N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 10/6/21 0600	**Patient Initials** C.H.	**Age** 32 years old	**Gender** Female
Race/Ethnicity Hispanic	**Occupation** N/A	**Marital Status** Married	**Allergies** KNA
Code Status Full Code	**Height** 165 cm	**Weight** 81 kg	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: G 2 P1 T 1 A0 L1

Past Medical History: The patient has a past medical history of asthma. The patient stated no previous complications during her last pregnancy.

Past Surgical History: The patient's past surgical history is a tonsillectomy.

Family History: The patient stated no family history.

Social History (tobacco/alcohol/drugs): The patient stated that she does not use tobacco products or alcohol, or recreational drugs.

Living Situation: The patient lives at home with her husband and other child.

Education Level: The patient's highest level of education is an associated degree.

Admission Assessment

Chief Complaint (2 points): Abdominal pain

Presentation to Labor & Delivery (10 points):

A 32-year-old female was admitted to OSF Heart of Mary Medical Center on 10/6/2021 at 0600 in the morning. The client is 39 weeks and five to seven days pregnant. The patient's GPTAL is G2 P1 T1 A0 L1. The patient reports to the emergency room for abdominal pain. The patient states that "it hurts in the lower abdomen area". The patient's pain started early in the morning on

10/6/2021 and progressively got worse. The patient then decided to come to the hospital. The patient states, "my water has not broken yet. The patient is here at the hospital with her husband as a support partner.

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:

The labor process occurs in four stages. The four stages are dilation, expulsion, placental, and restorative. It is essential to know these stages and how to identify them during the labor process.

The patient is in the first stage of labor. The first stage of labor will last from the onset of the uterine contractions until complete effacement and dilation of the cervix (Holman et al., 2019). The first stage is longer than the second and third stages combined. During the first stage, the cervix begins to progress in dilation. The first stage will end when the cervix is ten centimeters dilated (Ricci et al., 2021). The fetal membrane will rupture during the first stage. The nurse is to assess the amniotic fluid and its character, color, odor, and consistency. After the membrane ruptures, the nurse will measure the patient's temperature every two hours, watch for infection and cord prolapse. Pain is a complication during this stage due to contractions and dilation of the cervix. The first stage splits up into three phases. The first phase is the latent phase. The contractions during the latent phase are irregular and mild to moderate. The contractions occur every five to thirty minutes, lasting as long as 30 to 45 seconds, and cervical dilation of zero to three centimeters (Holman et al., 2019).

During the active phase, the contractions are regular, moderate to strong, the frequency is three to five minutes, lasting 40 to 70 seconds, and 4 to 7 centimeters dilated (Holman et al., 2019). Vital signs, contraction, and fetal heart rate monitoring should be complete every 30 to 60 minutes. The patient is in the active stage because her contractions are regular and moderate, four minutes apart lasting longer than 50 seconds. Vital signs, contractions, and fetal heart rate monitoring should be completed every 15 to 30 minutes. During the transition phase, the contractions are strong, and they are every two to three minutes, lasting 45 to 90 seconds, and complete dilation (Holman et al., 2019). Vital signs, contractions, and fetal heart monitoring should be obtained every 10 to 15 minutes. The nurse is listening for when the client says that they feel a bowel movement coming on. Because that can indicate the patient is fully dilated (Holman et al., 2019).

The second stage of labor begins with the complete cervical dilation and effacement and ends with the newborn's birth (Ricci et al., 2021). The second stage involves moving the fetus through the birth canal and out of the body. The cardinal movements of labor will occur during the second stage of labor (Ricci et al., 2021). Contractions are every one to two minutes during the second stage and are considered strong they last about 60 to 90 seconds. The mother is less agitated and irritable and feels in more control as they focus on pushing. The nurse should encourage the patient to push when the urge comes. Vital signs are to be obtained every 5 to 30 minutes. Fetal heart rate is being measured every 5 to 15 minutes (Holman et al., 2019). The nurse assesses for bloody show, uterine contraction, pushing efforts, and shaking of the extremities.

