N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 10/04/2021 - 0742	**Patient Initials** S.P.	**Age** 18	**Gender** Female
Race/Ethnicity Black/Non-Latino	**Occupation** Unemployed	**Marital Status** Single	**Allergies** None
Code Status Full	**Height** 5'4''	**Weight** 164 lbs	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History:

G1P0 -- 39 weeks, 4 days
Chlamydia

Past Medical History:

Asthma
Depression

Past Surgical History: None

Family History:

Cancer: paternal grandmother

Cleft lip: brother and mother

Diabetes: maternal grandfather

Thyroid disease: mother and maternal grandfather

Social History (tobacco/alcohol/drugs):

No alcohol use

Never smoked cigarettes or tobacco

Drugs: marijuana -- not currently using

Living Situation: Patient currently lives with her mother.

Education Level: 11th grade

Admission Assessment

Chief Complaint (2 points): Abdominal cramping

Presentation to Labor & Delivery (10 points):.Patient arrived at hospital on 10/4 complaining of abdominal cramping from labor pains. She is accompanied by her boyfriend (father of the child). She states that the pain started around 0200 this morning. Patient denies any abdominal discharge, leaking fluid or vaginal bleeding. Upon admission, and vaginal exam, it was determined the client was around 3-4 cm dilated. This is the clients first baby, no preterm or abortions, one term delivery, one living child.

Diagnosis

Primary Diagnosis on Admission (2 points):.Labor

Secondary Diagnosis (if applicable):.

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:

Upon admission, the client was 3 cm dilated and 20% effaced, which would put her in the latent phase of the first stage of labor. The latent phase of labor is identified by the start of regular contractions and the slow progression of cervical dilation up to 3 cm and effacement up to 40% (Ricci et al., 2020). Vaginal exams should be performed to determine the progression of cervical dilation and effacement. Signs and symptoms the client may experience during this stage include loss of mucus plug, bloody show, pain radiating from back to front of abdomen, and rupture of membranes (“Stanford Children’s Health”, 2020). Expected findings include contractions that occur every 5-10 minutes, and last 30-45 seconds. Patients may also feel tachycardia and increased blood pressure (Ricci et al., 2020). Nursing interventions include

assessing patients' psychological readiness, upright maternal position, teaching different relaxation techniques and providing pain relief (“Stanford Children's Health, 2020). During this stage, many women decided to get epidurals placed which numbs the lower half of their body (Ricci et al., 2020). When the client starts transitioning to the active phase of labor, assessment findings will include dilation between 5-7 cm, as well as 100% effacement (Ricci et al., 2020). In addition, contractions will become stronger, more frequent and last longer (Ricci et al., 2020).

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

Ricci, Susan., Kyle, Terri., Carman, Susen. *Maternity and Pediatric Nursing.* 4th ed., Philadelphia, Wolters Kluwer, 2020.

“Stanford Children’s Health.” Stanfordchildrens.org, 2019, www.stanfordchildrens.org/en/topic/default?id=overview-of-labor-90-P02896.

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	3.8-5.3 10^6/mL	3.52 10^6/mL	3.42 10^6/mL	3.42 10^6/mL	Client may have untreated iron-deficiency anemia (Capriotti, 2020)
Hgb	12-15.8	11.1	10.1	10.1	Client may have untreated iron-deficiency anemia (Capriotti, 2020)
Hct	36-47%	32.9%	30.7%	30.7%	Client may have untreated iron-deficiency anemia (Capriotti, 2020)
Platelets	140-440 10^3/uL	209 10^3/uL	209 10^3/uL	209 10^3/uL	
WBC	4-12 10^3/uL	7.5 10^3/uL	11.5 10^3/uL	11.5 10^3/uL	
Neutrophils	47-73%	57.5%	70.2%	70.2%	

Lymphocytes	18-42%	28%	19.6%	19.6%	
Monocytes	4-12%	8.9%	7.6%	7.6%	
Eosinophils	0-5%	5	2	2	
Bands	None	None	None	None	

