N432 Labor & Delivery Care Plan

Lakeview College of Nursing

Name: Christine Nlandu

Demographics (3 points)

Date & Time of Admission 09/20/21	Patient Initials EW	Age 26	Gender F
Race/Ethnicity White	Occupation Accounting	Marital Status M	Allergies No known allergy
Code Status Full code	Height 5'2"	Weight 152 lbs.	Father of Baby Involved The husband is involved and was helping during delivery at the bedside.

Medical History (5 Points)

Prenatal History: G2T1PAL1. This was her second pregnancy. The client did not have any previous complications but had excesses of amniotic fluid for the current pregnancy and edema that resolved a couple of weeks before labor.

Past Medical History: The past medical history includes asthma, postpartum depression, abnormal pap smear of the cervix, anemia, breast disorder, complication of anesthesia, diabetes mellitus, genital herps, heart diseases, infertility, immunodeficiency virus, hypertension, isoimmunization from blood group incompatibility in pregnancy, kidney disease, liver disease, mental disorder, seizure, sickle cell disease, systemic lupus, erythema, and thyroid disorder.

Past Surgical History: Cesarean

Family History: The client's family has a history of alcohol abuse, starting from paternal grandparents and the father. A history of blood pressure for paternal and maternal grandparents and both parents.

Social History (tobacco/alcohol/drugs): The patient has had a history of marijuana for three years, never used alcohol or drug.

Living Situation: The patient lives with her husband, a son 2 and a half, and a dog.

Education Level: High school degree.

Admission Assessment

Chief Complaint (2 points): Contraction

Presentation to Labor & Delivery (10 points): On September 20, a white, married female presented to the hospital with her husband due to contractions that started two weeks ago. The women stated that contractions were constant and decided to come to the hospital for induction. After her admission to the labor and delivery, the woman was required to sign an informed consent. EW was 39 weeks and 1 day, and the estimated due date should be September 26. When she arrived, her pain was 5 on a scale of 0 to 10, pulse 89, temperature 98.2, respiration rate 16, and blood pressure 111/65. She was placed on external fetal monitoring, and her fetal heartbeat was stable at 145 to 150 per minute. The nurse initiated an intravenous site and lactated ringer solution. The epidural was given when she was at 7.90 cm. Meconium was stained in fluid, and the baby was virginally delivered at 6:46 pm the same day and was fine. The woman had a first-degree laceration with a normal placenta.

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:

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

The first stage of labor starts from 0 to 10 cm of cervix dilation and 100% effacement. The first stage has three different phases, including the latent phase, active phase, and transitional phase. The client was admitted at 6:45am. The effacement was 40% and dilation -3, with mild contraction. At 11:35 am the effacement was 40% and dilation -0. The effacement was at 40% during clinical, and dilation progressed to 2.6 cm, with moderate contraction, which indicates the latent phase (Ricci et al., 2017). The contractions frequency occurs every one to two min and last 30 to 45 second. The woman described her contraction as the menstrual period. During this stage, nurses initiate intravenous with lactated ringer solution, were assessing vital signs, vaginal examination, monitoring fetal heart rate, management of pain using the birth ball and breathing techniques (Breman & Neerland, 2020).

The amniotic membrane was artificially ruptured at the end of the latent phase with meconium-stained fluid and moderate amount. This stage lasts about 8 hours. During the active phase, the cervix dilation was 7.0 cm, and effacement was 80% at 3:39 pm. Contraction frequency was 1 to 2 min, and duration was 50 to 60 seconds. The epidural was performed at 15:12pm and urethral catheter at 15:20pm. The client stated that she did not have any pain, and the stage lasted about one hour. Epidural helped the client to relax and progress quickly to the transitional phase after one hour. At 4:30 complete effacement and dilation was 10 cm. The frequency of contractions was every min, and the duration was 60 to 90 second. This stage lasted less than 30 minutes, and the client tolerated the procedure (Ricci et al., 2017).