The third stage of labor begins with the newborn's birth and ends with the separation and birth of the placenta (Ricci et al., 2021). The third stage of labor consists of placental separation and

expulsion. During the third stage, the nurse should assess vital signs every 15 minutes. They should assess signs of placental separation: fundus firmly contracting, a gush of dark blood, umbilical cord appears to lengthen, and the uterus shape changed to globular (Holman et al., 2019). Have the patient push once when the placenta has separated—the placenta may expellee within two to thirty minutes (Ricci et al., 2021). Average blood loss during vaginal birth is 500 mL and 1,000 mL during a cesarean birth. The nurse should encourage the skin to skin contact immediately following birth.

The fourth stage begins with the expulsion of the placenta and ends with the stabilization of the mother (Ricci et al., 2021). Stabilization of the mother usually is one to four hours after birth. The fourth stage is considered the postpartum period. The mother is excited about her newborn baby and desires to cuddle or feed them. The nurse should assess vital signs, fundus, lochia color, urine output, and baby-friendly activities. Vital signs are measured every 15 minutes for the first two hours, then every four hours for the first eight, and then every eight hours (Holman et al., 2019). The fundus is located at the midline of the umbilicus one hour after birth and will slowly fall below the umbilicus and is checked every 5 minutes for the first hour after labor (Ricci et al., 2021). The fundus is firm, not boggy, and if it is boggy, the fundus needs messaging. The lochia color is a red and moderate amount.

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

Holman, C. H., et al. (2019). *RN maternal newborn nursing* (11th ed.). Assessment Technologies Institute.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *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 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	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	45.3-79.0	N/A	N/A	N/A	
Lymphocytes	11.8-45.9	N/A	N/A	N/A	
Monocytes	4.4-12.0	N/A	N/A	N/A	
Eosinophils	0.0-6.3	N/A	N/A	N/A	
Bands	0-700	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	Positive	Positive	Positive	
Serology (RPR/VDRL)	Negative	Negative	Negative	Negative	
Rubella Titer	Immune	Immune	Immune	Immune	
HIV	Nonreactive	Nonreactive	Nonreactive	Nonreactive	
HbSAG	Negative	Negative	Negative	Negative	
Group Beta Strep Swab	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	8.8	
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	Negative	Negative	Negative	Negative	
Syphilis Treponema	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)	52.2-91.9	N/A	N/A	N/A	

Lab Reference (1) (APA):

Ricci, S. S., Kyle, T., & Carman, S. (2021). *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?**	The baseline is 140 bpm. The normal baseline of EFH is 110-160 bpm (Ricci et al., 2021). The baby's heart rate drop down to 90 bpm, then came back up to a baseline of 110 bpm.
Are there accelerations? • **If so, describe them and explain what these mean (for example: how high do they go and how long do they last?)** **What is the variability?**	There was no acceleration on the fetal heart monitoring strip during labor. The variability was moderate. Variability is a fluctuation in the fetal heart rate baseline that is irregular in frequency and amplitude. Moderate variability indicates healthy and normal (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 or fetus?**	There were prolong decelerations lasting more than two minutes. The declarations were late, which means that the declaration would occur after the peak of the contraction, not with the contraction (Ricci et al., 2021). Late decelerations need interventions. The interventions performed were moving the patient to her left side, apply oxygen, and fluid administration. Late decelerations signify uteroplacental insufficiency causing inadequate fetal oxygenation (Ricci et al., 2021). None of the interventions performed help the patient or the fetus. The umbilical cord prolapsed.
Describe the	

contractions at the beginning of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	The patient's contractions are four minutes apart. The patient's contractions last about 50 seconds each. The strength of the contractions is moderate. The patient's response to contractions is by screaming 'ouch' and groaning.
Describe the contractions at the end of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	The patient's contractions remained the same throughout the day. The contractions are four minutes apart and last about 50 seconds. The strength of the contractions is still moderate. The patient continues to scream out "ouch" and groan.

