N432 Labor & Delivery Care Plan

Lakeview College of Nursing

Jillian Kurtz

Demographics (3 points)

Date & Time of Admission 10/06/2021 0600	**Patient Initials** C.H.	**Age** 32 years old	**Gender** Female
Race/Ethnicity Hispanic	**Occupation** N/A	**Marital Status** Married	**Allergies** None
Code Status Full	**Height** 165 cm	**Weight** 81 kg	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: G2T1P1A0L1

Past Medical History: Patient has a medical history of asthma.

Past Surgical History: Patient has a past surgical history of a tonsillectomy.

Family History: Patient has no family history.

Social History (tobacco/alcohol/drugs): Patient has no history of tobacco, alcohol, or drug use.

Living Situation: Patient lives at home with her husband and kid.

Education Level: Patient has an associate's degree.

Admission Assessment

Chief Complaint (2 points): Abdominal pain

Presentation to Labor & Delivery (10 points):A 32-year-old female was admitted to the labor and delivery unit on 10/06/2021. Patient is 39 weeks and 5 days, and this is her second pregnancy. Patient presented to the unit with abdominal cramping. The patient's husband is here with her as her support person. The patient has a past medical history of asthma, but no past significant surgical history.

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):

My patient did not experience the normal stages of labor due to having a cesarean birth.

Labor is typically divided into four stages: dilation, expulsive, placental, and restorative (Ricci et al., 2021). The first stage is when true contractions begin, and it ends with full dilation of the cervix at 10cm. The fetal membranes usually rupture during this stage, but they can burst earlier or remain intact until birth. During this stage, women will experience visceral pain of abdominal cramping and uterine contractions. During this stage, the mother will have frequent cervical checks, vital checks, and the fetus will be monitored by a fetal strip (Ricci et al., 2021). Mothers are encouraged to use nonpharmacological pain management during this stage, such as deep breathing, bouncing on balls, and switching positions, but pain medications are often used as pain progresses to make the mother comfortable (Hutchison et al., 2021). This stage is usually the longest out of all the stages because it is divided into two subcategories, including latent and active. The latent and active phases of labor correspond to the progression of the cervix.

The second stage, the expulsive stage, begins with the complete dilation of the cervix and ends with the newborn's birth (Ricci et al., 2021). This stage can usually last from minutes to hours. Contractions during this stage occur every 2 to 3 minutes and last between 60-90 seconds, and are strong by palpation (Ricci et al., 2021). The mother is instructed to push when she feels a contraction and relax when she doesn't to help deliver the newborn. The head will usually

present fist and then the rest of the body. A cesarean section may be encouraged if the labor is too long, the fetus is in distress, or the mother fails to progress (Hutchison et al., 2021). It is crucial to monitor the mother and the newborn during this time.

The third stage, placental expulsion, begins after the newborn is born and ends with the separation and delivery of the placenta (Ricci et al., 2021). My patient's delivery of the newborn and the placenta happened very closely because she had a cesarean birth. Contractions are typical during this stage to assist the expulsion of the placenta. When the placenta separates from the placenta, there will be a gush of blood, lengthening of the umbilical bord, and the uterus will return to its globular shape upon palpation of the fundus (Hutchison et al., 2021). It is essential to monitor the mother's blood levels due to excessive loss of blood. This stage can last anywhere between 5 and 30 minutes (Ricci et al., 2021). If both the mother and newborn are stable, they will experience touching, and skin-to-skin contact during this stage.

The final stage is the restorative stage or immediate postpartum period. This period lasts between 1 to 4 hours after birth. During this time, the mother's body begins to stabilize after the work of labor and the loss of products of conception (Ricci et al., 2021). Often the fourth stage is not recognized as a proper stage, but it is critical for both the mother and newborn to continue to have that skin-to-skin contact. The mother will experience a physiological transition and new family attachment (Ricci et al., 2021). The nurse needs to perform a frequent assessment of both the mother and baby's well-being.