The second stage is from complete cervix dilation to the birth of the newborn. The patient had uterine contractions every minute, and the duration was 60-90 seconds. Nurses quickly prepared all materials needed for the care of the mother and baby. They helped the client by giving positive feedback, monitoring mother status, fetus, vital signs, breathing techniques, encourage pushing, have the client rest between contractions, and helped with the position. The baby was out at 6:46pm, and the stage took 16 minutes (Ricci et al., 2017). The baby was handed to her mother right away. Oxytocin was given after the baby was out to facilitate the delivery of the placenta during the third stage. The placenta was out about 5 minutes. She had a perineal laceration first-degree. Then during the fourth stage mother's body starts to adjust maternal physiologic function (Ricci et al., 2017). Clinical data correlated to a single client birth with vertex position is safe using induction at 39 weeks because it has low risk than the expected due date (Breman & Neerland, 2020).

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

Breman, R. B., & Neerland, C. (2020). Nursing support during latent phase labor: A scoping review. *MCN, American Journal of Maternal Child Nursing, 45,* 197-207. https://doi.org/10.1097/NMC.0000000000000626

Ricci, S.S., Kyle, T., & Carman, S. (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	3.80-5.30 10^6mcl	3.99	3.99	4.12	N/A
Hgb	12.0-15.8 g/dL	12.0	12.0	12.2	N/A
Hct	36.0-47.0 %	35.7	35.7	36.6	It decreases during anemia, iron deficiency, fluid retention, renal failure, chronic diseases, and recent hemorrhage. The client has a history of anemia and may be due to pregnancy, increasing demand to meet the fetal needs (Hinkle & Cheever, 2018)
Platelets	140-440 10^3 mcl	257	257	261	N/A
WBC	4.00-11.00 10^3 mcl	10.20	10.20	9.00	N/A
Neutrophils	47.0-73.0 %	75.7	75.7	69.6	Neutrophil are elevated during inflammation, infection, leukopenia, stress, and steroid usage. Client is under stress due to labor may also have an inflammatory process (Hinkle & Cheever, 2018)
Lymphocytes	18.0-42.0 %	16.6	16.6	21.8	Lymphocytes decrease in immunosuppression, HIV/AIDS, and bone marrow suppression. The client has a history of auto-immune diseases like lupus erythema (Hinkle & Cheever, 2018).
Monocytes	4.0-12.0%	7.1	7.1	7.0	N/A
Eosinophils	0.0-5 %	0.4	0.4	1.1	N/A
Bands	0.0-0.3.0%	0.00	0.00	0.00	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, O, AB	O+	O+	O+	N/A
Rh Factor	Positive negative	Positive	Positive	Positive	N/A
Serology (RPR/VDRL)	negative	negative	negative	negative	N/A
Rubella Titer	Immune	Immune	Immune	Immune	N/A
HIV	negative	negative	negative	negative	N/A
HbSAG	negative	negative	negative	negative	N/A
Group Beta Strep Swab	negative	negative	negative	negative	N/A
Glucose at 28 Weeks	140	65-140 Mg/dl	65-140 Mg/dl	65-140 Mg/dl	N/A This is a 1 hours post prandial.
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
Sars-Covid-2	Not detected	Not detected	Not detected	Not detected	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):

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer.

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH? **Has it changed during your clinical day? If yes, how has it changed?**	**The based of EFHM is the heartbeat at a normal range of 110 to 160 beat/min (Ricci et al., 2021). The baby base line was 145 to 150. They were no abnormal changes.**

Are there accelerations? • **If so, describe them and explain what these mean (for example: how high do they go and how long do they last?)** **What is the variability?**	**The heartbeats were very consistent and did not have any accelerations during clinical.**
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?**	**From the time we first meet the client until baby was born, there were no deceleration. The heartbeat stayed within normal limit.**
Describe the contractions at the beginning of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	**The contractions frequency occurs every one to two min and last 60 to 70 second. Strength: moderate when looking at nonverbal cues. The woman described her contraction as the menstrual period, and she had facial grimacing.**
Describe the contractions at the end of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	**The patient had uterine contractions every minute, and the duration was 60 to 90 seconds. The patient was under epidural influence and did not have a lot of pain. She cried during pushing but it was moderate.**

EFM reference (1 required) (APA format):

