastric acid secretion inhibitor	Antianxiety, sedative hypnotic	Analgesic, anesthesia adjunct
Mechanism of Action	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the PNS.	Blocks the small intestine from releasing serotonin and blocks serotonin receptors. This blocks signals to the CNS.	Reduces the hydrochloric acid formation in the stomach by binding with receptors of partial cells that help produce HCL.	Binds with benzodiazepine receptors in the CNS which blocks GABA, cortical and limbic arousal, and increases deep sleep.	Binds to the opioid receptors in the CNS which alters the perception of pain.
Reason Client Taking	To relieve moderate pain.	To relieve nausea and vomiting.	To treat heartburn.	To help with sleep.	To manage and relieve pain.
Contraindications (2)	Severe hepatic impairment. Severe active liver disease.	Congenital long QT syndrome. Hypersensitivity to ondansetron.	Hypersensitivy to famotidine. Hypersensitivity to other H2 receptor medications.	Hypersensitivity to zolpidem. Severe hepatic impairment.	Significant respiratory depression/ asthma. Myasthenia gravis.
Side Effects/Adverse Reactions (2)	Hypotension. Muscle spasms.	Bronchospasm. Diarrhea.	Elevated liver enzymes. Anxiety.	Abnormal thinking. Elevated liver enzymes.	Drowsiness. Paranoia.

Nursing Considerations (2)	Use acetaminophen cautiously in patients with hepatic disease and chronic alcoholism. Make sure that no more than 4,000 mg is given in a 24-hour period.	Monitor patient closely for signs of hypersensitivity. Monitor patient closely for serotonin syndrome (chills, confusion, diaphoresis, fever, restlessness).	Notify physician if patient develops pain or trouble swallowing. Use the correct route for the medication. The medication may come in a disintegrating, chewable, regular, or oral suspension.	Use cautiously in patients that have respiratory impairment. Give to patient right before they plan to go to sleep.	Use cautiously in patients with respiratory issues, as fentanyl may decrease the respiratory drive. The lowest dose possible should be given.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess vitals including temperature. Monitor liver function tests such as ALT, AST, bilirubin, and creatinine levels. Monitor renal function and urine. Blood or albumin in urine may indicate nephritis.	Vitals and respiratory rate should be checked before administration. Magnesium and potassium levels should also be checked because a deficiency could cause a heart dysthymia while taking this medication.	Ask patient if they are having heartburn symptoms. Assess level of consciousness and vital signs prior to administration.	Assess vitals, especially respirations. Assess lab values and liver enzymes. Assess for suicidal thoughts, this medication can increase suicidal thoughts in people with depression.	Vital signs should be assessed especially respirations and heart rate. Assess pain.
Client Teaching needs (2)	While taking Tylenol, caution patients when using over the counter medications to check if they contain acetaminophen. Teach patient to recognize signs of hepatotoxicity such as bleeding, easy bruising, and	Instruct client to report a rash or other adverse effects immediately. Tell the patient that this medication can cause transient blindness.	Instruct patient to wait 30 to 60 minutes after taking famotidine before using an antacid. Instruct patient not to use alcohol or smoke while taking this medication because the interaction can irritate the	Instruct patient to call for help if they experience cramps, flushing, light-headedness, or discomfort. Do not break, chew, or crush extended-release tablet.	Instruct patient to increase fiber as medication can cause constipation. Advise patient to avoid hazardous activities while taking this medication.

	malaise.		stomach and cause ulcers.		

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2019). *2019 Nurse's drug handbook* (18th Ed.).

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Alert x3, awake Oriented to person, place, and time. Doesn't appear to be in distress. She is having pain with contractions and appears uncomfortable. Clean, well groomed.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** 23 **Drains present: Y☐ N ☒** **Type:**	 Skin color appropriate for age and race. Appropriate character. Warm to the touch. Intact. Good skin turgor. No rashes, lesions, or bruises.
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Head normocephalic. Trachea midline. No lymphadenopathy noted. Hearing intact. Eyes clear, no discharge. Good dentition. .
CARDIOVASCULAR (1 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:**	.S1, S2 sounds present. No murmurs. Normal sinus rhythm. Pedal pulses 2+ Capillary refill < 3 seconds No neck vein distention. Slight non-pitting edema in ankles bilaterally.

Neck Vein Distention: Y ☐ N ☒ **Edema Y ☒ N ☐** **Location of Edema:**	
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Strong lung sounds. No wheezing, crackles, or rales. No shortness of breath. No assistive oxygen devices. 100% O2 saturation on room air.
GASTROINTESTINAL (5 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	Patient on full diet. No restrictions. Height: 5'3" Weight: 91.6 kg Bowel sounds present in all four quadrants. Patient stated she had diarrhea on Wednesday 6/9. No bowel movement since. Abdomen hard. No drains or wounds present. No scars.
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** Foley Catheter **Size:** 16 French **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Episiotomy/Lacerations:**	Urine clear, yellow. 250mL output. Foley placed on 6/11 at 1600 No pain with urination. Genitals inspected; no abnormalities noted. 16 Fr foley catheter Membranes not ruptured at time of assessment
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** 2 **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	Patient has appropriate mobility for age. Did not require assistance to get out of bed. Fall score 2 Remaining in bed after epidural. Is still able to turn herself with moderate assistance moving her legs.