EFM reference (1 required) (APA format):

Ricci, S. S., Kyle, T., & Carman, S. (2021). *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	Prenatal Vitamin Vi-Fe plus	Docusate Sodium Colace			
Dose	27 mg	100mg			
Frequency	Daily	Daily			
Route	Oral	Oral			
Classification	Vitamin	Pharmacological Surfactant Therapeutic Laxative, stool softener			
Mechanism of	A prenatal	Surfactant to			

Action	vitamin replaces vitamins that the mother may not consume enough of in her daily diet to support the baby. The vitamin helps with the babies development (Ricci et al., 2020).	soften the stool by decreasing the surface tension between oil and the water in feces. This will let more water penetrate into the stool. This will soften the stool (Jones & Bartlett, 2020).			
Reason Client Taking	The patient is taking a prenatal vitamin just incase she is not consuming the right amount of vitamins for her babies development.	Constipation			
Contraindications (2)	1)Hemolytic anemia 2)An increase in iron storage.	1)Fecal impaction 2)Hypersensitivity to Docusate Sodium or it's components.			
Side Effects/Adverse Reactions (2)	1)Vitamin toxicity 2)Upset stomach	1)Abdominal cramps 2)Syncope			
Nursing Considerations (2)	1)Avoid taking antacids, milk, or calcium supplements with vitamins. Avoid two hours before taking prenatal vitamin. 2)Have the patient take with a full glass of water.	1)Excessive or long-term use of docusate sodium can cause a dependence on laxatives for a bowel movement. 2)Assess for laxative abuse syndrome.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	The nurse should monitor signs and symptoms of prenatal vitamin toxicity.	The nurse needs to monitor the amount the client is taking and making sure they are not exceeding the recommend			

		dose.			
Client Teaching needs (2)	1)Educate the patient to not exceed recommended dose. 2)Educate the patient that if their stomach becomes upset that they can take the prenatal vitamin with food.	1)Educate the patient to take docusate sodium with a full glass or water or milk. 2)Encourage the patient to also increase their fiber and fluid intake to also help constipation.			

Hospital Medications (5 required)

Brand/Generic	Nalbuphine Nubian	Terbutaline Bricanyl	Oxytocin Pitocin	Cefazolin Ancef	Sodium lactate solution Lactated Ringers
Dose	10 mg	0.25 mg	0.5 to one milliunit	2 grams	500 mL
Frequency	Every one to two hours	Stat once	Continuous	Once	Once
Route	IV piggyback	Subcutaneous	IV	IV	IV bolus
Classification	Pharmacological Opioid Therapeutic Opioid analgesic	Pharmacological Beta adrenergic receptor agonist Therapeutic Bronchodilator	Oxytocic	Pharmacological First-generation cephalosporin Therapeutic Antibiotic	Alkalinizing Agents Isotonic solution
Mechanism of Action	Binds with kappa and mu opiate receptors in the spinal cord and higher levels in the CNS. Nalbuphine alters the perception of and emotional response to pain	Inhibits uterine contractions by reducing intracellular calcium levels. Terbutaline acts as tocolytic (Frandsen & Pennington, 2020).	Induces labor or arguments weak, irregular uterine contraction during labor (Frandsen & Pennington, 2020).	Interferes with bacterial cell wall synthesis by inhibiting linking peptidoglycan strand. This will cause bacterial cells to rupture and die without peptidoglycan (Jones &	Isotonic solutions allow water to flow freely without causing the cell to swell or shrink (Hinkle & Cheever, 2018).