Ricci, S.S., Kyle, T., & Carman, S. (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	**Acetaminophen/ Tylenol (Jones & Bartlett, 2020).**	**Prenatal Vitamin/ Fumarate/ ferrous fumarate (Jones & Bartlett, 2020).**			
Dose	**500 mg**	**27.08 Mg tab**			
Frequency	**Every 6 hours PRN**	**Once a day**			
Route	**oral**	**oral**			
Classification	**Antipyretic, non-opioid.**	**Vitamin and iron supplement**			
Mechanism of Action	**Inhibits the enzyme cyclooxygenase. Blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of**	**Provides pregnant body with necessary vitamins and iron to support fetal and maternal needs.**			

	prostaglandin E2.				
Reason Client Taking	**The patient might have pain related to pregnancy, such as back pain.**	**Prenatal care to prevent nutritional deficiency. It also treats and prevents low blood levels of iron**			
Contraindications (2)	**Hypersensitivity to acetaminophen & Severe liver disease**	**Hypersensitivity to any ingredient. Iron therapy is contraindicated in patients with hemolytic anemia.**			
Side Effects/Adverse Reactions (2)	**Damage liver & Thrombocytopenia.**	**Stomach cramping & constipation**			
Nursing Considerations (2)	**Use cautiously in patient with hepatic impairment. Monitor liver function.**	**Make sure that the patient has been taking vitamins during prenatal visits. Making sure that the client is having adequate nutrients during pregnancy.**			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Know other drugs that the patient taking, know their ingredients. Know liver functions.**	**Check iron and calcium levels.**			
Client Teaching needs (2)	**Teach the patient not to exceed to prescribed dose. Teach patient to know signs and**	**Educate the patient on the importance of taking vitamin daily. Teach the**			

	symptoms of hepatotoxicity.	**client to increase water and fiber intake because iron causes constipation.**			

Hospital Medications (5 required)

Brand/Generic	**Lactated/ Ringers solution (Jones & Bartlett, 2020).**	**Diphenylamine / Benadryl (Jones & Bartlett, 2020).**	**Oxytocin/ Pitocin (Jones & Bartlett, 2020).**	**Fentanyl/ Ropivacaine (Jones & Bartlett, 2020).**	**Ephedrine/ Sulfate (Jones & Bartlett, 2020).**
Dose	**125ml/hr**	**25 mg**	**30 Units/500 ml**	**500 mcg**	**5-10 mg**
Frequency	**IV continuous**	**Every 4 hours PRN**	**IV continuous**	**Every 2 hours PRN**	**Every 5 min PRN**
Route	**IV**	**IV**	**IV**	**IV**	**IV**
Classification	**Alkalinizing Agent**	**Antianaphylactic adjunct.**	**Oxytocin hormones**	**Opioid agonist/ Anesthetic**	**Alpha/beta adrenergic**
Mechanism of Action	**Helps water to flow freely at a cellular level without causing**	**Benadryl binds to central and peripheral H1 receptors, competing with histamine for these sites and preventing it from reaching**	**Oxytocin stimulates uterine contractions.**	**Anesthetic: block nerve impulses to send pain signal to brain. Opioid:**	**Acts on sympathetic nervous system to increase the activity of norepinephrine at the postsynaptic**

	cells to swell or shrink.	**its site of action.**		**binds to opioid receptor sites in the CNS, altering perception of and emotional response to pain.**	**alpha and beta receptors.**
Reason Client Taking	**To hydrate the client during delivery.**	**Itching**	**To expulse placenta and control bleeding during vaginal delivery**	**Severe pain during labor and delivery.**	**Severe hypotension**
Contraindications (2)	**Not given during severe metabolic acidosis or alkalosis & Severe liver disease.**	**Breastfeeding & hypersensitivity to Benadryl.**	**Fetal distress & abnormal fetal position.**	**Hyper-sensitivity to the agent & Infection at the site.**	**Avoid it in client with uncontrolled or sever hypertension & cardiac arrhythmias.**
Side Effects/Adverse Reactions (2)	**Agitation & Difficulty breathing**	**Arrhythmias & thrombocytopenia.**	**Nausea & vomiting.**	**Numbness or tingly feeling & Nausea and vomiting.**	**Dizziness & headache**
Nursing Considerations (2)	**Monitor electrolytes & vital signs.**	**Expect to give it parenteral only when oral ingestion is not possible & stope the treatment 72 hours before**	**Assess contraction pattern & intensity every 15 minutes.**	**Obtain informed consent for the procedure & Monitor**	**Ephedrine is not recommended for breastfeeding mother & monitor GI motility.**

