N432 Labor & Delivery Care Plan

Lakeview College of Nursing

Whitney Miller

Demographics (3 points)

Date & Time of Admission	**Patient Initials**	**Age**	**Gender**
9/21/21 1800	C.A.	31	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Nurse	Married	Nickel, penicillin
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full	157.5 cm	105.2 kg	A.A

Medical History (5 Points)

Prenatal History: Patient has a pregnancy outcome of G3T0P0A2L0. Patient has had two **previous pregnancies.** The outcome of two previous pregnancies was abortion. Patient has preeclampsia with no severe features.

Past Medical History: Patient has a history of chronic hypertension, diabetes mellitus, and has a BMI of 42.

Past Surgical History: Patient had a wisdom tooth extraction in 2005.

Family History: Patient has a history of diabetes mellitus and hypertension. Father has a history of diabetes mellitus and hypertension. Paternal grandmother has a history of melanoma, hypothyroidism, and diabetes mellitus. Maternal grandmother has a history of diabetes mellitus and myocardial infarction. Maternal uncle has a history of lung cancer. Maternal sister has a history of cardiomyopathy.

Social History (tobacco/alcohol/drugs): Patient denies use of alcohol, denies smoking and denies use of recreational drugs.

Living Situation: Patient lives at a private residence with her husband.

Education Level: Patient has some college education.

Admission Assessment

Chief Complaint (2 points): Induction of labor

Presentation to Labor & Delivery (10 points): A thirty-one-year-old female was admitted to the labor and delivery unit on 09/21/21. Patient is thirty-seven weeks pregnant. This is the patient's third pregnancy. Patient has had two abortions. Patient induced due to preeclampsia and her history of chronic hypertension as well as obesity. Patient is experiencing cramping and

abdominal discomfort. Patient states her pain started yesterday, 9/21, and continues into this morning. Patient states the pain “comes and goes”. Patient characterizes this pain as sharp. Aggressors of this pain include movement. Patient finds relief in laying down and resting. Patient's pain is being treated using acetaminophen and fentanyl.

Diagnosis

Primary Diagnosis on Admission (2 points): Induction of labor

Secondary Diagnosis (if applicable): N/A

Stage of Labor

Stage of Labor Write Up, APA format (20 points) This should include the progression of cervical effacement & dilation as well as pain management techniques:

During labor and delivery, it is important to be aware of the three stages of labor and to be able to identify the signs and symptoms of these stages to understand how far along the mother is in the labor process (Ricci et al., 2020). This patient is being induced because she suffers from chronic hypertension, obesity, and preeclampsia.

This patient is currently in the first stage of labor. During the first stage of labor, the mother will begin to feel regular contractions and the cervix will begin to dilate, soften, and efface. The goal of the uterus during this time is to open and stretch out in order to allow an easy passageway for the baby to move through (Mayo Foundation for Medical Education and Research, 2020). The first stage of labor is split up into the early phase and the active phase. This patient is in the early phase. In the early phase, the mother may feel light contractions that are irregular. The mother may pass the mucus plug through discharge during this time. This stage of

labor may last hours or days. The cervix will be dilated between zero and six centimeters during this phase. This patient's uterus is at a closed dilation. This patient has irregular, mild contractions. This patient's symptoms align with the symptoms of stage one labor. Vital signs should be assessed every thirty to sixty minutes during this phase and temperature should be assessed every four hours. The active phase is characterized by more frequent contractions and a cervical dilation of six to ten centimeters. Contractions begin to grow stronger and closer together. This stage of labor typically lasts four to eight hours but can be longer. Vital signs should be assessed every fifteen to thirty minutes during this phase and temperature should be taken every four hours. As a nurse, it is essential to support the patient during the first stage of labor. Encouragement and support are an important part of keeping the patient's morale up and giving her the energy to get through labor. Breathing exercises and relaxation techniques may be implemented for pain. Further nursing interventions may include changing the patient's position, rolling on a birthing ball, having the patient take a warm bath, allowing the patient to take a walk, and giving the patient a massage between contractions. The nurse may also treat the patient by administering pain medication during this phase (Ricci et al., 2020). This patient received fentanyl and acetaminophen for her pain. Cervical dilation beyond ten centimeters as well as frequent and regular contractions indicate the patient is progressing to the next stage of labor.

