N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 10/10/21 13:00	Patient Initials AS	Age 36	Gender Female
Race/Ethnicity Filipino	Occupation Bank clerk	Marital Status Married	Allergies Shellfish
Code Status FULL	Height 157 cm	Weight 83 kg	Father of Baby Involved Yes

Medical History (5 Points)

Prenatal History: The patient is G2, T1, P1, A0, L1. The patient had gestational diabetes with her first child and delivered him vaginally in 2018.

Past Medical History: Gestational diabetes.

Past Surgical History: The patient has no past surgical history.

Family History: The patient stated they were adopted and have no information on their family history.

Social History (tobacco/alcohol/drugs): The patient denies any tobacco, alcohol, or drug use.

Living Situation: The patient lives with her husband and son. They have no pets.

Education Level: The patient has completed high school.

Admission Assessment

Chief Complaint (2 points): Induction of labor

Presentation to Labor & Delivery (10 points):

The patient is a 36-year-old female at 39 weeks of gestation. She is gravida 2, preterm 1, abortion 0, with one living son. The patient was admitted to labor and delivery 24 hours ago for induction of labor. The patient practiced imagery to distract herself from the pain during the latent phase. When the contractions began to occur more frequently, the patient could not speak

due to moaning in pain. Repositioning did not alleviate any of her pain. Per protocol, the patient

was started on oxytocin at 1mL/1mU that was steadily increased. Lactated Ringers were infused

at 125 mL/hr. The patient was given an epidural after her cervix was dilated to 4 centimeters.

Diagnosis

Primary Diagnosis on Admission (2 points): Gestational diabetes

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:

Labor is broken down into four different stages, with the first stage being the longest.

(Ricci et al., 2020). There are three phases in the first stage of labor that represent how dilated

the cervix is. (Ricci et al., 2020). Dilation of the cervix is indicated in centimeters. (Ricci et al.,

2020). The first stage of labor is called the early/latent phase, defined by cervical dilation

ranging from 0-3 centimeters with mild contractions. (Ricci et al., 2020). Mild contractions,

similar to menstrual cramps, transpire every 5 to 10 minutes persisting for 30 to 45 seconds.

(Ricci et al., 2020). During this phase, cervical effacement ranges from 0% to 40%. (Ricci et al.,

2020). The mother is usually talkative and excited during the latent phase. (Ricci et al., 2020).

No pharmacological interventions are usually needed during this phase, and the mothers usually

stay home during this phase. (Ricci et al., 2020). The active phase is the second phase of the first

stage of labor. (Ricci et al., 2020). This phase is defined by dilation of the cervix ranging from 4

to 7 centimeters and can last up to six hours. (Ricci et al., 2020). Contractions intensify during

this phase, happening every 2 to 5 minutes and persisting for 45 to 60 seconds—cervical

effacement ranges from 40% to 80%, with the fetus descending more thoroughly into the pelvis.

(Ricci et al., 2020). The transition phase is the last phase of the first stage of labor. (Ricci et al.,

2020). This phase is defined by cervical dilation of 8 to 10 centimeters and cervical effacement that ranges from 80% to 100%. (Ricci et al., 2020). The transition phase is the shortest phase of the first stage of labor. (Ricci et al., 2020). Contractions are more painful and occur every 1 to 2 minutes and persist for 60 to 90 seconds, giving mothers a powerful urge to push during this phase. (Ricci et al., 2020).

The patient presented to the labor and delivery department dilated 2 centimeters and effaced 80%; this suggests that she progressed from the latent to the active phase. (Ricci et al., 2020). The patient practiced imagery to distract herself from the pain. (Ricci et al., 2020). The patient progressed to the transition phase 24 hours later. (Ricci et al., 2020). The patient was at 4cm, 100% effaced at 14:00, and received an epidural shortly after. (Ricci et al., 2020).