References (2) (APA):

Hutchison, J., Mahdy, H., & Hutchison, J. (2021). Stages of Labor. https://doi.org/NBK544290

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and Pediatric Nursing*. 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	2.72-4.43	N/A	4	4	
Hgb	9.5-15.0	N/A	12.7	12.7	
Hct	28-40%	N/A	38.1	38.1	
Platelets	146-429	N/A	178	178	
WBC	5.6-16.9	N/A	11	11	
Neutrophils	47.0-73.0%	N/A	N/A	N/A	
Lymphocytes	18.0-42.0 %	N/A	N/A	N/A	
Monocytes	4.0-12.0 %	N/A	N/A	N/A	
Eosinophils	0.00-0.50	N/A	N/A	N/A	
Bands	0.00-0.33	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	
Rh Factor	Positive or negative	+	+	+	
Serology (RPR/VDRL)	Positive/ Negative	Negative	Negative	Negative	
Rubella Titer	Immune/ Nonimmune	Immune	Immune	Immune	
HIV	Positive/ Negative	Negative	Negative	Negative	
HbSAG	Positive/ Negative	Negative	Negative	Negative	
Group Beta Strep Swab	Positive/ Negative	Negative	Negative	Negative	
Glucose at 28 Weeks	>140	110	110	110	

MSAFP (If Applicable)	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
MCV	82.4-100.4	N/A	91.2	91.2	
MPV	8.2-10.4	N/A	8.8	88	
RDW	11.4-16.6%	N/A	12.3	12.3	
MCH	29-32	N/A	30	30	
MCHC	31.9-35.5	N/A	33.5	33.5	
Gonorrhea/ Chlamydia	Positive/ Negative	Negative	Negative	Negative	
Syphilis	Reactive/ Nonreactive	Nonreactive	Nonreactive	Nonreactive	

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 0.25	N/A	N/A	N/A	

Lab Reference (1) (APA):

OSF Lab Reference per Epic Charting

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and Pediatric Nursing*. 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?**	140 Yes, the baby showed prolonged decelerations which caused the EFH to drop to 90, but then it returned back to 110.
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?**	No The baby had moderate variability ranging between 6-25 beats per minute (Ricci et al., 2021).
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**	There were prolonged decelerations lasting longer than 2 minutes and late decelerations which appeared after the contractions. The nurse preformed a few interventions including relieving pressure from the cord, administering 2L of oxygen via simple mask, and turned the patient into left tilt position.

or fetus?	No, these interventions did not benefit the patient or the fetus because the only treatment option for cord prolapse is caesarean section.
Describe the contractions at the beginning of your clinical day: **Frequency:** 4 minutes **Length:** 50 seconds **Strength:** Moderate **Patient's Response:**	My patient had moderate contractions occurring every 4 minutes and lasting 50 seconds. The patient responded by screaming, moaning, and yelling "ow."
Describe the contractions at the end of your clinical day: **Frequency:** 4 minutes **Length:** 50 seconds **Strength:** Moderate **Patient's Response:**	The patient's contractions remained the same as the beginning of the day. The patient's response also remained the same, she responded by screaming, moaning, and yelling "ow."

EFM reference (1 required) (APA format):

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and Pediatric Nursing*. 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	Prenatal Multivit-Min-Fe-FA (Tricare Prenatal DHA)	Acetaminophen (Tylenol)
Dose	0.8 mg	500 mg
Frequency	Once	Q4 hours

Route	Oral	Oral
Classification	Vitamin	Analgesics
Mechanism of Action	Replaces vitamins not consumed enough in the diet	Relives pain by elevating the pain threshold, reduce the production of prostaglandins in the brain
Reason Client Taking	Insufficient number of vitamins and nutrients in the diet to support both the baby and mom	Pain reliver and fever reducer
Contraindications (2)	Allergic to ingredients, B12 deficiency	Caloric undernutrition, severe renal impairment
Side Effects/Adverse Reactions (2)	Upset stomach unusual taste in mouth	Hypersensitivity, anemia
Nursing Considerations (2)	Seek emergency help if an overdose occurs, avoid taking with milk or other dairy products	Should not be given for more than 4-5 days without physician reassessment, severe hepatic damage can occur
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor intake of vitamin dose, monitor ALT/AST for liver damage	Monitor liver enzymes and monitor hematocrit and hemoglobin as anemia is a side effect
Client Teaching needs (2)	Never take more than the recommended dose, take the prenatal vitamin with a full glass of water	Never take more than the recommended dose, store at room temperature away from heat and moisture

Hospital Medications (5 required)

Brand/Generic	Nalbuphine (Nubain)	Lactated Ringers (Sodium chloride)	Terbutaline (Brethine)	Pitocin (Oxytocin)	Ancef (Cefazolin)
Dose	10 mg	500 mL	0.25 mg	30 units/ 500 mL	2 grams