	(Jones & Bartlett, 2020).			Bartlett, 2020).	
Reason Client Taking	Pain	Relaxes smooth muscles and inhibits uterine contraction.	Improve or begin contractions	Prophylaxis before cesarean section	Non reassuring fetal heart pattern
Contraindications (2)	1)Hypersensitivity to nalbuphine or its components 2)Asthma	1)Diabetes 2)Hypersensitivity to terbutaline	1) Fetal distress 2)Hypertonic uterus	1) Hypersensitivity to Cefazolin 2)Hypersensitivity to penicillin	1)Hypersensitivity to sodium lactate solution 2)Newborn less than 28 days old.
Side Effects/Adverse Reactions (2)	1)Hypotension 2)Respiratory Depression	1)Hypokalemia 2)Palpitations	1)Hypertension 2)Cardiac dysrhythmias	1)Abdominal cramping 2)Unusual bleeding	1)Decrease heart rate 2)Edema
Nursing Considerations (2)	1)For IV injection through an IV line use a compatible solution. Compatible solutions include normal saline, D5W, and lactated ringers. 2)Infuse solution slow and give no more than 10 mg over three to five minutes.	1)Notify the provider if the patients heart rate is above 130 bpm and a blood pressure of 90/60 mmHg. 2)Look to discontinue the medication if the client is not tolerating the side effects well.	1)If a labor and delivery nurse is not present to monitor fetal and maternal effects then suspend the infusion. 2)The nurse should closely monitor uterine activity and fetal response to oxytocin therapy.	1)Monitor IV site for irritation, extravasation, and phlebitis. 2)Assess bowel sounds and their pattern. Severe diarrhea can indicate inflammation of large intestine.	1) Monitor the IV site for phlebitis, edema, or irritation. 2)Make sure to double check the flow rate of the lactated ringers solution.
Key Nursing Assessment(s)/Lab (s) Prior to Administration	Assess maternal vital signs and FHR monitor before and after administration. Verify that labor is well established before administering preform a vaginal exam.	Obtain vital signs before administration to have a baseline to go off of during Terbutaline therapy. Assess for contraindications before administering medication.	Receive a baseline of maternal vital signs and fetal heart monitoring strip. These will be compared to during therapy.	Obtain a culture and sensitivity test prior to giving the drug. Monitor BUN and creatine for nephrotoxicity. Monitor for allergic reaction may be common if people do not know they are allergic to penicillin's.	Assess the IV site to make sure the IV is still good. There should be no edema, irritation, or phlebitis.
Client Teaching needs (2)	1)Educate the patient to allow someone to help with ambulation after taking nalbuphine.	1)Educate the patient to report any sings or respiratory depression or palpitations.	1)Educate the patient to report if her contractions are getting more	1)Educate the client to report sever diarrhea or even bloody stools. 2)Educate the	1)Educate the client to help monitor IV site for edema or redness. 2) Educate the

	2)Educate the patient that the medication causes drowsiness.	2)Educate the patient on the importance of a detailed health history. This will help make sure the patient has no contraindication to Terbutaline.	stronger and frequent. 2)Educate the patient to report any adverse effects of oxytocin.	client to report any signs or symptoms of an allergic reaction.	client to report any hypersensitivity signs or symptoms.

Medications Reference (1 required) (APA):

Frandsen, C. & Pennington, S. S. (2020). *Abrams' clinical drug therapy: Rationales for nursing practice* (12th ed.). Lippincott, Williams, Wilkins.

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

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

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is alert and responsive. The patient is oriented to person, place, situation, and time. The patient is in pain. The patient screams "ouch' when contractions occur. The patient is also moaning and groaning. The patient is dress appropriately, well-groomed, and has good hygiene.
INTEGUMENTARY (2 points):	The patient's skin color is usual for ethnicity.

Skin color: **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The character of the patient's skin is dry and intact. The temperature is warm to the touch. Skin turgor is elastic and returned to normal in less than three seconds. No rashes No bruises No wounds/incisions Braden Score: 15 No drains present
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The head, face, and skull are symmetrical, with no deformities or hematomas. The neck is symmetrical. The neck moves freely. The trachea was midline with no deviation. The patient's thyroid and lymph nodes were not palpable. The patient's ears were symmetrical. The patient states no problems with hearing. The external ear shows no signs of redness or drainage. The tympanic membrane was pearly grey. The patient's eyes were symmetrical on the face. The sclera of the eyes was white—no conjunctiva, redness, or drainage. The patient reports no problems with eyesight. The patient's nose was symmetrical. There were no polyps, deviated septum, or turbinates'. The patient's teeth were all intact. Good hygiene. The mucosa membranes were pink and moist.
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 patient's heart rhythm was sinus rhythm. The patient's heart sounds were S1 and S2. S3, S4, gallops, or murmurs were heard. The patient's peripheral pulses were +3 normal. Capillary refill was less than three seconds for the blanched nail to return to normal. No neck vein distention No edema
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The patient's respirations were regular and unlabored. The respiratory pattern was regular. The patient's breath sounds were clear posterior and anterior. The lung aeration are equal.
GASTROINTESTINAL (4 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:**	The patient's diet at home is regular. The patient's current diet at the hospital is only ice chips. The patient's height is 165 cm. The patient's weight is 81 kg. The patient's bowel sounds were active in all four quadrants. Last BM: 10/5/2021 No mass, pain, or tenderness felt upon palpation of the abdomen.