The second stage of labor occurs once the cervix has completely dilated to 10 centimeters and 100% effacement. (Ricci et al., 2020). This stage can last for up to an hour and ends once the newborn has been delivered. (Ricci et al., 2020). Contractions are happening every 2 to 3 minutes and persisting every 60 to 90 seconds. (Ricci et al., 2020). The mother is more concentrated on her pushing and less irritated than she was during the transition phase. (Ricci et al., 2020). When the abdominal pressure increases, the urge to push becomes overwhelming. (Ricci et al., 2020).

The patient progressed to the second stage of labor at 17:00. (Ricci et al., 2020). Her cervix was fully dilated, and she started feeling a powerful urge to push. (Ricci et al., 2020). The fetal head was slow to show. (Ricci et al., 2020). Despite having an epidural, the patient was still moaning and writhing in pain. She was still in the second stage of labor towards the end of our clinical rotation and becoming tired of pushing. (Ricci et al., 2020). The fetal head started to crown but began to retract. (Ricci et al., 2020). The provider was called. (Ricci et al., 2020). The

nurses assisted the patient into the McRoberts position, and suprapubic pressure was applied to the abdomen per the provider's orders. (Ricci et al., 2020).

The third stage of labor occurs with the delivery of the newborn. (Ricci et al., 2020). The end of this stage is once the placenta has been delivered. (Ricci et al., 2020). Signs that anticipate the delivery of the placenta are the umbilical cord lengthening, a sudden trickle of blood, and the uterus changing to a globular shape. (Ricci et al., 2020). The placenta is usually expelled within 30 minutes. (Ricci et al., 2020). The nurse can expect to massage the uterus to be massaged after the placenta has been delivered. (Ricci et al., 2020). The patient has not progressed to this stage yet.

The fourth stage begins once the placenta has been expelled. (Ricci et al., 2020). This stage is defined as the postpartum period. (Ricci et al., 2020). With the attachment phase beginning, the nurse can expect the mother to feel a sense of peace and accomplishment. (Ricci et al., 2020). The nurse should encourage skin-to-skin contact to initiate bonding between mother and infant. The nurse's main goal during this stage is to prevent hemorrhaging and venous thrombosis. (Ricci et al., 2020). The nurse should also monitor the mother for bladder distention since the mother may have limited sensation and be unable to feel the need to void. (Ricci et al., 2020). The patient has not progressed to this stage yet.

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

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

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

Laboratory Data (15 points)

CBC <mark>Highlight All Abnormal Labs</mark>—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	3	4	4	This lab is within normal range. (Ricci et al., 2020).
Hgb	9.5-15	14	13	13	This lab is within normal range. (Ricci et al., 2020).
Hct	28-40	40	36	36	This lab is within normal range. (Ricci et al., 2020).
Platelets	146-429	225	200	200	This lab is within normal range. (Ricci et al., 2020).
WBC	5.6-19.9	7	11	11	This lab is within normal range. (Ricci et al., 2020).
Neutrophils	45%-75%	N/A	N/A	N/A	N/A
Lymphocytes	15%-40%	N/A	N/A	N/A	N/A
Monocytes	4%-6%	N/A	N/A	N/A	N/A
Eosinophils	<7%	N/A	N/A	N/A	N/A
Bands	0.0-3.0%	N/A	N/A	N/A	N/A

Other Tests <mark>Highlight All Abnormal Labs</mark>—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 – O	O	O	O	This lab is

					within normal range. (Ricci et al., 2020).
Rh Factor	**Positive or Negative**	**Positive**	**Positive**	**Positive**	**This lab is within normal range. (Ricci et al., 2020).**
Serology (RPR/VDRL)	**Non-reactive or reactive**	**Non-reactive**	**Non-reactive**	**Non-reactive**	**This lab is within normal range. (Ricci et al., 2020).**
Rubella Titer	**Immune or Not immune**	**Immune**	**Immune**	**Immune**	**This lab is within normal range. (Ricci et al., 2020).**
HIV	**Positive or Negative**	**Negative**	**Negative**	**Negative**	**This lab is within normal range. (Ricci et al., 2020).**
HbSAG	**Positive or Negative**	**Negative**	**Negative**	**Negative**	**This lab is within normal range. (Ricci et al., 2020).**