Frequency	Q1-2 hours	Once	Once STAT	Continuous	Once
Route	IV piggyback	IV bolus	Subcutaneous	IV	IV
Classification	Opioid analgesic	Alkalinizing Agents	Bronchodilator	Oxytocic hormones/ uterine contractions stimulator	Semi-synthetic cephalosporin/ antibacterial
Mechanism of Action	Binds with and stimulants kappa and mu opiate receptors in the spinal cord and higher levels in the CNS	Restores fluid and electrolyte balances, produced diuresis, and reduced acidity	Relaxes bronchial smooth muscles, thereby increasing bronchial airflow and relieving bronchospasm	Increases the concentration of calcium inside the muscle cells that control the contraction of the uterus	Inhibits cell wall biosynthesis by binding penicillin-binding proteins which stops spectinomycin synthesis
Reason Client Taking	To relieve pain	Non-reassuring fetal HR	Relax smooth muscles in uterus for fetal HR	Control bleeding after childbirth	Prophylactic to reduce the incidence of postoperative infections
Contraindications (2)	Hypersensitivity, severe or active bronchial asthma	Hypersensitivity to corn products or severe liver disease	Hypersensitivity, hypersensitivity to sympathomimetic amines	Hypersensitivity, fetal is in distress prior to birth	Hypersensitivity to cephalosporins; hypersensitivity to penicillin's
Side Effects/Adverse Reactions (2)	Hypotension, respiratory depression	Lightheadedness, swelling of face, arms, hands, lower legs, feet	Irregular heartbeat, dyspnea	Runny nose, cramping	C-diff associated diarrhea, anaphylaxis
Nursing Considerations (2)	Be aware of abuse and misuse, during pregnancy can result in	Monitor for hypovolemia, increased intercranial pressure may cause	Use cautiously in patients with cardiovascular disease, assess	Watch for fast, slow, or uneven HR; watch for shallow breathing or	Caution should be exercised when breastfeeding, assess

	NOWS	cerebral edema	patient's respiratory rate, depth, and quality	breathing that stops	baby; assess for allergic reaction frequently
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess blood pressure, monitor respirations	CMP panel, monitor fluid balance	Assess patient's respirations and oxygen saturation	Verify vitals and dose before administration	Assess renal status before giving
Client Teaching needs (2)	Warn patient that excess use of the drug can lead to abuse and addiction, advise patient to avoid hazardous activities until CNS effects are known	Teach patient to recognize S/S of hypercalcemia, check with doctor before breastfeeding	Urge patient to seek medical attention if symptoms worsen, inform patient she may experience transient nervousness or tremors	Notify doctor or nurse is severe vomiting, or excessive bleeding	Explain the purpose of the medication is to prevent post-op infection, notify provide if any reactions occur

Medications Reference (1 required) (APA):

Jones & Bartlett Learning. (2020). *2020 Nurses drug handbook*. Burlington, MA.

RxList. (2021). *The internet drug index for prescription drug information, interactions, and side effects*. RxList. Retrieved October 6, 2021, from https://www.rxlist.com/script/main/hp.asp.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Alert and oriented to time, place, person, and date X4 No distress Well groomed, nourished, and developed

INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Pink Dry/elastic Warm Elastic turgor 2+ No rashes No bruises No wounds/incisions 15
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Head/neck symmetrical, equal range of motion Tm gray/pearly, free of discharge Eyes symmetrical, EOM intact Nose symmetry, no deviation Gum's pink/moist, good dentition .
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:**	. Heart sounds auscultated S1 and S2 present No murmurs No gallops or rubs in S3 and S4 Carotid, radial, ulnar, brachial, femoral, popliteal, dorsal pedis, and posterior tibial pulses +2 Capillary refill less than 3 seconds
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	No crackles or wheezes. Lungs clear posterior and anterior in all lobes.
GASTROINTESTINAL (4 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	 Regular Ice chips 165 cm 81 kg Bowel sounds active in all four quadrants 10/05 No masses/ palpations No distention No incisions No scars No drains No wounds
GENITOURINARY (2 Points): **Bleeding:**	 No bleeding

Color: **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Straw, yellow Clear, no odor Quantity non-measurable, patient able to ambulate to bathroom Genitals clean and dry
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☐**	 30 Ambulatory Independent (up and lib)
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:**	 Patient is orientated to person, place, time, and date. No mental status changes Articulative speech Alert No gross focal neurological deficits All 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):**	 Husband is at bedside for support and is attentive to patient. Mature, no depression/suicidal thoughts Patient is Catholic and follows religious practices. Patient is calm, cooperative, and pleasant. Patient is involved in plan of care and appears to have a strong family support and structure.
Reproductive: (2 points) **Rupture of Membranes:** o **Time:** o **Color:** **Amount:** o **Odor:** **Pain medication or Epidural:**	 Artificial 0735 Clear Moderate No odor Nalbuphine

