N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 10/13/2021 0530	**Patient Initials** R.M.	**Age** 29	**Gender** Female
Race/Ethnicity Caucasian American	**Occupation** Stay at home mom	**Marital Status** Married	**Allergies** NKA
Code Status Full Code	**Height** 5’4” (162.6 cm)	**Weight** 244.1 lbs. (110.7 kg)	**Father of Baby Involved** Involved

Medical History (5 Points)

Prenatal History: The mother is G2P1T0A0L1. Meaning she has been pregnant twice, one pregnancy that has been full term, no preterm births, no abortions (spontaneous or assisted), and one living child. Furthermore, the client's first pregnancy was an emergency cesarean section, with the reason unknown. The mother has type II diabetes, which places this infant at risk for large for gestational (LGA) age and labor and delivery complications. The mother has a history of anemia during pregnancy during the first and this one; the mother is scheduled for a cesarean section delivery today (10/13/2021) at 0800 hours**.**

Past Medical History: The mother has a history of diabetes type II, asthma, morbid obesity, history of abnormal cervical pap smear, and low-grade squamous intraepithelial lesions.

Past Surgical History: The mother has a past surgical history of a cesarean section in 2010, and a cholecystectomy in 2011.

Family History: The patient has an extensive family history, the patient's dad has a history of hypertension, diabetes type II, and high cholesterol, and the patient's mother and grandmother both have a history of esophageal cancer.

Social History (tobacco/alcohol/drugs): The mother states she does not use illicit drugs, nor tobacco, the patient states when she is not pregnant, she occasionally uses alcohol about 2 beers a month.

Living Situation: The client lives at home with her husband and 11-year-old son**.**

Education Level: The client is a high-school graduate.

Admission Assessment

Chief Complaint (2 points): Scheduled cesarean section

Presentation to Labor & Delivery (10 points):. O: On 10/13/2021, at 0630 R.M., a 29-year-old Caucasian female presented to the labor and delivery unit for a scheduled cesarean section L: The patient reports no pain. D: The patient is not in any pain, so no time log of pain C: She states, "she is ready for this baby to come out." A: The pain is not in any pain; therefore, there are no aggravating factors. R: The patient is not in pain, so no relieving measures are needed. T: No treatment is needed since the patient was not in any pain.

Diagnosis

Primary Diagnosis on Admission (2 points):. Scheduled cesarean section

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 first stage of labor begins with regular contractions and slow, steady dilation of the cervix (Ricci et al., 2021). Furthermore, the first stage of labor has three phases; latent, active, and transition (Ricci et al., 2021). The latent phase happens when cervical dilation of 0-3 cm, irregular contractions, mild to moderate strength, occurring every 5 to 30 minutes and lasting 30-45 seconds (Ricci et al., 2021). The active phase happens when the cervix is between 4 to 7 cm,

contractions are more regular, mild to moderate in strength, occurring every 3 to 5 minutes, and lasting roughly 40 to 70 seconds (Ricci et al., 2021). Latent is the last phase of the first stage of active labor, which consists of 8-10 cm cervical dilation; contractions are strong to very strong, occurring every 2-3 minutes and lasting 30-45 seconds. (Ricci et al., 2021). Typically, the latent phase can last from hours to days (Ricci et al., 2021)

Once the mother has completely effaced and is 10 cm dilated, and the fetus is in the true pelvis, intense contractions are every 1 to 2 minutes and lasting 60-90 seconds, all of which denote the mother is in the second stage of labor (Ricci et al., 2021). The mother will have a strong desire to push, and the nurse should instruct her to do so (Ricci et al., 2021). Pushing results in the birth of the fetus, and this notes the end of the second stage and the beginning of the third stage, and once the neonate is delivered, if appropriate, engage the newborn in skin-to-skin bonding (Ricci et al., 2021). This phase typically lasts 30 minutes to 2 hours (Ricci et al., 2021). Throughout this stage, the mother's pain is most likely from the following: lacerations of the soft tissue, pressure and pulling on the pelvis structure, and pressure and distension (Holman et al., 2019).