Group Beta Strep Swab	Positive or Negative	Negative	Negative	Negative	This lab is within normal range. (Ricci et al., 2020).
Glucose at 28 Weeks	**>140**	**Not charted**	**Not charted**	**Not charted**	**The patient has gestational diabetes, but glucose has not been monitored in her chart. Gestational diabetes can cause neonatal complications. (Ricci et al., 2020).**
MSAFP (If Applicable)	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A

Additional Admission labs Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal

N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A

<mark>Highlight All Abnormal Labs</mark>—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Explanation of Findings
Urine protein/creatinine ratio (if applicable)	N/A	N/A	N/A	N/A	N/A

Lab Reference (1) (APA):

Ricci, S. 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	**The EFM baseline was 120 bpm at 13:00.**

(BPM) EFH? **Has it changed during your clinical day? If yes, how has it changed?**	**There was no change during my 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 they last?)** **What is the variability?**	**Yes, there was an increase of 20 beats for 40 seconds.** **The variability was moderate.**
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?**	**Yes, there were early decelerations going into late decelerations. Early decelerations mean there is fetal head compression and that the baby is coming. The nurse changed the patient to a better position. The position changed benefited the patient.**
Describe the contractions at the beginning of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	**The contractions were mild with a frequency of every 5 to 10 minutes and persisted for 30 to 45 seconds.** **The patient was deep breathing.**
Describe the contractions at the end of your clinical day:	**The contractions were strong with a frequency of every 2 to 3**

Frequency: Length: Strength: Patient's Response:	minutes and persisted every 60 to 90 seconds. The patient was moaning.

EFM reference (1 required) (APA format):

Ricci, S. 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	Prenatal vitamins/ One A Day Women's prenatal	Tums/ Calcium carbonate	Patient only taking 2 home medications.	Patient only taking 2 home medications.	Patient only taking 2 home medications.
Dose	200 mg	1500 mg	N/A	N/A	N/A
Frequency	daily	As needed	N/A	N/A	N/A
Route	oral	oral	N/A	N/A	N/A
Classification	Multivitamin and mineral supplement	Antacid	N/A	N/A	N/A
Mechanism of Action	To prevent vitamin	Neutralizing hydrochloric	N/A	N/A	N/A

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	deficiency before, during, and after pregnancy.	acid in gastric secretions.			
Reason Client Taking	**Prenatal care**	**Heartburn, indigestion, sour stomach.**	**N/A**	**N/A**	**N/A**
Contraindications (2)	**Allergies to soy. Liver problems.**	**Hypercalcemia. Hypophosphatemia.**	**N/A**	**N/A**	**N/A**
Side Effects/Adverse Reactions (2)	**Upset stomach. Diarrhea.**	**Hypotension. Paresthesia.**	**N/A**	**N/A**	**N/A**
Nursing Considerations (2)	**Ensure the patient takes it regularly to get the most benefit. Suggest**	**Store at room temperature. Protect from direct sunlight.**	**N/A**	**N/A**	**N/A**

	that the patient take the multivitamin with a full glass of water.				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Test for any vitamin deficiencies.**	**Monitor serum calcium level, as ordered, and evaluate therapeutic response by assessing for Chvostek's and Trousseau's signs, which shouldn't appear.**	**N/A**	**N/A**	**N/A**
Client Teaching needs (2)	**Take 1 hour before or 2 hours after**	**Urge patient to chew chewable tablets thoroughly**	**N/A**	**N/A**	**N/A**

	a meal. Do not take with antacids.	before swallowing and to drink a glass of water afterward. Instruct patient to avoid taking TUMS within 2 hours of another oral drug because of risk of interactions.			