Assistive delivery: **Episiotomy/Lacerations:** **Immediate Postpartum:** o **Fundal Height & Position:** o **Bleeding amount:** o **Lochia Color:** o **Character:**	Not assisted N/A- cesarean section Firm and equal with umbilicus Light Rubra Red
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	 10/06/2021 0740 Cesarean 450 mL Male 7 at 1 minute, 9 at 5 minutes 7 lbs 14.3 oz Breastfeeding

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	65	117/75	18	98.6 F (37 C) (Orally)	98%
Admission to Labor/Delivery	84	128/78	16	98 F (36.7 C) (Orally)	98%
During your care	88	136/82	15	99 F (37.2 C) (orally)	98 %

Vital Sign Trends and pertinence to client's condition in labor: The patient's vitals all remained within preferred ranges during prenatal, admission, and care.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric	Back, pelvis,	1	Moaning,	Turned the

		lower abdomen		yelling, cramping	patient, deep breathing techniques
0723	Numeric	Back, pelvis, lower abdomen	2	Moaned, yelled, screamed	Turned the patient, administered Nalbuphine

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV:	18 gauge
Location of IV:	Left wrist
Date on IV:	10/06/2021
Patency of IV:	IV patent
Signs of erythema, drainage, etc.:	No signs of erythema/drainage
IV dressing assessment:	No phlebitis/infiltration; dressing clean, dry

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
Ice chips 500 mL- IV bolus	Non-measurable: Patient able to ambulate

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 prescribed medications (T)	As scheduled or as needed	This treatment was provided to the patient to help reduce pain and keep the patient as comfortable as possible.
Assess patient's pain (N)	Every 2 hours	This intervention is used to ensure the

		patient is comfortable and as pain free as they can be. This can also help us identify if the patient needs more medication or not.
Rotating the patient and practice deep breathing techniques (N)	As needed	This intervention is used to help the mother breathe easier and reduce anxiety. Turning the patient will reduce pressure on the mother, as well as move the baby around if variabilities and late decelerations are shown on the EFM.

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 infection related to surgery as evidenced by caesarean section	I chose this diagnosis because the patient had surgery which increases their risk for infection of the opening.	1.Monitor for elevated temperature every 4 hours. **Rationale:** This is important because if the patient has an elevated temperature this will indicate an infection in the body (Ricci et al., 2021). 2.Teach the patient signs and symptoms of an infection and when she should report them	Goal met. The patient was able to state the signs and symptoms of an infection and when she should be reporting them. Temperature was monitored every 4 hours and the patient was assess further if an elevated temperature was present.

		Rationale: This is important because this will allow the infection to be caught and treated early to prevent further infection (Ricci et al., 2021).	
2. Risk for acute pain related to incision as evidenced by cesarean section	I chose this diagnosis because the patient had surgery and was pulled open to deliver the baby.	1. Educate proper relaxation techniques **Rationale:** This is important to help reduce anxiety and tension; this will help to promote comfort (Ricci et al., 2021). 2.If indicated, administer prescribed medications **Rationale:** Promotes comfort by blocking pain impulses (Ricci et al., 2021).	Goal met. Patient practiced deep breathing exercises. Patient was administered prescribed pain medicine when the pain was too uncomfortable to function.
3. Knowledge deficit related to infant safety as evidenced by a new newborn.	I chose this diagnosis because there is a lot of care and safety precautions when it comes to a newborn.	1. Educate the parents on safe sleeping and other risk factors to reduce SIDS. **Rationale:** Education on SIDS and proper sleeping is important for the newborn's safety (Ricci et al., 2021). 2. Education the parents on car seat safety. **Rationale:** The parents need to be educated on keeping the newborn in a rear-facing car sear and ensuring all the straps are tight enough but as least a finger in-between (Ricci et al., 2021).	Goal met. The parents were educated on car seat safety and safe sleeping arrangements for the newborn. The parents used the verbal teach back method to state the risk factors of SIDS and the understanding of car seat safety.
4. Knowledge deficient related to unfamiliarity with condition as evidenced by need for information	I chose this diagnosis because the patient was unfamiliar with the cesarean section and why it was	1. Education the purpose of the procedure and answer any questions **Rationale:** Educating the patient will help them have a better understanding of why the cesarean was the safer option for delivery	Goal met. Patient was educated on the need for a cesarean section. Patient responded well to teaching by asking questions and feeling more confident about the procedure and the

	needed for delivery	(Ricci et al., 2021). 2. Give accurate information in easy-to-understand terms **Rationale:** This gives the patient the ability to understand information, which can be difficulty in stressful situations (Ricci et al., 2021).	baby's safety.

Other References (APA)