N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 07/15/21 @0846	**Patient Initials** LT	**Age** 33 y/o	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Teacher	**Marital Status** Married	**Allergies** NKA
Code Status Full	Height 160 cm (5'3")	Weight 82.5kg (181kg 12.8oz)	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: Primigravida, G1P0T0L0.

Past Medical History: Anxiety, eczema, HSV-1 (herpes simplex virus 1) infection, ovarian cyst, pyelonephritis, and urinary tract infection (UTI).

Past Surgical History: Wisdom teeth extraction and breast biopsy.

Family History: Father had prostate cancer and Parkinson's (deceased). Maternal aunt had breast cancer.

Social History (tobacco/alcohol/drugs): Patient is a former smoker 0.75 packs/day of cigarettes for five years, she quit 01/18/15. Denies use of alcohol or drugs.

Living Situation: Patient lives with her husband.

Education Level: Bachelor's degree.

Admission Assessment

Chief Complaint (2 points): Scheduled induction

Presentation to Labor & Delivery (10 points):

This is a 33-year-old patient that presented to the hospital for her scheduled induction. She is at 40 weeks and 6 days of gestation and patient is a primigravida. During the night of her stay before she could be induced, she had a spontaneous rupture of membranes. When they checked

her cervix, she was dilated 1 cm. Patient was placed on a monitor and her vital signs showed: pulse 82, BP 120/72, RR 18, temp 98.4, and O2 100%. Patient started feeling contractions around 1215 and rated her pain 3/10 but denied pain medication at that time. Patient is G1P0T0L0. She is a primigravida.

Diagnosis

Primary Diagnosis on Admission (2 points): Scheduled induction

Secondary Diagnosis (if applicable): Spontaneous rupture of membranes at 1 am.

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 exists when the contractions help the cervix thin and begin to open, this is called effacement and dilation. During this stage, the cervix will open to 10 cm, and the first stage of labor can last about 12 to 13 hours for the first child (Ricci et al., 2021). There are three subsets of the first stage of labor: early labor, active labor, and the transition to the second stage (Ricci et al., 2021). During early labor, most of the time is spent at home. Active labor is when it is time to go to the hospital, and contractions will occur every 3 to 4 minutes (Ricci et al., 2021). The transition to the second stage is when the cervix opens from 7 to 10 cm and can be the most complicated, most painful part of labor (Ricci et al., 2021). The patient LT was in the first stage of labor because she was only 1 cm dilated, and the cervix was starting to open. Epidurals are given at this stage and this patient requested one to relieve her pain.

The second stage of labor occurs when the cervix is completely dilated and ends with the baby's birth (Ricci et al., 2021). The contractions push the baby down towards the birth canal, causing significant pressure. The patient should start pushing with the start of each contraction.

The end of the first stage of labor is when the pushing phase starts of the second stage of labor (Greene, 2019).

The third stage of labor is after the birth of the baby. This is when the uterus continues to contract, and the placenta is pushed out (Ricci et al., 2021). The placenta usually delivers about 5-15 minutes after the baby arrives. The third stage of labor is the quickest. After the baby is born, the umbilical cord is cut after waiting for several minutes for the pulsations to stop (Greene, 2019). All women lose some blood after delivery when the placenta is pushed out (Greene, 2019). The provider checks to ensure all pieces of the placenta are intact, and there are no remaining fragments inside the uterus (Greene, 2019). After delivery of the placenta, the nurse or provider will massage the fundus to determine location and firmness. Medication is sometimes given to keep the uterus contracted (Greene, 2019).

Lastly, the fourth stage of labor is the hour or two after delivery, and the tone of the uterus is reestablished as the uterus contracts again (Ricci et al., 2021). The contractions are promoted with breastfeeding, which stimulates the production of oxytocin (Ricci et al., 2021). This is also the time of rest and recovery (Ricci et al., 2021). The baby starts breastfeeding, the mother is fatigued, and there is much skin-to-skin time (Ricci et al., 2021).

Stage of Labor References (2) (APA):

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

Greene, J. (2019, January 3). *The four stages of labor*. The Four Stages of Labor | Kaiser Permanente Washington. https://wa.kaiserpermanente.org/healthAndWellness/index.jhtml?item=%2Fcommon%2FhealthAndWellness%2Fpregnancy%2Fbirth%2FlaborStages.html.