The third stage is seen with the delivery of the neonate and typically lasts from 5 to 30 minutes resulting in delivery of the placenta (Ricci et al., 2021). In the third stage, the mother's pain is likely from placental expulsion, uterine contractions, and pressure and pulling of pelvic structures (Holman et al., 2019). The fourth and final stage begins after the expulsion of the placenta, noting the beginning of the postpartum period; as the uterus contracts to returns to pre-pregnancy shape, bloody vaginal discharge will flow, mixed with small Rubra colored blood clots (Ricci et al., 2021). In the fourth stage of labor, pain is likely from distension and stretching of the vagina and perineum incurred during the second stage (Holman et al., 2019).

The client's objective data of her contractions occurring every 3 to 5 minutes apart, lasting 70-80 seconds in duration, and a mild strength would suggest the client is in the first stage active phase of labor. Furthermore, pain management throughout the stage and phases are different and are as follows; cesarean deliveries, the patient will receive an epidural (block) anesthesia, spinal (block) anesthesia, and or general anesthesia (Holman et al., 2019). For vaginal births, epidural (block) anesthesia of analgesia pudendal block, spinal block anesthesia, and more (Holman et al., 2021). The client received an epidural block for her cesarean delivery.

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

Holman, H. C., McMichael, M., Johnson, J., Williams, D., Sommer, S., Wheless, L. K., McMichael, M. G., & Barlow, M. S. (2019). Rn Maternal newborn nursing: Review module. 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	3.75-5.0 million/mm^3	N/A	4.20	4.20	N/A
Hgb	11.5-14 g/dL	N/A	11.2	11.2	The mother has a prenatal history of anemia which would explain this abnormal hemoglobin finding (Jarvis & Nelson-Piercy, 2020).

Hct	32%-42%	N/A	33.9	33.9	N/A
Platelets	150-350 million/mm^3	N/A	222	222	N/A
WBC	5.0-15 million/mm^3	N/A	13.10	13.10	N/A
Neutrophils	47%-73%	N/A	70.3	70.3	N/A
Lymphocytes	15%-40%	N/A	23.6	23.6	N/A
Monocytes	4%-12%	N/A	4.6	4.6	N/A
Eosinophils	0%-5%	N/A	0.5	0.5	N/A
Bands	0%-1%	N/A	N/A	N/A	N/A

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	A, B, AB, O	O	O	N/A	N/A
Rh Factor	Negative or Positive	+	+	N/A	N/A
Serology (RPR/VDRL)	Non-reactive	Nonreactive	Nonreactive	N/A	N/A
Rubella Titer	Immune	Positive (immune)	Positive (immune)	N/A	N/A
HIV	Negative	Not Detected	Not detected	N/A	N/A
HbSAG	Not detected	Negative	N/A	N/A	N/A
Group Beta Strep Swab	Negative	Neg	Neg	N/A	N/A
Glucose at 28 Weeks	< 140 mg/dL	N/A	N/A	N/A	The client checks her glucose levels Q6 hours, the client has DM type II of which is controlled with diet and medication.
MSAFP (If Applicable)	Negative	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	Negative	N/A	N/A	N/A
Gonorrhea	Negative	Negative	N/A	N/A	N/A

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

Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Explanation of Findings
Urine protein/creatinine ratio (if applicable)	120-160 mL/min	N/A	N/A	N/A	N/A

Lab Reference (1) (APA):

Jarvis, S., & Nelson-Piercy, C. (2020). Common symptoms and signs during pregnancy. *Obstetrics, Gynecology & Reproductive Medicine*, *30*(10), 321–325. https://doi.org/10.1016/j.ogrm.2020.07.005

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?	The baseline electronic fetal heart rate (FHR) was 135 beats per