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	+/-	+	+	+	
Serology (RPR/VDRL)	+/-	-	-	-	
Rubella Titer	Immune / Not immune	Not immune	Not immune	Not immune	Client is not immune to the rubella virus and should be vaccinated prior to leaving the hospital postpartum (Ricci et al., 2020)
HIV	+/-	-	-	-	
HbSAG	+/-	-	-	-	
Group Beta Strep Swab	+/-	+	+	+	Client tested positive for group B streptococcus bacteria, upon admission she received antibiotics (penicillin G) (Ricci et al., 2020)
Glucose at 28 Weeks	<140	90 after 1 hr			
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
Chlamydia	Negative	Positive	Positive	Positive	The client admitted to having unprotected sex with her boyfriend and did not complete her full treatment regimen.
COVID	Negative	Negative	Negative	Negative	

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	

Lab Reference (1) (APA):

Capriotti, T. M. (2020). *PATHOPHYSIOLOGY : introductory concepts and clinical perspectives*. F A Davis.

Ricci, Susan., Kyle, Terri., Carman, Susen. *Maternity and Pediatric Nursing.* 4th ed., Philadelphia, Wolters Kluwer, 2020.

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 (BPM) EFH: 145 bpm Heart rate remained around 135-145 bpm throughout the duration of clinical.
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?**	Yes - 15/15 Variability: Normal
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?**	Early decelerations -- Category I Interventions: we turned the patient, every 15 minutes, on each of her sides (left and right lateral recumbent) and placed a pillow under her back Unfortunately these interventions did not work for the patient, and she still had early decels.
Describe the contractions at the beginning of your clinical day: **Frequency:** **Length:** **Strength:**	When I arrived on the clinical floor, my patient was having contractions every 1.5-3.5 minutes, and each contraction lasted 70 seconds. The strength of the contractions was moderate, upon palpation it felt like a chin. Patient response to contractions was minimal because she had an epidural in place, she denied any pain or discomfort.

Patient's Response:	
Describe the contractions at the end of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	By the end of the clinical day the contractions became more intense and strong, feeling like a forehead upon palpation. The contractions started occurring every 1-2 minutes until finally the patient gave birth to a healthy baby girl at 1702. The patient denied any pain throughout the labor process, but did complain of feeling pressure.

EFM reference (1 required) (APA format):

Ricci, Susan., Kyle, Terri., Carman, Susen. *Maternity and Pediatric Nursing.* 4th ed., Philadelphia, Wolters Kluwer, 2020.

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

Home Medications (2 required)

Brand/Generic	Azithromycin / Zithromax	Albuterol Sulfate
Dose	1 gm pack	2 puffs
Frequency	Once	PRN for SOB
Route	Oral	Oral: inhalation
Classification	**<u>Pharmacologic:</u>** Macrolide **<u>Therapeutic:</u>** Antibiotic **<u>Pregnancy:</u>** B	**<u>Pharmacologic:</u>** Adrenergic **<u>Therapeutic:</u>** Bronchodilator **<u>Pregnancy:</u>** C
Mechanism of Action	Inhibits bacterial protein synthesis	Relax bronchial smooth muscle cells and inhibit histamine release
Reason Client Taking	Chlamydia infection	Asthma
Contraindications (2)	Taking concurrently with other macrolide antibiotics	Hypersensitivity to albuterol Hypokalemia

	Hypersensitivity to azithromycin	
Side Effects/Adverse Reactions (2)	Hepatic necrosis or failure Leukopenia	Hypotension Bronchospasm
Nursing Considerations (2)	Obtain culture and sensitivity tests before starting treatment Assess client for bacterial or fungal superinfection	Administer pressurized versions during second half of inspiration
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Culture and sensitivity Liver enzymes	Potassium levels
Client Teaching needs (2)	Take one hour before or 2-3 hours after eating Abdominal pain and loose, watery stools may occur	Wash mouth piece once a week and let air-dry Wait at least 1 minute between inhalation if dose is more than one puff