Distention: **Incisions:** **Scars:** **Drains:** **Wounds:**	No distention No incisions No scars No drains No wounds
GENITOURINARY (2 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The color of the patient's urine is yellow. There is no signs of bleeding. The character of the urine is clear. The patient reports urination has been normal and no complications. No pain with urination No catheter
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	The patient does not need assistance with daily living activities. Fall risk score: 30 (Low risk) The patient activity/mobility status is ambulatory The patient is up ad-lib one. The patient is on bed rest with bathroom privileges. The patient should have a person by her side when she is standing or walking. The patient may need help with the IV pole
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:**	The patient moves all extremities well. The patient's pupils are equal and reactive to light and accommodation. The patient's strength is equal. The patient is oriented to person, place, time, and situation. The patient has normal cognition. The patient's speech is clear. The patient is alert, awake, responsive, and answering questions.
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient has her husband in the room with her as a support partner. The husband is doing a good job supporting her through the labor process. The patient's religion is catholic. The patient lives at home with her husband and another child. The patient has a good family structure and support.
Reproductive: (2 points) **Rupture of Membranes:** **o Time:**	The rupture of membranes was artificial The time was at 0735.

o **Color:** **Amount:** o **Odor:** **Pain medication or Epidural:** **Assistive delivery:** **Episiotomy/Lacerations:** **Immediate Postpartum:** o **Fundal Height & Position:** o **Bleeding amount:** o **Lochia Color:** o **Character:**	The color was clear. The amount was moderate. There was no odor. The patient had Nalbuphine as a pain medication. No assistive devices were used during delivery. No episiotomy and lacerations The fundal height and position is firm and even with the umbilicus. The bleeding amount was light The lochia color was rubra The character was red.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	The delivery date was 10/6/2021 The time was 0740. Cesarean section The quantitative blood loss was 450mL Male Apgar's: 7 & 9 Weight: 7lbs 14.3 oz Feeding Method: Breastfeeding

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	65 bpm	117/75 mmHg	18 breaths per minute	98.6 F	98%
Admission to Labor/Delivery	84 bpm	128/78 mmHg	16 breaths per minute	98.8 F	98%
During your care	88 bpm	136/82 mmHg	15 breaths per minute	99 F	98%

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

The oxygen saturation has remained stable. The patient's blood pressure is increasing from her prenatal blood pressure. The blood pressure has even increased from the time of admission to during the care given. The heart rate has risen a little bit between admission and during care. The respiration rate remains around the same from admission to during care. The temperature needs further monitoring to make sure the 99F does not progress to higher. That will indicate any infection and puts the baby at risk.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	0-10	Back, pelvis, and lower abdomen	1	The patient is groaning and moaning. The patient states "ouch" during contractions.	Turn the patient and deep breathing exercises.
0730	0-10	Back, pelvis, and lower abdomen	2	The patient moans and groans during contractions and the patient screams "ouch" during contractions.	Administer Nalbuphine

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gage **Location of IV:** Left wrist **Date on IV:** 10/6/21 **Patency of IV:** The IV flushed well and good blood return. **Signs of erythema, drainage, etc.:** No signs of erythema or drainage **IV dressing assessment:** Dry and intact	Saline lock at the time of the assessment.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
The patient is only allowed ice chips	The patient is able to get up and use the restroom. No void was measured.

Lactated ringers 500 mL bolus	

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.
Deep breathing exercises (N)	Every time the client is in pain, discomfort, feeling anxious.	The patient appears to be in distress. The patient moans and groans because of pain and will occasionally scream out "ouch". Deep breathing exercises are an excellent nonpharmacological way to help reduce pain and anxiety.
Turn the patient to left-side lying position (N)	When late decelerations occur.	The patient was having late decelerations. Late decelerations can indicate placental insufficiency. One nursing intervention to help placental insufficiency is turning the patient to their left side.
Administer Nalbuphine (M)	Every one to two hours	The client rates her pain a two out of ten on the pain scale. The client verbalizes her pain by saying "ouch". Administering prescribed pain medications is an efficient way to help relieve the patient's pain.