Has it changed during your clinical day? If yes, how has it changed?	minute (BPM). The expected baseline fetal heart rate is 110 – 160 bpm. Throughout the clinical day no change in the FHR seen. The FHR monitor was placed at 0635 after the mother's admission to the unit, and the baseline of 135 BPM seen. The EHFM was removed at 0745 baseline prior to the mother going into the operating room.
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 were accelerations noted. The fetal heart rate accelerated from the baseline of 135 bpm to 150-155 bpm for 20 - 40 seconds intervals. The accelerations could indicate fetal movement or the fetus being awake and active (Ricci et al., 2021). Furthermore, these accelerations are normal findings as the FHR elevated to 15 bpm above the baseline for more than 15 seconds and less than 2 minutes (120 seconds) (Ricci et al., 2021). Lastly, moderate variability is between 6 to 25 bpm noted. For moderate variability, the normal range is approximately 6 to 25 bpm for adequate, well-developed and oxygenation for the fetus (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?**	No, there are no decelerations present. Decelerations are prolonged fetal heart rate decrease equal to or greater than 2 minutes but less than 10 minutes (Ricci et al., 2021). A deceleration on a strip would look like a mirror image of the contraction (Ricci et al., 2021). If the EFHM shows late or variable decelerations the nurse should turn the patient to her left side-lying position, prepare to administer

	oxygen via a face mask or nonrebreather, and discontinue oxytocin is prescribed (Ricci et al., 2021).
Describe the contractions at the beginning of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	Upon assessment and before delivery, the contractions had a frequency of 3 to 5 minutes, 70 to 80 seconds duration, and mild strength. The patient was completely unaware that the contraction s happening, and the patient had no complaints of any pain or discomfort. The mother was in the first stage, the active phase of labor, from the objective data of the contractions. The active phase consists of contractions every 3 to 5 minutes, 40 to 70 seconds, and moderate to strong strength (Ricci et al., 2021).
Describe the contractions at the end of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	Unable to assess due to the cesarean section.

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	**Metformin/Glucophage**	**Aspirin/acetylsalicylic**

		acid
Dose	500 mg (AM) 1000 mg (PM)	81 mg
Frequency	BID	Daily
Route	Oral	Oral
Classification	Antidiabetic. Biguanides.	Antipyretics. Nonopioid analgesics. Salicylates.
Mechanism of Action	Metformin decreases hepatic glucose production, decreases intestinal absorption of glucose, and improves insulin sensitivity by increasing peripheral glucose uptake and utilization.	Inhibits the production of prostaglandins which lead to a reduction of fever and inflammation, decreases platelet aggregation leading to a decrease in ischemic diseases.
Reason Client Taking	The client has type II diabetes.	Preeclampsia prevention.
Contraindications (2)	Known hypersensitivity to metformin hydrochloride. Renal disease or renal dysfunction.	Breastfeeding. Hypersensitivity, including asthma, angioedema urticarias or rhinitis linked to aspirin or non-steroidal anti-inflammatory drug (NSAIDs)
Side Effects/Adverse Reactions (2)	Epigastric discomfort, and weakness.	Increased bleeding times. Gastrointestinal irritation or upset.
Nursing Considerations (2)	May cause diarrhea, nausea, vomiting and lactic acidosis.	In long-term therapy monitor renal and liver function and ototoxicity. Assess pain, and or pyrexia one hour before and after administration.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor patients closely for ketoacidosis and lactic acidosis, discontinue medication immediately if acidotic.	Monitor liver function test and monitor for signs and symptoms of ototoxicity.
Client Teaching	May cause a metallic	Restrict alcohol intake.

needs (2)	taste. Inform patient medication does not cure diabetes, only treats it.	Report any tinnitus, sweating, or hyperventilation to the healthcare provider immediately.