The second stage of labor is the birth of the baby. This stage can last anywhere from a few minutes to a few hours. The cervix is fully dilated and effaced during this stage. It is normal for the mother's heart rate to be between eighty and one hundred beats per minute during this stage (Ricci et al., 2020). It is important that the mother breath while pushing and dealing with painful contractions. The nurse may do breathing exercises with the patient and offer support and encouragement. The patient may also be treated with an epidural or other pain medication.

Delivery of the baby indicates that the patient is moving onto the next stage of labor (Mayo Foundation for Medical Education and Research, 2020).

The third and final stage of labor is the delivery of the placenta. This stage typically lasts five to thirty minutes but may last an hour. The mother will continue to have mild contractions and will need to continue to push to deliver the placenta. The uterus will slowly begin to contract and return to normal size. Vital signs should return to normal during this stage (Ricci et al., 2020). Nursing interventions during this stage may include allowing the mother to hold her newborn and allowing her to attempt breast-feeding. Treatment during this stage may include medication to encourage uterine contractions and minimize bleeding and local anesthetic if stitches are needed in the vagina (Mayo Foundation for Medical Education and Research, 2020).

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

Mayo Foundation for Medical Education and Research. (2020, February 6). *Stages of labor and birth: Baby, it's time!* Mayo Clinic. Retrieved September 27, 2021, from https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/stages-of-labor/art-20046545.

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing* (4th 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	Prenatal	Admission	Today's	Reason for

	Range	Value	Value	Value	Abnormal Value
RBC	3.50-5.20	4.09	3.96	3.96	N/A
Hgb	11.0-16.0	12.60	11.90	11.90	N/A
Hct	34-47	36.20	35.60	35.60	N/A
Platelets	140-400	177	181	181	N/A
WBC	4-11	11.68	11.30	11.30	Hight white blood cell count can be caused by stress from pregnancy (Ricci et al., 2020).
Neutrophils	1.60-7.70	8.97	7.90	7.90	Elevated neutrophils can be caused by preeclampsia

					(Ricci et al., 2020).
Lymphocytes	18-42%	16.50%	17.60%	17.60%	Low lymphocyte level can be caused by stress from pregnancy (Ricci et al., 2020).
Monocytes	4-12%	5.20%	4.70%	4.70%	N/A
Eosinophils	0.00-0.50	1.20	1.20	1.20	High eosinophils can be caused by stress from pregnancy (Ricci et al., 2020).
Bands	0.00-0.33	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, O	O	O	O	N/A
Rh Factor	Positive or negative	Negative	Negative	Negative	N/A
Serology (RPR/VDRL)	Nonreactive	Nonreactive	N/A	N/A	N/A
Rubella Titer	Nonreactive (positive for titer)	Nonreactive	N/A	N/A	N/A
HIV	Nonreactive	Nonreactive	N/A	N/A	N/A
HbSAG	Nonreactive	Nonreactive	N/A	N/A	N/A
Group Beta	Negative	Negative	N/A	N/A	N/A

Strep Swab					
Glucose at 28 Weeks	<140	121	N/A	N/A	N/A
MSAFP (If Applicable)	<10 ng/mL	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**
Sodium	133-144	N/A	134	N/A	N/A
Potassium	3.5-5.0	N/A	3.8	N/A	N/A
Chloride	98-107	N/A	105	N/A	N/A
CO2 Venous	21-31	N/A	20	N/A	Low CO2 level can be caused by diabetes (Ricci et al., 2020).
Anion gap	8.0-16	N/A	9.0	N/A	N/A