Hospital Medications (5 required)

Brand/Generic	Carboprost / Hemabate	Diphenhydramine / Benadryl	Fentanyl / Sublimaze
Dose	250 mcg	25 mg	25 mcg
Frequency	PRN q15 min	PRN q4h	PRN q2h
Route	IM	IV	SubQ
Classification	**Pharmacological:** Prostaglandin **Therapeutic:** Endocrine-Metabolic Agent **Pregnancy:** D	**Pharmacologic:** Antihistamine **Therapeutic:** Antianaphylactic, antidyskinetic, antiemetic, antihistamine, antitussive, antivertigo **Pregnancy:** B	**Pharmacologic:** Opioid **Therapeutic:** Opioid analgesic **Pregnancy:** C **Controlled Substance:** II
Mechanism of Action	Causes uterine contractions to slow bleeding	Prevents histamine from reaching site of action, which blocks its effects	Binds to opioid receptor sites in CNS, alters perception of and emotional response to pain
Reason Client Taking	To reduce bleeding	Itching	Pain
Contraindications	Hypersensitivity to	Hypersensitivity to	Opioid intolerance

(2)	carboprost Acute pelvic inflammatory disease	diphenhydramine Bladder-neck obstruction	Hypersensitivity to fentanyl
Side Effects/Adverse Reactions (2)	Shortness of breath Tachy or Bradycardia	Photosensitivity Dizziness	Respiratory depression Bradycardia
Nursing Considerations (2)	Monitor force, duration and frequency of contractions Monitor amount of vaginal discharge	Monitor for hypotension Monitor respiratory function	Monitor respiratory status Assess for opioid abuse risk
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor vital signs Monitor bleeding Monitor for adverse effects	Assess for allergies to antihistamines Obtain baseline data Renal and Liver function tests	Cardiac monitoring
Client Teaching needs (2)	Inform client about purpose of medication Know S/S of adverse effects	Take with food to avoid GI upset Wear sunscreen	Increase fluid intake Know s/s of allergic reaction

Brand/Generic	Methylergonovine / Methergine	Ondansetron / Zofran
Dose	200 mcg	4 mg
Frequency	PRN q2h	PRN q6h
Route	IM	IV
Classification	**<u>Pharmacological:</u>** Ergot alkaloids **<u>Therapeutic:</u>** Oxytocic **<u>Pregnancy:</u>** C	**<u>Pharmacological:</u>** Selective serotonin (5-HT_3) receptor antagonist **<u>Therapeutic:</u>** Antiemetic **<u>Pregnancy:</u>** B
Mechanism of Action	Causes uterine contractions to slow bleeding	Reduces nausea and vomiting by blocking the serotonin release in the small intestine -- blocks signals in the vagal nerve terminals and CNS
Reason Client Taking	To reduce bleeding	Nausea
Contraindications (2)	Hypertension Renal problems	Hypersensitivity to ondansetron Bradycardia
Side Effects/Adverse Reactions (2)	Diaphoresis Headache	Arrhythmias Hypotension

Nursing Considerations (2)	Monitor uterine bleeding Monitor HR, BP, and uterine response	Monitor patient closely for serotonin syndrome Monitor for decreased bowel activity
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess calcium levels -- effectiveness of medication decreases with hypocalcemia	Electrolyte status -- should hold medication if hypokalemia or hypomagnesemia present
Client Teaching needs (2)	Should only be used after delivery of baby Tell provider about any depression medication -- could potentially cause interaction	Know S/S of hypersensitivity reaction -- such as rash/hives Take with a full glass of water