		skin test.		**for side effects.**	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Assess signs of fluid overload and electrolyte.**	**Ask the patient if they are taking MAO inhibitor for possible interaction.**	**Monitor for signs of fetal distress & assess maternal blood pressure.**	**Assess for vital signs and pain level before and after procedure & Assess respiratory function.**	**Assess for allergies.**
Client Teaching needs (2)	**Educate the client to remain NPO during labor & teach the client to recognize signs of infection or discomfort at the IV site.**	**Teach the client to avoid alcohol & use sunscreen when outdoor for photosensitivity.**	**Advice the client to expect contractions as menstrual cramps after administration & teach the client about the reason why oxytocin is given.**	**Teach client to report any adverse effect such as tremor & Teach client the procedure.**	**Teach the client about possible drug interaction & avoid St john wort during treatment.**

Medications Reference (1 required) (APA):

Jones & Bartlett Learning. (2020). *Nurse's drug handbook* (19th ed.). Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The client appears alert and oriented to person, time, and place. The client is well-groomed and does not seem to be afraid about the procedure. She is confident, open, cooperative and speaks English well.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**Braden scale: 23** **The client's skin is warm, pink, and dry. Skin turgor is expected because the client is not dehydrated. She does not have rashes, bruises, wounds, and no drains noted.**
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head normocephalic and neck is symmetrical, the trachea is midline without deviation, normal thyroid, carotid pulse palpable 3+ bilateral. The ear canal is transparent, and the tympanic membrane is pearly grey bilateral. Pupils: PERLA, conjunctive pink bilateral. The client does not wear glasses, the nose is midline, no polyp, and the denture is intact.**
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:**	**The client is not on telemetry. Clear S1 and S2 are noted. Regular rhythm and apical pulse are present. Peripheral pulses palpable 2+ throughout bilateral, capillary refill is less 2 sec, no cyanosis or murmur noted, pitting edema bilateral, neck vein distention noted.**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒**	**Normal rhythm, rate, and pattern.** **Respiration is not labored bilateral anterior**

Breath Sounds: Location, character	**and posterior; no crackles, rhonchi, wheezing were noted bilaterally.**
GASTROINTESTINAL (4 points): **Diet at Home:** **Current Diet:** **Height: 5'2"** **Weight: 152 lbs.** **Auscultation Bowel sounds:** **Last BM: 9/20/21** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	**The client is on a regular diet at home and was NPO during labor except ice chips. The abdomen is soft, non-tender, mass, incisions, drains, wound noted during palpation and inspection of all four quadrants. Normal bowel sounds for all quadrants. Before epidural pain was 5.**
GENITOURINARY (2 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**The client reports that urine is clear and yellow, average quantity, and no urge, incontinence noted. She does not have pain during urination. Genital is clean, used urinary catheter after epidural and was removed before birth. Most of the time she used the restroom and was voiding regularly. The amniotic membra was artificially ruptured at 2:21pm. The fluid color was clear with moderate amount. No odor, episiotomy but had first degree of laceration observed.**
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 4** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**The client is alert and oriented to person, place, and time. She tested negative for the Homan sign. Normal range of motion bilateral, equal strength 5/5, does not use an assistive device. She used the birth ball for exercise during first stage of labor. The patient can do activities of daily living. Fall risk score is 4, she is a low fall risk during epidural. The patient is active, able to stand up alone and walk.**
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:**	**The patient is awake, oriented PERLA, equal strength, expected level of conscience, no sensory deficit, and an average pace of speech. Normal tendon reflex 2+ bilateral with full range of motion. Normal balance and gait.**

Sensory: **LOC:** **Deep Tendon Reflexes:**	
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 uses family and religious (Christian) support for coping methods, has a high school diploma, and lives with her husband, a son, and a dog. She has good family support. Normal development level for her age.**
Reproductive: (2 points) **Rupture of Membranes: was done artificially.** o **Time: 2:21pm** o **Color: Meconium-stained fluid Amount: Moderate was not measure.** o **Odor: no odor noted.** **Pain medication or Epidural: She used epidural.** **Assistive delivery: She had a normal vaginal delivery with the help of healthcare and the husband support at bedside.** **Episiotomy/Lacerations: She had a first-degree laceration and was stitched.** **Immediate Postpartum:** o **Fundal Height & Position is midline and palpable halfway between symphysis pubis and the umbilicus.** o **Bleeding amount: After stitched there were no visible bleeding.** o **Lochia Color: was dark red** o **Character: They were like small blood clots**	
DELIVERY INFO: (1 point) **Delivery Date: 09/20/21** **Time: 6:46 pm** **Type (vaginal/cesarean): Vaginal delivery.** **Quantitative Blood Loss: The quantity was less than expected according to the doctor.** **Male or Female: She had a female.**	