Hospital Medications (5 required)

Brand/ Generic	**Acetaminophen/ Tylenol**	**Cefazolin/ Ancef**	**Zofran/ Ondansetron HCl**	**Oxytocin/ Pitocin**	**Bicitra/ Sodium citrate/ Citric acid**
Dose	975 mg	2g	4 mg	20 units	15 mL
Frequency	Once, PRN	ONCE	Q6H, PRN	Continuous infusion	ONCE
Route	Oral	IV	PO	IV	Oral
Classification	Nonopioid analgesics Non salicylate.	Cephalosporin- 1st generation Anti-infectives	Antiemetic, selective serotonin ($5\text{-}HT_3$) receptor antagonist	Hormones/ Oxytocic's	Alkalinizing agent/
Mechanism of Action	May block pain impulses peripherally that occur in response to inhibition of prostaglandin synthesis; does not possess anti-inflammatory properties.	Bactericidal actions because of cephalosporin inhibition of cell wall synthesis. Binds to specific penicillin-binding-proteins located in	Blocks serotonin receptors in the vagal nerve terminals in the intestine. Reduces nausea and vomiting by preventing the release	Oxytocin is a natural hormone secreted by the pituitary gland. It causes contraction of the uterus during labor. It can be given supplementally through IV to contract	Citrate chelates free calcium ions preventing them from forming a complex with tissue factor and coagulation factor X. Furthermo

		the cell wall, it inhibits the third and last stage of bacterial cell wall synthesis.	of serotonin in the small intestine and by blocking signals to the CNS	uterus and prevent hemorrhage.	re, metabolized to bicarbonate which then acts as a systemic alkalizing agent, raising the pH of the blood and urine.
Reason Client Taking	Prophylactic pain medication for c-section.	Prophylactic treatment for possible GBS infection.	Nausea and vomiting	To produce uterine contractions during the third stage of labor and to control postpartum bleeding	Prophylactic nausea properties.
Contraindications (2)	Breastfeeding. Pregnancy.	Hypersensitivity to any cephalosporin and related antibiotics. Lactation.	Concomitant use of apomorphine Congenital long QT syndrome	Uterine prolapse. Clients who are at risk of uterine rupture.	Severe renal insufficiency. Sodium-restricted diet.
Side Effects/Adverse Reactions (2)	Hepatotoxicity. GI bleeding.	Anaphylaxis. Urticaria.	Serotonin syndrome. Constipation.	Nausea. Painful contractions.	Diarrhea. Hyperkalemia.
Nursing Considerations (2)	Monitor liver function studies: AST, ALT, bilirubin, and creatinine. Monitor blood	Perform culture and sensitivity testing prior to and during	Be aware that disintegrating tablets contain aspartame	Monitor for hypotension and perform fundamental checks Q15 for the first	Administer after meals to avoid laxative effects. May be

	studies: CBC, and PT.	therapy. Monitor I&O rates and patterns, and monitor for changes in BUN, and serum creatinine	and must be avoided in patients with phenylketonuria. Monitor patients closely for signs and symptoms associated with serotonin syndrome.	hour of administration.	ordered as modified Shohl's solution; dilute with 30-60 mL of chilled water to enhance taste.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Monitor liver function studies prior to administration.	Monitor injection site for pain, swelling and irritation. Report prolonged or excessive injection site reactions to the physician.	Monitor ECG prior to administration and after administration as ondansetron can prolong the QT interval, resulting in life-threatening arrhythmias.	Assess contraction frequency, intensity, and duration.	Monitor for hypernatremia, hyperkalemia, and salicylates usage.
Client Teaching needs (2)	Inform the delivering mother that urine may become dark brown because of acetaminophen metabolization. May be used when breastfeeding, short term.	Instruct patient to notify the nurse or doctor about GI problems (nausea, vomiting, and diarrhea).	Advise the patient to use a calibrated container or oral syringe to appropriately measure oral solution.	Expect contractions to begin shortly after administration. Report signs and symptoms of itching, burning, or rash.	Inform the patient they may experience diarrhea, or nausea, or vomiting. Report changes in CNS status

		Do not breastfeed while taking this medication.	Advise the patient to immediately seek medical attention if symptoms of hypersensitivity are present.		such as irritability, tremors, and confusion.