Hospital Medications (5 required)

Brand/Generic	Pitocin/ oxytocin	Zofran/ ondansetron	Sublimaze/ fentanyl	Ancef/ cefazolin sodium	Lactated Ringer
Dose	30 units/500 mL bag	10 mg	0.05 mg	2 g	500 mL
Frequency	Continuous	Every 8 hours	Every 1-2	Once	Once

			hours		
Route	Intravenously (I.V.)	I.V.	I.V.	I.V.	I.V. Bolus
Classification	Hormones	Antiemetic	Opioid analgesic	Antibiotic	Alkalinizing Agent
Mechanism of Action	By increasing the concentration of calcium inside muscle cells that contraction of the uterus.	Block serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at the vagal nerve terminals in the intestine. This action reduces nausea and vomiting.	Binds to opioid receptor sites in the CNS, altering perception of and emotional response to pain by inhibiting ascending pain pathways.	Interferes with bacterial wall synthesis by inhibiting the final step in the cross-linking of peptidoglycan strands.	It restores fluid and electrolyte balances, produces diuresis, and acts as alkalizing agent.

Reason Client Taking	To initiate or improve uterine contractions.	To prevent nausea and vomiting.	To induce and maintain anesthesia.	To prevent infection.	To prevent dehydration during labor and delivery.
Contraindications (2)	Genital herpes. Hypertension.	Concomitant use of apomorphine. Hypersensitivity to ondansetron or its components.	Hypersensitivity to fentanyl. Upper airway obstruction.	Hypersensitivity to cefazolin. Hypersensitivity to other cephalosporins.	Hypersensitivity to sodium lactate. Hepatic insufficiency.
Side Effects/Adverse Reactions (2)	Nausea. Headache.	Hypotension. Serotonin syndrome.	Asystole. Respiratory depression.	Seizures. Anaphylaxis.	Angioedema. Hypervolemia.
Nursing Considerations (2)	Monitor for any signs of fetal distress. Monitor	Monitor patient for signs and symptoms of hypersensitivity.	Monitor patient for respiratory depression. Be aware that 100 mcg	Monitor I.V. site for irritation, phlebitis, and extravasati	Use as directed. Use aseptic technique.

	for seizures.	Monitor patient for serotonin syndrome.	of fentanyl is the equivalent in potency to 10mg of morphine.	on. Be aware that an allergic reaction may occur a few days after the therapy starts.	
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Assess a 20-minute electric fetal monitoring tracing strip.	If hypokalemia or hypomagnesemmia are present, these electrolyte imbalances should be corrected before ondansetron is	Assess the patient's pain level.	Assess for bleeding.	Inspect visually for particulate matter and discoloration prior to administration.

		administered.			
Client Teaching needs (2)	**Educate the patient to notify provider if she experiences any vision changes. Advise the patient to report any signs of an allergic reaction.**	**Advise patient to report any worsening symptoms. Reassure patient with transient blindness that it will resolve within a few minutes to 48 hours.**	**Advise patient to report any trouble breathing. Advise the patient not to try to get out of bed after receiving an epidural.**	**Advise patient to report watery bloody stools to prescriber immediately, even up to 2 months after drug therapy has ended. Advise patient to report any signs of an allergic reaction.**	**Advise the patient to report and loss or change in taste. Advise the patient to report any swelling, rash, itching, or burning at the infusion site.**

Medications Reference (1 required) (APA):

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

    Publishers.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The patient was alert to person, place, time, and reason for visit. She is well groomed but flushed from pain.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** **Braden Score: 11** **Drains present: Y ☐ N ☒** **Type:**	**The patient's skin is caramel color and normal for ethnicity. Her skin is warm, dry, and intact. Her skin turgor is elastic. The patient is free of any rashes, bruises, and wound/incisions. The patient's Braden score is 11. There are no drains present.**

HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**The patient's head and neck are midline and symmetrical. There is no deviation of the trachea. The ears are symmetrical bilaterally. Both patient's eyes were symmetrical and proportionally placed. The patient's nares are equal bilaterally with no deviation of septum. There was no drainage of the eyes, ears, or nose upon inspection. The patient's teeth were intact.**
CARDIOVASCULAR (1 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	**S1 and S2 sounds were present. No S3 sounds, S4 sounds, or murmurs were heard. Both carotid pulses were palpated one at a time and 2+. Radial, brachial, posterior tibial, popliteal, dorsalis pedis pulse sites were 2+ bilaterally. The femoral pulses were 1+ bilaterally. The patient's capillary refill was less than 3 seconds on their fingers and toes bilaterally. No pitting edema was present when assessing the patient's extremities.**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Upon auscultation, the patient's breath sounds were clear and even bilaterally without any use of accessory muscles.**

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:
	The patient states that they try to eat healthy at home.
	