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:**	Moves all extremities well. Appropriate range of motion in all four extremities. Equal strength throughout. Oriented to person, place, and time. Appropriate speech. No sensory impairments. No loss of consciousness. Deep tendon reflexes present.
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):**	Patient stated she had a great support system. Her husband was present. She also mentioned that her mother and their family members are excited to help when they get home with the baby. High developmental level. Works as a nurse.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	Infant not delivered at time of clinical.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	123	128/84	N/A	N/A	N/A
Admission to Labor/Delivery	109	133/83	18	98.3	100%
During your care	92	129/78	14	Not taken while at clinical	100%

Vital Sign Trends:

The vital signs were stable throughout the afternoon. Her systolic blood pressure was slightly elevated, but this is not a major concern. The staff will continue to keep monitoring it to make sure the systolic pressure doesn't reach 140 or above. The patient had excellent oxygen saturation on room air.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1630	Numeric 0-10	Back, pelvis	Rated at 5	Intermittent with contractions	Epidural consented for and completed.
1730	Numeric 0-10	Back, stated just feels uncomfortable	Rated at a 2	Intermittent	Rolled over to side/repositioned.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	18 gauge
Location of IV:	Left hand
Date on IV:	6/10/21
Patency of IV:	Patent
Signs of erythema, drainage, etc.:	No erythema or drainage.
IV dressing assessment:	Dressing clean, dry, and intact.
	Lactated ringer running at 125 ml/hour

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Not documented at time of clinical	250 mL urine

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.
Encourage and help the patient move into different positions while in bed. (N)	Every 30 to 45 minutes to the nurses helped and suggested the patient roll on to the side or sit up.	This nursing intervention is helpful to promote comfort. The patient had an epidural, therefor she wasn't able to walk or sit on the ball. Turning the mother also helped improve some of the late decelerations in the fetal heart rate.
Establish and maintain IV access. (T)	IV access was established, and lactated ringer solution was running at 125 mL/ hour.	This intervention is important to deliver scheduled medications as well as to have a means to quickly deliver emergency medication if needed. Providing the patient with fluid is also important to prevent dehydration and hypotension.
Keep patient's room quiet and calm. (N)	The staff frequently checked on the patient but avoided any unnecessary interruptions or distractions.	This intervention is important because it allows the patient to rest and conserve energy before the delivery.

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) Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	Rationale (1 pt each) Explain why the nursing diagnosis was chosen	Intervention/Rationale(2 per dx) (1 pt each) Interventions should be specific and individualized for this patient. Be sure to include a time interval such as "Assess vital signs q 12 hours." List a rationale for each intervention and using APA format, cite the source for your rationale.	Evaluation (2 pts each) • How did the patient/ family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for	This diagnosis	**1.**Establish and maintain IV	The patient responded

	dehydration related to decreased oral intake and diaphoresis as evidence by patient experiencing labor.	was chosen because dehydration during labor can endanger the mother and baby.	access with lactated ringer's solution running at 125 mL/ hour. **Rationale** IV access and fluid is the best way monitor intake (Swearingen & Wright, 2019). **2.**Provide the patient with ice chips. **Rationale** Providing the patient with ice chips allows her to wet her dry mouth, without consuming large amounts of fluid before delivery.	well to receiving IV fluids . She wanted and accepted a small amount of ice chips and was content.
2.	Risk for caregiver burden related parenthood as evidence by first-time parents.	Caregiver burden can occur for parents raising a new baby.	**1.** Educate the patient that feeling overwhelmed is a normal feeling. Encourage the caregivers to discuss their feelings and concerns about new fears and responsibilities. **Rationale** Discussing feelings and concerns helps the caregivers to identify realistic expectations (Swearingen & Wright, 2019). **2.**Educate parents to identify tasks that would be beneficial for outside help. **Rationale** Having a list of activities and family willing to help can decrease caregiver burnout. It also confirms that the caregivers know it is okay to ask for help.	The patient and her husband are first time parents and were openly discussing how different their lives will be after having a child. They seem to have good communication. The patient and her husband stated that there are four sets of grandparents that are wanting to spend time with the infant and help the family in any way they need.
3.	Need for health teaching related to skin integrity as evidence by	Perineal wounds are a normal part of childbirth, however there are signs and	**1.** Educate signs and symptoms of an infection such as a fever, chills, odor, and wound dehiscence (Swearingen & Wright, 2019).	The patient is a nurse and understands the signs and symptoms of infection.

postpartum wounds.	symptoms to look out for.	**Rationale** If an infection should occur, it is essential that the patient seek medical help right away. **2.** Educate the patient and her husband that intercourse is not recommended while birth wounds are healing (Swearingen & Wright, 2019). **Rationale** During the first six weeks postpartum the cervix is closing, lochia is stopping, and tears are healing. Intercourse could delay healing.	Avoiding intercourse was not discussed but I feel the patient will be open to advise about promoting wound healing without complications.
4. Risk for acute pain related to labor as evidence by cervical dilation, contractions, and stretching of tissue.	Acute pain was chosen because labor is painful and having a plan and open communication about the pain can help manage it.	**1.** Assess for nonverbal and verbal cues of pain. **Rationale** It is essential to develop good communication with the patient about the pain they are feeling. It is also important for the nurse to assess nonverbal cues such as moaning (Swearingen & Wright, 2019). The nurse could use relaxation techniques to help decrease pain for the patient. **2.** Medicate with prescribed medication. **Rationale** Pain medication not only helps relieve pain but allows the woman to rest.	The patient was able to communicate with the staff about her pain level. She communicated that she understood that not all the pain could be taken away but agreed that it was at a manageable level. The medication given through the epidural decreased the patients pain level.

Other References (APA)

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