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	3.50-5.20	3.73	3.85	3.85	N/A
Hgb	11-16	12.0	12.4	12.4	N/A
Hct	34-47	35.4	36.0	36.0	N/A
Platelets	140-400	262	206	206	N/A
WBC	4-11	10.89	13.12	13.12	Can be elevated to due physiologic stress during labor and inflammation (Ricci et al., 2021).
Neutrophils	1.5-8	N/A	N/A	N/A	N/A
Lymphocytes	1-49	N/A	16.4	16.4	N/A
Monocytes	2-8	N/A	5.9	5.9	N/A
Eosinophils	0-5	N/A	1.0	1.0	N/A
Bands	0-5	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, AB, B, O	O	O	O	N/A
Rh Factor	+/-	+	+	+	N/A
Serology (RPR/VDRL)	Nonreactive	Nonreactive	N/A	N/A	N/A
Rubella Titer	>1.0	17.30	N/A	N/A	N/A
HIV	Negative	Negative	N/A	N/A	N/A
HbSAG	Nonreactive	Nonreactive	N/A	N/A	N/A
Group Beta Strep Swab	Negative	Negative	N/A	N/A	N/A
Glucose at 28 Weeks	<140	113	N/A	N/A	N/A

MSAFP (If Applicable)	0.5-5.0	N/A	N/A	N/A	N/A

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

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
N/A					

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)	0.60-1.80	N/A	N/A	N/A	Not drawn

Lab Reference (1) (APA):

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

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	135
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?**	There are accelerations that go up for 15 seconds and last for 30 seconds. There is 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?**	Patient has late and variable decelerations. The intervention performed was turning the patient on her side and benefited the fetus.
Describe the contractions: **Frequency:** **Length:** **Strength:** **Patient's Response:**	Contractions were 2-3 minutes apart and lasted for 60-120 seconds. Patient states she can feel her contractions and rates them a 3/10 on the pain scale and is moaning and grimacing from the pain every time they occur. Contractions are being monitored with an external device so strength can only be measured by palpation. Strength is

	undetermined.

EFM reference (1) (APA format):

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing (3rd ed.).* Philadelphia, PA: 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	Acyclovir (Sitavig)	Prenatal Vitamin
Dose	200mg	27mg
Frequency	TID	Daily
Route	PO	PO
Classification	Antiretroviral	Vitamin
Mechanism of Action	Inhibition of DNA polymerase, premature termination of DNA synthesis and thymidine kinase specificity. These actions combine to inhibit herpes virus replication.	Provides patient body with necessary vitamins and minerals to support fetal and maternal needs.

Reason Client Taking	Herpes simplex virus. To prevent lesions from opening during birth.	Prenatal
Contraindications (2)	Hypersensitivity to acyclovir and renal impairment.	Hyperparathyroidism and Hypercalcemia
Side Effects/Adverse Reactions (2)	Acute renal failure and leukopenia.	Stomach cramping and constipation
Nursing Considerations (2)	Use caution when administering to patients with existing renal diseases because of increased risk of renal impairment. Ensure patient is adequately hydrated before drug is given.	Make sure patient has been taking vitamins during prenatal visits. Well-balanced diet.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Once dilated for administration, each dose should be used within 24 hours. Administer IV form only as infusion over 1 hour.	Check calcium levels. Check iron levels.
Client Teaching needs (2)	Inform that it does not cure herpes. Stress importance of maintaining hydration.	Take daily to ensure necessary vitamins are obtained during pregnancy. Avoid other OTC medications.

Hospital Medications (5 required)

Brand/Generic	Lactated Ringers	Oxytocin (Pitocin)	Ropivacaine (Naropin)	Promethazine injection (Phenergan)	Fentanyl Citrate (Fentora)
Dose	125 ml/hr	30 units in LR 500 ml	24 mg/hr	12.5 mg	50 mcg

Frequency	Continuous	Continuous	Continuous	Q4h PRN	Q2h PRN
Route	IV	IV	IVPB	IV	IV
Classification	Alkalinizing agent	Oxytocic	Amide local anesthesia.	Antiemetic, antihistamine, antivertigo, sedative-hypnotic.	Opioid analgesic
Mechanism of Action	Replaces lost fluids and electrolytes during labor	Increases concentration of calcium inside muscle cells to increase uterine contraction.	Causes reversible inhibition of sodium ion influx, and therapy blocks impulse conduction at nerve fibers.	Competes with histamine for H1 receptor sites, thereby antagonizing many histamine effects and reducing allergy signs and symptoms. Prevents motion sickness, nausea, and vertigo by acting centrally on medullary chemoreceptive trigger zone and by decreasing vestibular stimulation in the inner ear. Promotes sedation and relieves anxiety by blocking receptor sites in CNS, directly reducing	Binds to opioid receptor sites in the CNS, altering perception of and emotional response to pain by inhibiting ascending pain pathway.