Glucose	70-99	N/A	117	N/A	High glucose can be caused by diabetes (Ricci et al., 2020).
BUN	7-25	N/A	10	N/A	N/A
LDH	140-271	N/A	14.95	N/A	N/A
Uric Acid	2.4-5.7	N/A	6.4	N/A	High uric acid can be caused by patient being obese and diabetic (Ricci et al., 2020).
Creatinine Blood	6-20	N/A	15	N/A	N/A
Total protein	6.4-8.9	N/A	6.3	N/A	Low total protein may indicate liver or kidney problems

					(Ricci et al., 2020).
Albumin	3.5-5.7	N/A	3.3	N/A	Low albumin levels may indicate liver or kidney problems (Ricci et al., 2020).
A/G ratio	1.0-2.7	N/A	1.1	N/A	N/A
Calcium	8.6-10.3	N/A	9.7	N/A	N/A
T Bili	0.2-0.8	N/A	0.3	N/A	N/A
AST	13-39	N/A	18	N/A	N/A
ALT	7-52	N/A	16	N/A	N/A
Alkaline Phosphate	34-104	N/A	104	N/A	N/A
GFR,EST, non African	>=60	N/A	>60	N/A	N/A
CRF, EST. African	>=60	N/A	>60	N/A	N/A
UR protein	0.00-12.00	N/A	18.3	N/A	High UR protein may indicate kidney

					damage (Ricci et al., 2020).
Urine creatinine	28-217	N/A	62.2	N/A	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)	Less than or equal to 0.2	N/A	0.29	0.29	High urine protein creatinine ratio may indicate kidney problems likely secondary to diabetic ketoacidosis (Ricci et al., 2020).

Lab Reference (1) (APA):

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing* (4th 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?**	Baseline: 130 bpm Baseline has not changed throughout the clinical day.
Are there accelerations? • **If so, describe them and explain what these mean (for example: how high do they go and how long do**	There are accelerations. Accelerations occur when the heart rate rises at least 15 bpm and this elevation lasts at least 15 seconds. This baby had 15x15 accelerations as well as 30x30 accelerations. Accelerations mean the baby is

they last?) **What is the variability?**	being stimulated or the uterus is contracting and typically means the baby is doing well. Accelerations can also occur with vaginal examinations (Ricci et al., 2020). Variability occurs when the babies' heartbeat fluctuates from the baseline (Ricci et al., 2020). This baby had moderate variability.
Are there decelerations? **If so, describe them and explain the following:** **What do these mean?** • **Did the nurse perform any interventions with these?** • **Did these interventions benefit the patient or fetus?**	There are no decelerations with this baby. Decelerations occur when the heartbeat drops 15 bpm or more from the baseline heart rate and this decrease lasts 15 seconds or longer. The mother also must have a contraction right before this drop in heart rate (Ricci et al., 2020).

Describe the contractions at the beginning of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	Frequency: 3-7 minutes Length: 50-80 seconds Strength: Moderate Patient's Response: Patient states pain is "5/10" and works through her contractions with breathing exercises. Pt requested pain medication which was administered.
Describe the contractions at the end of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	Frequency: 3-7 minutes Length: 30-90 seconds Strength: Mild Patient's Response: Patient rates pain a "3/10". Patient continues to do breathing exercises with contractions.

EFM reference (1 required) (APA format):

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing* (4th 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	Folvite/ folic acid	Prenatal Multivit-Min-Fe-FA			
Dose	400 mcg	20 mg			
Frequency	Daily	Daily			
Route		PO			

	PO				
Classification	Vitamin	Vitamin			
Mechanism of Action	Exogenous source of folate needed for nucleoprotein synthesis and maintenance of normal erythropoiesis.	This medication replaces vitamins not consumed in high enough quantities in the diet.			
Reason Client Taking	Extra source of folate required to prevent congenital defects and	Insufficient amount of nutrients in the diet to supply the baby and mother.			

	supply mother and baby with nutrients.				
Contraindications (2)	Breast feeding Renal impairment	Allergic to ingredients B12 deficiency			
Side Effects/ Adverse Reactions (2)	Rash Itching	Constipation Diarrhea			
Nursing Considerations (2)	Pregnant woman should take daily before conception to prevent neural tube defects Check patient for low red blood cell	Avoid overdose of vitamins Watch for signs and symptoms of iron overdose			

	count				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check folic acid levels Assess for signs and symptoms of hypersensitivity	Monitor intake of vitamin doses Monitor ALT and AST for liver damage			
Client Teaching needs (2)	Take at the same time each day Take with a glass of water	Never take more than he recommended dose. Treat constipation with water, exercise, and fiber.			