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	The patient is	**1.** Administer prescribed	The client received a

	to contractions as evidence by the patient stating her pain is a two out of ten on the pain scale.	currently in pain. The patient is on and off, moaning and groaning. The patient will scream out, "ouch". The patient states her pain severity is a two out of ten on the pain scale. The patient describes her pain as cramping. The patient states, 'it hurts in my back, lower abdomen, and pelvis".	Nalbuphine **Rationale:** Nalbuphine is an opioid prescribed for reliving pain (Jones & Bartlett, 2020). **2.** Sacral counterpressure **Rationale:** Applying consistent pressure against the patient's sacral area help counteract the pain in the lower back (Ricci et al., 2021).	dose of Nalbuphine. The patient was still moaning and groaning. The pain medications needed more time to work. Apply sacral counterpressure helped relieve the pain a little bit. The patient needs continuous monitoring of her pain status.
2.	Risk for infection related to expected deliver cesarean deliver as evidence by the client receiving antibiotics.	The patient's umbilical cord has prolapsed, and since the patient is not entirely dilated, she will need an emergency cesarean section. The client is orders antibiotics as a prophylactic for infection.	**1.** Administer prescribed Cefazolin. **Rationale:** Cefazolin will interfere with bacterial cell wall synthesis. This will cause bacterial cells to rupture and die without peptidoglycan (Jones & Bartlett, 2020). **2.**Practice sterile technique **Rationale** Sterile technique is a great way to prevent infection. Sterile technique eliminates germs and is used in a surgery setting (Hinkle & Cheever, 2018).	The patient received one dose of Cefazolin. The patient was informed of why she was receiving a dose of Cefazolin. The patient will need monitoring for infection after cesarean section.
3.	Deficit knowledge related to umbilical cord prolapse as evidence by the patient stating, "what is happening"?	The patient's umbilical cord has prolapsed. Meaning the prolapsed cord is seen or palpitated outside of the vagina. The patient is very confused about what is going on and why she needs an emergency cesarean section. The patient does not know what an umbilical cord prolapse means and its severity.	**1.** Educate the patient on what positions to switch to and why switching position is important during umbilical cord prolapse. **Rationale:** Place the patient in modified sims, Trendelenburg, or knee-chest position to help relieve cord pressure (Ricci et al., 2021). **2.** Educate the patient that examiner will place on a sterile glove and place hand into vagina to hold the presenting part of the umbilical cord. **Rationale** This helps reelevate cord compression. The person will hold the presenting parts until delivery (Ricci et al., 2021).	The patient was educated on umbilical cord prolapse and the provider's options the husband, and she had. The patient is nervous about the cesarean section but understands why the cesarean section is performed. The examiner placed her hand into the patient vagina to relieve cord compression. The patient understood the importance of turning herself. The nurse also made sure the patient was turning herself. The patient needs emotional support during this time.

4. Deficit knowledge related to non-pharmacological pain relief as evidenced by the patient not preforming nonpharmacological ways to help relieve her pain.	The patient is moaning and groaning in pain. Her lower abdomen, back, and pelvis hurt. The pain is characterized by cramping. The patient will sometimes scream out the word 'ouch'. The patient is only relying on pain medications. This can indicate that she does not know non-pharmacological ways can also relieve her pain.	**1.** Educate the spouse about therapeutic touch and massages. **Rationale** A massage or back rub is a non-pharmacological way to help pain relief and promote relaxation (Ricci et al., 2021). **2.** Educate the patient on how to preform deep breathing exercises. **Rationale** Deep breathing exercise focus promotes relaxation for the patient (Ricci et al., 2021).	After educating on non-pharmacological ways to relieve pain, the patient started using non-pharmacological ways like deep breathing exercises. The husband also gave her a massage to help relieve the pain. The patient needs to perform more deep breathing exercises to help with her nervousness for the cesarean section.

Other References (APA)