				stimuli in the brain.	
Reason Client Taking	Hydration during labor and fluid replacement.	Induction of labor.	Pain relief	Nausea	To relieve severe pain due to no response to less potent drugs.
Contraindications (2)	Renal failure and CHF.	Fetal intolerance and placenta previa.	Infection or inflammation at injection site.	Glaucoma and hypertensive crisis.	Hypersensitivity to fentanyl. Opioid nontolerance. Intermittent pain.
Side Effects/Adverse Reactions (2)	Hyperkalemia and hypercalcemia.	Weight gain and hirsutism.	Nausea or vomiting.	Seizures and bradycardia.	Seizures, asystole, bradycardia, hypotension, and apnea.
Nursing Considerations (2)	Administer prior to delivery. Monitor IV site for infiltration.	Check 2h glucose. Monitor weight.	Monitor for signs of metabolic acidosis. Monitor cardiovascular and respiratory status closely.	Give IV injection at no more than 25 mg/min. Monitor respiratory function.	Use cautiously in patients at risk for opioid abuse. Know to achieve optimum pain control with the lowest possible fentanyl dose.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Electrolytes and vital signs.	Monitor electrolytes and blood pressure.	Before administration get a baseline blood pressure and heart rate.	Monitor hematologic status. Monitor blood pressure and heart rate.	Monitor heart rate. Monitor BP.
Client Teaching needs (2)	Let client know why they need LR. Let them know that	Inform client of why she is receiving it. Notify that	Inform patient that this drug is used to ease pain. Inform	Advise patient to avoid taking any OTC drugs. Notify provider if	Caution patient to avoid hazardous activities. Tell patient to

	this is a medication that will only be administered while in hospital.	the medication is not harmful to fetus.	them that they may experience a headache, nausea, or vomiting.	experiencing involuntary movements and restlessness.	increase fluid intake.

Medications Reference (1) (APA):

Loebl, S. (2020). *2020 Nurse's drug handbook*. Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented x3. Appears distressed due to being uncomfortable from feeling of pressure. Overall appearance was clean except for unwashed hair.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒**	 Skin color is usual for ethnicity. Skin is dry and intact. Temperature is normal on upper and lower extremities. Skin turgor is normal. Braden score is 20. No wounds or rashes upon inspection. Patient does not have catheter placed by the time the student left the floor.

Type:	
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is symmetrical to skull and face. Neck has structure, movement, and nonpalpable lymph nodes. Patient can see and hear without aids. Teeth are intact and dentition is good. Nose is patent and free of polyps or bleeding. .
CARDIOVASCULAR (1 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	. Clear S1 and S2 were heard, no adventitious sounds. Pulses were 3+ normal. Capillary refill was less than 3 seconds. No edema or neck vein distention.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations are regular and nonlabored. Respiratory pattern is regular. Breath sounds are clear.
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 was on a regular diet at home and is currently NPO but can still have ice chips and sips of water when taking medications. Height is 160 cm. Weight is 82.5 kg. Bowel sounds are normoactive in all four quadrants. Last bowel movement was 07/15/21. Abdomen shape is round due to pregnancy, no abnormal distention. Normal obstetric abdominal assessment overall. No drains, wounds or scars. No incisions, scars, or wounds seen.
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **Rupture of Membranes:**	Patient has no bleeding. Genitals are normal. Urine is clear and yellow, no odor, no episiotomy/lacerations. No catheter. Patient had SROM @ 0100. The fluid was clear with moderate amount and no odor.

Time: **Color:** **Amount:** **Odor:** **Episiotomy/Lacerations:**	
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	. The patient can perform her own ADLs. She is not a fall risk with a fall score of 0. She can ambulate independently and does not need assistance.
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:**	. Oriented to person, place, time, and situation. Normal cognition with ability to follow commands. Memory intact when having discussion. Speech is clear. Level of consciousness is alert, awake and answers questions appropriately. DTR are 3+
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):**	. The patient has a history of anxiety. Her religion was not determined. She relies on her husband for emotional support and coping mechanisms. Currently coping well. She lives with her husband who is her family support.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	Baby not delivered yet.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	76	114/72	18	98.6	100 % RA
Admission to Labor/Delivery	82	120/72	18	98.4	100 % RA
During your care	79	128/58	18	98.3	100% RA

Vital Sign Trends:

Patient vital signs are within the expected ranges. BP ranges from 114/72-128/58, RR remains at 18, pulse ranges from 76-82, temperature ranges from 98.3-98.6, and O2 remains at 100% on room air (RA).