Medications Reference (1 required) (APA):

Jones & Bartlett Learning. (2021). *2021 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert, responsive, and oriented to time, place, and person; A&O x4. The patients express concern for her newborn's oxygen and breathing pattern. The patient does not appear to be in distress, and her appearance is well-groomed and appropriately dressed.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score: 22** **Drains present: Y☐ N ☒** **Type:**	The patient's skin color is normal for the Caucasian American race. The patient's skin character is dry, intact, and pink. Skin turgor is normal, and elastic and no signs dependent edema noted in the lower extremities. Skin temperature is warm, and skin turgor is normal and elastic. No rashes or bruises were present. Post-procedure, the patient had a lower transverse cesarean incision. The patient has a Braden score of 22.

HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head is normocephalic; the head and neck are symmetrical; active, equal movement, and there are no abnormalities in the trachea, thyroid, vessels, or lymph nodes. PERRLA noted, and eyes are symmetrical and have good extraocular movement. Nose symmetrical, no deviation, and no nasal draining or discharge present; teeth well maintained and free of noticeable dental caries. Hearing is equal on both sides, and the ear canal is free of debris, and the tympanic membrane is pearly gray.
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:**	Normal S1 and S2 auscultated, heart sounds are normal with no signs of murmurs. Cardiac strip reads normal sinus rhythm; pulses are 3+ (normal) in the following locations: radial, brachial, carotid, femoral, popliteal, dorsalis pedis, and tibialis posterior. Capillary refill is less than 3 seconds in the fingertips and toes bilaterally—no signs of neck vein distension, nor any signs of edema noted in the upper and lower extremities.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Upon auscultation, clear breath sounds were auscultated in all five lobes anteriorly and posteriorly. Regular and unlabored respirations noted, and lung aerations are equal in both lungs bilaterally.
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 is on a diabetic diet at home because she has diabetes type II; the current diet is a clear liquid diet post-procedure. The client is 162.65 cm (5ft 4 inches) tall and weighs 110.7 kg (244.1 lbs.). Bowel sounds are active in all four quadrants; the last bowel movement was 10/12/2021, around 1900 hours. Upon palpation, the client reported no sensation due to the epidural and no masses seen. Upon inspection, no distension, incision, scars, or drains, or wounds are present. Post-procedure, a lower transverse cesarean section incision is present.

GENITOURINARY (2 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: French (indwelling)** **Size: 16**	Urine is amber and straw-like, urine character is clear, and the patient has an output of 50 mL. The patient has no pain with urination, genitals cleansed, post-cesarean section, and a 16 French indwelling catheter. No bleeding noted from the urinary catheter placement.
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 40 (moderate risk)** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐ NO** **Needs support to stand and walk☐ YES**	The patient needs ADL assistance and is a fall risk due to the epidural anesthesia for cesarean section. The patient is at a fall risk of 40 (moderate risk) because of impaired gait, IV lock present, which places her at a moderate fall risk. The patient needs support to stand and walk due to weakness caused by epidural anesthesia.
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 is cognitive and oriented to person, place, situation, and time; A&O x4. The patient's speech is clear, patient's sensory is alert; however, due to the epidural anesthesia, she does not have sensory of her lower limbs. The patient's deep tendon reflex was 2+, indicating a normal response. The patient is alert, awake, and able to answer 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 copes through the support of her husband and family; she and her husband are family oriented. The patient practices Christianity and states she tried to go to church as much as possible. The patient lives with her husband and 11-year-old son in Rantoul. The patient states she feels safe at home and has no fears of her home life. Furthermore, the patient can read, write, and speaks in clear, complete sentences, and she is entirely capable of making fully informed decisions.
Reproductive: (2 points) **Rupture of Membranes:** o **Time:** o **Color:** **Amount:**	Artificial rupture of membranes (AROM) occurred at 0803 (8:03 A.M.). The amniotic fluid was clear, odorless, and the amount not documented. The patient received an epidural to relieve the pain of the cesarean section.