Hospital Medications (5 required)

Brand/					Gluconate and

Generic	Tylenol/ acetaminophen	Tums/ calcium carbonate	Sublimaze/ fentanyl	Zofran/ ondansetron	Ca/ calcium gluconate
Dose	650 mg	1000 mg	25 mg	4 mg	1g
Frequency	Q4h PRN	Q8h PRN	Q2h PRN	Q6h PRN	Once PRN
Route	PO	PO	Sub Q	PO	IV
Classification	Non salicylate	Antacid	Opioid agonist	Selective serotonin receptor antagonist	Calcium salts
Mechanism of Action	Prevents	Contains alkaline ions to chemically	Increase sympathetic effects to	Blocks serotonin receptors to	Regulates release and storage of

	cyclooxygenase and blocks production to decrease pain impulses.	neutralize stomach gastric acid	produce analgesia and sedation.	trigger zone and intestine to block nausea and vomiting.	neurotransmitters and hormones, uptake of binding and amino acids, and absorption of B12 and gastric secretions.
Reason Client Taking	Mild pain	Heartburn	Severe pain	Nausea	Prevent intrapartum and postpartum hemorrhage
Contraindications (2)	Hypersensitivity to acetaminophen Hepatic impairment	Constipation Dehydration	Tolerance to other opioid agonists Patients who are	Low levels of magnesium Low levels of potassium	Hypersensitivity High amount of calcium in urine

			susceptible to respiratory depression		
Side Effects/ Adverse Reactions (2)	Nausea Stomach pain	Loss of appetite Vomiting	Slow heartbeat Low blood pressure	Headache Constipation	Low blood pressure Excessive sweating
Nursing Considerations (2)	Severe hepatic impairment is sometimes not apparent until several days after overdose. Hepatic impairment and alcoholism can make a patient more susceptible to toxicity.	Administer apart from other oral medication to ensure adequate drug absorption. Antibiotics and oral contraceptives may interfere with absorption.	Respiratory depression can occur. Be alert for excessive sedation.	Patient may experience GI problems. Assess fluid and electrolyte status if vomiting and diarrhea occur.	Assess for burning sensations and peripheral vasodilation Assess for fall in blood pressure

Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor for signs of liver toxicity. Monitor liver enzymes.	Monitor for signs of acid rebound. Assess mucus membrane status for signs of dehydration.	Monitor respiratory rate. Body warmth and adequate fluid intake should be maintained.	Monitor patient for prolonged headache. Monitor patient for weakness, fatigue, or GI problems.	Monitor ECG for hypercalcemia. Determine level of calcium and phosphorus during therapy.
Client Teaching needs (2)	Acetaminophen is for temporary use of 3-5 days. Do not take more than the recommended dose.	Do not use for more than two weeks. Take one hour after eating or when you have heartburn.	This medication may make you disoriented. Do not drive or do activities that require alertness.	Take medication with food. Take with a full glass of water.	Report signs and sympotms of hypercalcemia. Do not breast feed while taking this drug without consulting physician.