Apgars: 8-9 **Weight: 3,055 grams** **Feeding Method: Both bottle and breast milk.**	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**85**	**112/58**	**20**	**97.8**	**96% room air**
Admission to Labor/Delivery	**89**	**111/65**	**16**	**98.2**	**Not drawn.**
During your care	**75**	**103/62**	**20**	**97.8**	**99% Room air**

Vital Sign Trends and pertinence to client's condition in labor: Vital signs are within normal range.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1420	**0/10**	**Back and lower abdomen**	**7/10**	**sharp**	**breathing**
1600	**0/10**	**Back and lower abdominal**	**5/10**	**sharp**	**Relaxation techniques**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock

Size of IV: 18 gauge **Location of IV: Right median vein** **Date on IV: 09/20/21** **Patency of IV: IV flow of lactated ringers** **Signs of erythema, drainage, etc.: No signs of erythema.** **IV dressing assessment: Dressing is clean, dry, and intact without signs of infiltration.**	**Lactated ringer. Rate 125 ml/hr.**

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
1100 ml	**Patient is using the restroom regularly.**

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.**
Using relaxation techniques between contractions (N).	**PRN**	**Pushing a baby out of birth canal requires energies. Relaxation techniques conserve energy for the next pushing.**
Giving the client positive feedback during labor and delivery (N).	**PRN**	**Positive feedback helps the patient to put all her effort to push the baby out during vaginal birth.**
Electronic fetal heart monitoring (T)	**continuous**	**It helps to monitor the mother and the fetal status during labor and delivery. I also, helps to monitor for any changes and take an action as soon as possible.**

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. Acute pain related to labor as evidenced by facial grimaces and frequent contractions.	To minimize the discomfort for the mother and conserve energy needed to expulse the fetus.	1. Assisting with comfort measures such as position change, back rub, and use a birth ball Rationale: Prevent muscle fatigue and enhance circulation (Ricci et al., 2021). 2. Administer analgesic medications once dilation and contraction are established. Rationale: assess the pain and promote relaxation (Ricci et al., 2021).	The client will report pain is reduced and appear relax between contractions. The client will participate in behaviors that reduce pain sensation and improve comfort.
2 Knowledge deficit related to induction as evidenced by the patient refused epidural.	The epidural decreases pain and facilitates delivery.	1. Assess the client's baseline knowledge and expectations during labor. Rationale: To establish learning needs and set priorities (Ricci et al., 2021). 2.Provide information about epidural and the	The patient accepted the epidural, felt relaxed, and wholly dilated, ready for delivery.

		normal progression of labor. **Rationale: Prenatal education facilitates the labor and delivery (Ricci et al., 2021).**	
3 Risk for maternal infection related to pathogen exposure as evidenced by a first-degree perineal laceration.	**This diagnosis is pertinent because inadequate genital care after vaginal birth with perineal laceration increases the chance of infection.**	**1. Monitoring temperature, pulse, and WBC count as indicated.** **Rationale: Increasing in temperature and WBC indicate infection (Ricci et al., 2021).** **2. Provide frequent perineal care per protocol and pad changes to maintain good perineal hygiene.** **Rationale: Prevents the development of ascending uterine infection and possible sepsis (Ricci et al., 2021).**	**The patient will be free of infection.**
4 Risk for ineffective coping related to the inadequate support system as evidenced by the patient's history of post-partum depression.	**The client had a diagnosis of post-partum depression disorder, which can reoccur during the next birth.**	**1. Educate the husband to monitor signs and symptoms of depression. Also encourage the husband to be supportive or helpful.** **Rational: To seek for early medical care (Ricci et al., 2021).** **2. Encourage the client to verbalize feelings, concerns, and fears.** **Rational: Verbalizing fears decreases anxiety (Ricci et al., 2021).**	**The husband is supportive and verbalize to monitor signs and symptoms of depression. The client will verbalize awareness of her own coping ability. The patient will identify individual appropriate behavior to maintain control.**

Other References (APA)

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