Medications Reference (1 required) (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** A&O x4 **Orientation:** A&O x4 **Distress:** no acute distress -- has epidural in place **Overall appearance:** well-groomed	
INTEGUMENTARY (2 points): **Skin color:** normal for race **Character:** clean and moisturized **Temperature:** warm to touch **Turgor:** normal **Rashes:** none **Bruises:** none **Wounds/Incision:** none . **Braden Score:** 23 **Drains present:** **Y**☒ **N** ☐ **Type:** Urinary Catheter	Braden Score: Sensory: 4 Moisture: 4 Activity: 4 Mobility: 4 Nutrition: 4 Friction & shear: 3

HEENT (0.5 point): **Head/Neck:** symmetrical, no deviation noted **Ears:** pink & moist **Eyes:** PERRL, no drainage or lesions, sclera white, conjunctive pink bilaterally **Nose:** septum midline, no deviation **Teeth:** no missing teeth, mucosa pink and moist	.
CARDIOVASCULAR (1 point): **Heart sounds:** Normal S1 & S2 **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** normal **Peripheral Pulses:** +2 **Capillary refill:** <3 sec **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Breath sounds are normal and unlabored. Chest rises and falls equally and bilaterally. No wheezes, rhonchi, or rubs are present.
GASTROINTESTINAL (4 points): **Diet at Home:** Normal **Current Diet:** NPO **Height:** 5’ 4’’ **Weight:** 164 lbs **Auscultation Bowel sounds:** normoactive **Last BM:** 10/4 -- 0200 **Palpation: Pain, Mass etc.:** none **Inspection:** **Distention:** none **Incisions:** none **Scars:** none **Drains:** urinary catheter **Wounds:** none	.
GENITOURINARY (2 Points): **Bleeding:** none **Color:** yellow **Character:** clear, no foul odor **Quantity of urine:** 450 mL **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** some hair, but overall clean & well-groomed. **Catheter: Y ☒ N ☐** **Type:** urinary	

Size:	
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** 0 **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	.
NEUROLOGICAL (1 points): **MAEW: Y☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** A&O x4 **Mental Status:** Alert **Speech:** normal rate, no slurred speech, understandable **Sensory:** No impaired senses **LOC:** None **Deep Tendon Reflexes:** 0	.
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s):** **Developmental level:** no developmental delays **Religion & what it means to pt.:** non-religious **Personal/Family Data (Think about home environment, family structure, and available family support):** Patient currently lives at home with her mother who has been supportive throughout the pregnancy. Her boyfriend also accompanied her through delivery and has been present throughout the pregnancy.	.
Reproductive: (2 points) **Rupture of Membranes:** Artificial o **Time:** 1315 o **Color:** clear **Amount:** scant o **Odor:** none **Pain medication or Epidural** **Assistive delivery:** no **Episiotomy/Lacerations:**	

1st degree right & left labial tear **Immediate Postpartum:** o **Fundal Height & Position:** at umbilicus, 0 o **Bleeding amount:** scant o **Lochia Color:** rubra o **Character:** light	
DELIVERY INFO: (1 point) **Delivery Date:** 10/04/2021 **Time:** 1702 **Type (vaginal/cesarean):** vaginal **Quantitative Blood Loss:** 300 mL **Male or Female** **Apgars:** 1 min: 8 5 min: 9 **Weight:** 7 lbs 7 oz **Feeding Method:** Bottle	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal 1215	103	130/80 Sitting	17	97.9 Oral	99% Room Air
Admission to Labor/Delivery 0730	103	135/78 Sitting	16	98.1 Oral	98% Room Air
During your care 1406	105	133/80 Sitting	17	98.0 Oral	99% Room Air

Vital Sign Trends and pertinence to client's condition in labor: Client's vital signs remained stable throughout the entirety of clients pregnancy.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1330	Numeric 1-10	Abdomen	0		
1730	Numeric 1-10	Vaginal	0		

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20-gauge **Location of IV:** Right hand **Date on IV:** 10/04 **Patency of IV:** patent **Signs of erythema, drainage, etc.:** none **IV dressing assessment:** dry/intact	Oxytocin - 30u/500mL Penicillin G - 100mL/hr Fentanyl - 12mL/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1,100 mL	450 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.
Turning Patient - N	q15 min	Upon assessment, it was found that the fetus was having early decelerations. By turning the client, it may relieve pressure on the fetus which in result will stop early decels.
Epidural - T	Once	This intervention was given to patient to numb the lower half of the body to

		reduce pain related to contractions and active labor.
Fundal Assessment - N	q15 min for first hour	Helps decide uterine size, rate of descent and degree of firmness.