	They are currently NPO until after delivery.
	
	Their height is 157 cm. Their weight is 83 kg.
	
	The patient's bowel sounds were normoactive in all four quadrants. The patient's last BM was yesterday. Upon palpation, the abdomen was free of any masses. Upon inspection the patient 's abdomen was round and reflects pregnancy. Her abdomen was free of distention, incisions, scars, drains, and wounds.

GENITOURINARY (2 Points):
Bleeding:
Color:
Character:
Quantity of urine:
Pain with urination: Y ☐   N ☒
Inspection of genitals:
Catheter: Y ☒   N ☐
   Type: Indwelling foley catheter
   Size: 16-gauge
	The patient was free of any bleeding. The patient's urine is yellow and clear. The patient expelled 168 mL of urine. The patient's genitals were normal for pregnancy. The patient has a 16-gauge indwelling urinary catheter inserted.

MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score: 55** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	**The patient has an epidural needs assistance. The patient is a fall risk with a Morse fall score of 55. The patient is currently unable to stand or walk due to the epidural.**
NEUROLOGICAL (1 points):	**The patient moves all extremities without**

MAEW: Y ☒ N☐ **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **Deep Tendon Reflexes:**	**difficulty and with equal strength. Her pupils are equal, round, and reactive to light and accommodation. She is alert and oriented to person, place, time, and reason for the visit. The patient does not seem to have an impaired mental status. Her speech started clear and concise but is now moaning in pain. The patient has not lost consciousness. The patient has deep tendon reflexes 2+ bilaterally.**
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 was using imagery to distract herself from pain when her contractions were mild. Her developmental level is appropriate for her age. The patient identifies as Catholic. The patient has a good support system through her husband and son.**

Reproductive: (2 points)
Rupture of Membranes:
   o   **Time: At admission**
   o   **Color: clear**
      Amount: not documented
   o   **Odor: none noted**
Pain medication or Epidural:
Assistive delivery: Not delivered at this time.
Episiotomy/Lacerations: Not delivered at this time.
Immediate Postpartum: Not delivered at this time.
   o   **Fundal Height & Position: N/A**
   o   **Bleeding amount: N/A**
   o   **Lochia Color: N/A**
	The patient's membranes ruptured at 13:00. The fluid was clear, but the amount was not documented. No odor was noted. The patient received an epidural. The baby has not been delivered at this time.

o **Character: N/A**	
DELIVERY INFO: (1 point) **Delivery Date: Not delivered at this time** **Time:** **Type (vaginal/cesarean): N/A** **Quantitative Blood Loss: N/A** **Male or Female: N/A** **Apgars: N/A** **Weight:N/A** **Feeding Method: N/A**	**The labor was still ongoing and delivery not complete.**

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**72**	**120/86**	**18**	**98.7**	**100**
Admission to Labor/Delivery	**92**	**146/83**	**21**	**98.6**	**98**
During your care	**92**	**139/83**	**18**	**99**	**98**

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

The patient's pulse is within normal range but has increased since admission. The patient's blood pressure has greatly increased since admission, but the systolic pressure has slightly decreased during my care. The increase in blood pressure could be due to the patient being in pain. The patient's respirations increased upon admission but fell back into range during my care. The patient's temperature stayed within normal limits but increased during my care. This could also be due to pain. The patient's oxygen stayed within normal limits.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
13:00	Numeric	Abdomen	2/10	Cramping pain	The patient distracted herself with imagery.
14:00	Adult non-verbal pain scale	The patient was unable to speak from the pain.	6/10	The patient was unable to speak due to the pain.	The patient was given an epidural per provider's order.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18-gauge Location of IV: left antecubital Date on IV: 10/11/21 Patency of IV: flushes without difficulty Signs of erythema, drainage, etc.: none IV dressing assessment: dry and intact	The patient has an 18-gauge I.V. in her left antecubital vein that was placed on 10/11/21 as indicated by the tape over the insertion site. Her I.V. is flushing without complications. No drainage, swelling, warmth, or redness was present. The dressing was dry and intact.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