Medications Reference (1 required) (APA):

Jones & Bartlett Learning. (2019). *2020 nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

WebMD Staff. (2020). *Better information. Better health.* WebMD. https://www.webmd.com/.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alertness: Alert and responsive Orientation: Oriented to person, place, situation, and time Distress: No distress Appearance: Appropriate
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:**	Skin color: usual for ethnicity Character: Dry Temperature: Warm Turgor: Elastic Rashes: N/A

Rashes: **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N X** **Type:**	Bruises: N/A Wounds: N/A Braden Score: 21
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head: Symmetrical skull and face, bilaterally round head with no contusions or abnormalities Neck: No tracheal deviation, thyroid rises and falls with swallowing, lymph nodes non palpable Ears: tympanic membrane pearly grey, ears are bilateral on the head, no auditory impairment Eyes: 20/20 vision in right and left eye, no eye glasses, sclera white, no redness, no discharge Nose: No deviated septum, no polyps, nasal airway patent, no drainage Teeth: Mucous membranes moist, pink, firm. Teeth are white and none are missing. Rise and fall of the soft palate was observed and tonsils and uvula pink and moist.
CARDIOVASCULAR (1 point): **Heart sounds:**	Heart rhythm: SR Heart sounds: S1 and S2 heard

S1, S2, S3, S4, murmur etc. **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N X** **Edema Y X N ☐** **Location of Edema:**	Pulses: 3+ Capillary refill time: less than two seconds Edema: +1 pitting edema in legs bilaterally
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N X** **Breath Sounds: Location, character**	Respirations: regular, unlabored Respiratory pattern: regular Breath sounds: clear breath sounds were heard in anterior and posterior lobes Lung aeration: equal
GASTROINTESTINAL (4 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:**	Diet at home: Normal diet Current diet: Normal diet Height: 157.5 cm Weight: 105.2 kg Auscultation bowel sounds: Active in all four quadrants Last BM: 9/22 Palpation: No pain with palpation, no masses detected Inspection: No distention, no incisions, no scars, no drains, no wounds

Scars: **Drains:** **Wounds:**	
GENITOURINARY (2 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N X** **Inspection of genitals:** **Catheter: Y ☐ N X** **Type:** **Size:**	Bleeding: No bleeding Lochia color: No lochia present Character: N/A Quantity of urine: 300 mL Inspection of genitals: No abnormalities
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N X** **Fall Risk: Y ☐ N X** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	Neurovascular status: Nail beds smooth without pits or grooves, extremities warm and red, extremities motor function is fluid ROM: Active Supportive Devices: Use of walker Strength: 5 - active motion against full resistance Fall score: 20 Activity/Mobility Status: Up independently

NEUROLOGICAL (1 points): **MAEW: Y X N☐** **PERLA: Y X N☐** **Strength Equal: Y X N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **Deep Tendon Reflexes:**	Orientation: Oriented to person, place, situation, and time Cognition/mental: Appropriate for age Speech: Clear LOC: Alert - awake and answers questions appropriately Deep tendon reflexes: strong and reactive
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):**	Coping methods: Talking to a loved one Developmental level: Patient can read and write, patient is able to form a full structured sentence, patient can make a fully informed decision Religion and what it means to pt: Christian Personal/Family Data: Patient lives at home with her husband. Patient says her family is very supportive
Reproductive: (2 points) **Rupture of Membranes:**	Rupture of membranes: Patient has not yet ruptured membranes.

• **Time:** • **Color:** **Amount:** • **Odor:** **Pain medication or Epidural:** **Assistive delivery:** **Episiotomy/Lacerations:** **Immediate Postpartum:** • **Fundal Height & Position:** • **Bleeding amount:** • **Lochia Color:** • **Character:**	Patient has not yet delivered.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	Delivery info: Patient has not yet delivered.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	77	133/90	18	97.3 F	98
Admission to Labor/Delivery	103	163/112	16	99 F	98
During your care	81	140/86	16	97.5 F	99

Vital Sign Trends and pertinence to client's condition in labor:

Patient's vital signs were all within normal range during her prenatal visit. Apon admission, the patient had a slightly elevated pulse and a high blood pressure; all other vitals were within normal range. During my care of the patient, her pulse was back to normal range and her blood pressure dropped but her systolic pressure was still abnormal. All other vital signs were within normal limits when I was caring for the patient.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric pain scale	Uterus	5/10	Cramping and contractions	Breathing well through contractions, acetaminophen administered
1000	Numeric pain scale	Uterus	3/10	Cramping and contractions	Breathing well through contractions