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1215	Numeric	Abdomen	3/10	Contraction	Patient denies medication at this time.
1600	Numeric	Abdomen	6/10	Contraction	Patient received an epidural.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:**	18 gauge Anterior left lower forearm. Placed on 07/15/21. Flushes without difficulty and has continuous

Signs of erythema, drainage, etc.: **IV dressing assessment:**	LR running. No signs or erythema or drainage. IV has transparent dressing and tape.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
205 IV	600 ml

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.**
Epidural	Once	This was requested by patient for pain relief. Patient refused cervical check before epidural was given, therefore, her dilation is unknown currently.
Repositioning	PRN	Patient was repositioned whenever her baby was having decelerations and to ensure her comfort.
EFM Monitoring	Continuous	The mother and baby were on continuous monitoring so that their condition can be monitored and ensure everything is normal.

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 (2 pts each)**
Identify problems that are specific to	Explain why the nursing	Interventions should be specific and individualized	• How did the patient/ family respond to

this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	diagnosis was chosen	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.	the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related contractions as evidence by progression of labor.	Patient is getting closer to delivery and her contractions are becoming stronger.	**1.**Assess degree of discomfort through verbal and nonverbal cues. **Rationale:** Attitudes and reactions to pain are individual and based on past experiences (Martin, 2021). **2.**Record the time, frequency, intensity, and duration of contractions. **Rationale:** This helps to monitor labor progress and provide information to the client (Martin, 2021).	Patient identifies and uses techniques to control pain and discomfort such as breathing exercises. Patient knows when to report when discomfort is minimized. After epidural patient is relaxed and rested between contractions. Husband is assisting in comforting her.
2. Risk for maternal injury related to epidural as evidence by getting stuck with a needle over 10 times.	Patient requested an epidural, and it took many tries before they were able to get it in the correct spacing in the spinal cavity.	**1.** Monitor temperature and pulse. **Rationale:** Increased temperature and pulse are indicators of infection (Martin, 2021). **2.**Assess for signs of headache. **Rationale:** Patient can develop a spinal headache due to how many times they were in the spinal cavity (Team, 2019).	Patient verbalizes understanding of individual risk and reasons for specific interventions. Patient follows directions to protect herself and fetus from injury. Patient is free of injury and complications.
3. Knowledge deficit related to epidural catheter as evidence by thinking it was for urine.	Patient thought all catheters were for urine and asked how she is going to urinate through her epidural catheter.	**1.** Assess patient baseline knowledge and expectations during pregnancy. **Rationale:** This can help guide in establishing learning needs and set priorities (Martin, 2021). **2.** Provide information about procedures. **Rationale:** Education can facilitate maintaining control during labor, and	Patient verbalizes understanding of the procedure of an epidural. Patient participates in the decision-making process.

		reduce anxiety (Martin, 2021).	
4. Knowledge deficit related to breastfeeding as evidence by primigravida.	Patient is a first-time mother so she will need information on the proper techniques of breastfeeding.	**1.** Assess patient knowledge of breastfeeding. **Rationale:** Support and teaching must be individualized to the client's level of understanding (Martin, 2021). **2.** Educate mother and husband about breastfeeding techniques to improve chance of success. **Rationale:** Correct positioning and getting the infant to latch on is critical for breastfeeding to get off to a good start and contributes to breastfeeding success (Martin, 2021).	Patient will promote successful latching on through correct positioning. The patient will successfully feed the infant.

Other References (APA)

Martin, P. (2021, June 11). *Nursing Guides, Care Plans, NCLEX Practice Questions*. Nurseslabs. https://nurseslabs.com/.

Team, N. S. P. C. (2019, September 25). *Spinal Headaches: What Are the Symptoms and Is There a Gold Standard of Treatment?* https://www.treatingpain.com/. https://www.treatingpain.com/news-updates/2019/may/spinal-headaches-what-are-the-symptoms-and-is-th/.