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. Knowledge deficit related to bottle feeding as evidenced by being a first time mom	Client stated that she wants to bottle feed her infant but does not know much about it.	**1.** Educate client on different types of formula options, demonstrate how to properly make a bottle, allow client to ask questions when needed **Rationale:** The client should be shown how to make a bottle including how to make a proper feeding schedule as well. To ensure the client retained the information, have her demonstrate making one (Ricci et al., 2020). **2.** Determine if client needs assistance paying for formula	Client was properly educated about formula feeding and was provided handout information about assistive programs. Goals met

		Rationale The client is 18 years old, which is pretty young to be a first time mom. The client might need assistive programs like WIC to help pay for formula (Ricci et al., 2020).	
2. Knowledge deficit related to proper sleeping techniques as evidenced by being a first time mom	Client should be educated on proper sleeping techniques to reduce the chances of SIDS	**1.** Teach that baby should always sleep on their back **Rationale:** The American Academy of Pediatrics has recommended this position since 1992 ("Sleep Position: Why Back Is Best.", 2020). **2.** Teach that babies should sleep with just bedding **Rationale:** When babies sleep with stuffed animals, pillows, and other cute nick nacks, it increases their risk for suffocation (Ricci et al., 2020).	Client was educated on the best sleep practices to help reduce SIDS, client verbalized she understood. Goals met.
3. Risk for infection related to chlamydia as evidenced by testing positive twice throughout the pregnancy	The client needs to be educated about how to prevent STIs.	**1.** Antibiotic therapy **Rationale:** The client should be placed on antibiotics and properly educated on the importance of finishing the whole therapy and not stopping once they 'feel better' (Ricci et al., 2020). **2.** Barrier-protected sex **Rationale:** The client should use condoms when initially having sex with someone new or someone who has not been tested recently, this will reduce her chances of contracting an STI (Capriotti, 2020)	The client was prescribed antibiotics and informed on the importance of barrier-protected sex. Her boyfriend also received antibiotic treatment, and both were told to not engage in sexual activities until after the treatment was complete. The patient agreed and understood Goals met.
4. Risk for disturbed thought processes related to postpartum	The client has a history of depression and anxiety which puts her at an increased risk	**1.** Support system for client **Rationale:** It is important to ensure the client has at least one person for a support system that can monitor if the client starts developing	In addition to these nursing interventions, client was also informed of common signs and symptoms to watch for that may indicate

depression as evidenced by history of depression	for developing postpartum depression	signs and symptoms of postpartum depression (Ricci et al., 2020). **2.** Ongoing focused assessment of mental health **Rationale:** The nurse should also check in with mom to see how she is feeling during routine check ups for the baby. If the client does develop postpartum depression it is important to catch it early so she can get the treatment she needs (Ricci et al., 2020).	postpartum depression. Client verbalized understanding. Goals met.

Other References (APA)

Capriotti, T. M. (2020). *PATHOPHYSIOLOGY : introductory concepts and clinical perspectives*. F A Davis.

Ricci, Susan., Kyle, Terri., Carman, Susen. *Maternity and Pediatric Nursing.* 4th ed., Philadelphia, Wolters Kluwer, 2020.

“Sleep Position: Why Back Is Best.” HealthyChildren.org, 2020, www.healthychildren.org/English/ages-stages/baby/sleep/Pages/Sleep-Position-Why-Back-is-Best.aspx.