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Size of IV: 18 Location of IV: Left peripheral hand Date on IV: 9/21 Patency of IV: IV patent Signs of erythema, drainage, etc: no infiltration present IV dressing assessment: Magnesium sulfate

	drip. Dressing clean, dry, and intact

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
600 mL IV magnesium sulfate drip	300 mL urine void 550 mL urine void

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.**
Administer pain medication (T)	Q2h PRN	

		Administer around the clock painkillers to give patient pain relief.
Reposition patient (N)	PRN	Increase the patient's level of comfort.
Fetal heart monitoring (N)	Q30min	This intervention is to ensure the fetus is in stable condition.

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 this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	Explain why the nursing diagnosis was chosen	Interventions should be specific and individualized for this patient. Be sure to include a time interval such as "Assess vital signs q 12 hours." List a rationale for each intervention and using APA format,	• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.

		cite the source for your rationale.	
• **Risk for pain related to contractions as evidenced by patient stating her pain was "5/10" in the first stage of labor.**	Pain can increase stress in the patient and potentially cause further complications.	**1. Assess patient's pain status Q2h. Administer pain medication to decrease pain level. Rationale: Assess patient's pain frequently can prevent her pain levels from getting too high. Administering pain medication can lower her pain level.** **2. Educate the patient on deep breathing techniques and how to breathe through contractions. Rationale:**	The patient and family responded well to the interventions. Client was willing to do deep breathing exercises. Patient received pain medication. Patient's pain went from 5/10 to 3/10. Goal met with no modifications.

		Allowing the patient to deep breath will help her to relax and not hold her breath. **(Ricci et al., 2020)**	
• **Fatigue related to patient being drowsy as evidenced by patient stating, "I feel exhausted and need to rest".**	It is important that the patient has energy to push when the second stage of labor comes.	**1. Allow the patient to relax between contractions.** **Rationale:** **Allowing the patient's body to relax will help prevent exhaustion.** **2. Assess patient's level of consciousness Q2h.** **Rationale:** **It is important to ensure the patient is alert and oriented to her situation.**	Family and patient responded well to this intervention. Client was able to relax between contractions. Client stayed alert and oriented throughout the day. Patient stated she "feels a little better after relaxing". Goal met with no modifications.

		(Ricci et al., 2020)	
• Knowledge deficit related to patient not understanding what an epidural is as evidenced by patient stating she “is worried about being paralyzed” when she receives her epidural.	It is important that the patient understands the treatment she is undergoing to avoid unnecessary anxiety and stress, preventing complications.	**1. Teach the patient about the risks of getting an epidural. Rationale: Educating the patient on the risks of an epidural allows her to process and understand what an epidural does.** **2. Educate the patient on the misconceptions about epidurals. Rationale: Educating the patient on misconceptions helps to stop unnecessary anxiety. (Ricci et al., 2020).**	Patient and family responded well to this intervention. Client listened to the education. Client said she is “no longer worried” about receiving an epidural. Goal met with no modifications.

• Knowledge deficit related to why patient is being induced as evidenced by patient asking "so what is the doctor so worried about?"	It is important the patient is aware of her health status and how her health history plays a role in her labor.	**1. Educate patient on the effect hypertension can have on her pregnancy and delivery.** **Rationale: Hypertension can lead to serious complications in pregnancy and it is important the patient is aware of these risks.** **2. Educate patient on preeclampsia and what the staff is doing to ensure she has a safe delivery.** **Rationale: Preeclampsia is a serious consideration for**	Patient was nervous when I educated her on hypertension and preeclampsia during labor and delivery. Patient was appreciative of the education. I was able to calm the patient down and help her feel relaxed. Goal met with no modification to plan.

		the health and safety of both mother and baby. The patient should be educated on the serious impact preeclampsia can have on her pregnancy. (Ricci et al., 2020)	

Other References (APA)

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.