500 mL bolus of lactated ringers.	**168 mL of urine.**

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.
EFM monitor (N)	**Continuous**	**To monitor the fetal heart rate for any complications because the patient is going into labor.**
Assisted patient to McRoberts position (N)	**Once**	**To assist in the delivery of the fetal shoulders.**
Encouraged the patient to push (N)	**Intermittently**	**To give emotional support because the patient is getting tired from pushing.**

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	Rationale	Intervention/Rationale(2	Evaluation

each) Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	(1 pt each) Explain why the nursing diagnosis was chosen	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.	(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 maternal injury related to changes in diabetic control as evidenced by gestational diabetes.**	**I chose this nursing diagnosis because gestational diabetes can negatively impact the mother's health.**	1. **Assess the client for vaginal bleeding and abdominal tenderness.** **Rationale: Vascular changes associated with gestational diabetes puts the patient at risk for abruptio placenta. (Phelps, 2020).** 2. **Assess and monitor for signs of edema.** **Rationale: Vascular changes associated with gestational diabetes can cause excess fluid**	**The patient will remain normotensive. The patient responded well to the nursing interventions, but the status is still ongoing.**

		retention and pregnancy-induced hypertension. (Phelps, 2020).	
2. **Risk for fetal injury related to elevated maternal serum blood glucose levels as evidenced by gestational diabetes.**	**I chose this nursing diagnosis because gestational diabetes can negatively impact the fetus.**	**1. Assess fetal movement and fetal heart rate as indicated.** **Rationale: Fetal movement and fetal heart rate can be negatively affected when maternal ketosis occurs. (Phelps, 2020).** **2.Perform non-stress test and oxytocin challenge test/ contraction stress test as appropriate.** **Rationale: This assesses the fetal well-being and adequacy of placental perfusion. (Phelps, 2020).**	**The fetus will display a reactive normal stress test and negative oxytocin challenge test/contraction stress test.** **The patient responded well to the interventions, but the status is still going,**
3. **Knowledge deficit of gestational**	**I chose this nursing diagnosis**	**1. Assess the patient's knowledge on gestational diabetes.**	**The patient will participate in the management of**

diabetes related to lack of recall as evidenced by inaccurate follow through of instructions.	**because the patient has had gestational diabetes before and was noncompliant.**	**Rationale: By identifying the patient's level of knowledge, the nurse can fill in the gaps and help her to make informed decisions. (Phelps, 2020).** **2. Encourage the client to make better dietary decisions.** **Rationale: By monitoring what she eats, the patient can have a better control of her blood glucose levels. (Phelps, 2020).**	diabetes during pregnancy. **The patient responded positively to the interventions, but the status is still ongoing.**
4. **Knowledge deficit of pregnancy-induced hypertension related to unfamiliarit y with information**	**I chose this nursing diagnosis because the patient was unaware that gestational diabetes could lead to**	**1. Provide information about signs/symptoms indicating worsening of condition and instruct patient when to notify provider.** **Rationale: Providing information helps to ensure that the patient**	**The patient verbalizes understanding of the disease process and appropriate treatment plan.** **The patient was appreciative of the information**

| resources as evidenced by request for information. | pregnancy-induced hypertension. | seeks timely treatment and may prevent additional complications. (Phelps, 2020). 2.Have patient informed of health status and fetal well-being. Rationale: Fears and anxieties can increase when the patient does not have adequate information about the disease process or how it can impact the fetus. (Phelps, 2020). | provided and able to verbalize an understanding of the disease process, but the status is still ongoing. |

Other References (APA)

Phelps, L. L. (2020). *Sparks and Taylor's nursing diagnosis reference manual* (11th ed.).

Wolters Kluwer.