o Odor: **Pain medication or Epidural:** **Assistive delivery:** **Episiotomy/Lacerations:** **Immediate Postpartum:** **o Fundal Height & Position:** **o Bleeding amount:** **o Lochia Color:** **o Character:**	Yes, the patient did have an assistive delivery via a cesarean section. The patient did not have an episiotomy or any lacerations due to the cesarean section. Immediately postpartum, the patient had a fundal height of U-1, which is 1 cm below the umbilicus with a midline position. The bleeding was moderate, the lochia color was Rubra, and the character was thick, dark clots.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	The delivery date of the neonate is 10/13/2021 at 0804 (8:04 A.M.). The patient delivered via cesarean section. In total, the quantitative blood loss is 829 mL, which is within normal limits of cesarean birth. The patient delivered a female. At one minute, the female neonates' Apgar score was 8, and the Apgar score at five minutes was 8. The female neonate's weight is 4080 grams, 8 lbs., 15.2 ounces. The patient chose to bottle feed as the feeding method**.**

Vital Signs, 3 sets (5 points)

Time	**Pulse**	**B/P**	**Resp Rate**	**Temp**	**Oxygen**
Prenatal	N/A	120/68	N/A	N/A	N/A
Admission to Labor/Delivery	89	123/78	16	36.9 C 98.4 F	94%
During your care	69	107/60	18	36.0 C 96.8 F	99%

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

The client did most of her prenatal visits at Christie clinic, so blood pressure was the only vital recorded for her prenatal visit. The client's vital signs prenatally, admission, and during care provided are all within normal limits. The client underwent a cesarean section, so vitals are Q15

for the first postpartum hour and after. It is essential to monitor blood pressure and temperature throughout postpartum care because of the risk for infection and postpartum hemorrhaging.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numerical	N/A	0/10	N/A	N/A
0950	Numerical	N/A	0/10	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	The patient has an 18 gauge IV. The IV is in the right-hand metacarpal vein. The date of the IV is 10/13/2021. The patency of the IV is adequate. There are no abnormal signs of erythema or drainage; the IV dressing is clean, dry, and intact. The patient Pitocin is running at 60 mL/hr.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Lactated Ringers 250 mL 20 mL Pitocin units in 500 mL Normal saline Total = 770 mL	50 mL Urine (indwelling catheter) 829 mL QBL Total = 879 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,	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.

identify medical treatments with "T" after you list them.)		
The nurse checks maternal vital signs to identify the sign of hypotension or hypertension. (N)	Q15-Q30 Mins	The mother receives epidural anesthesia, which places her at risk for hypotension during the delivery. Completing frequent blood pressure and respiratory checks will give a baseline and help to identify when to intervene.
Show respect to the delivering mother and allow her husband and family members to be present. (N).	PRN, Q5 Mins	Displaying respect, kindness, and inclusion of the family members aids in reducing stress for the delivering mother. Having one support person in the delivery room could offer therapeutic communication and aid in the delivery of the neonate.
Establish therapeutic relationship with the pregnant women and her relatives. (N)	PRN, Q10 Mins	Establishing a therapeutic relationship with the mother and her support person or partner aids in fostering more effective and clear communication between the clinical staff, the delivering mother, and the support person or partner.

Nursing Diagnosis (30 points)
Must be NANDA approved nursing diagnosis and listed in order of priority
Two of the Nursing diagnoses must be education related i.e. the interventions must be education for the client."
2 points for the correct priority

Nursing Diagnosis (2 pt each)	**Rationale (1 pt each)**	**Intervention/Rationale(2 per dx) (1 pt each)**	**Evaluation (2 pts each)**
Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by"	Explain why the nursing diagnosis was chosen	Interventions should be specific and individualized for this patient. Be sure to include a time interval such as "Assess vital signs q 12 hours." List a rationale for	● How did the patient/ family respond to the nurse's actions? ● Client response, status of goals and outcomes,

components		each intervention and using APA format, cite the source for your rationale.	modifications to plan.
1. Risk for bleeding related to the potential of postpartum complications as evidenced by quantitative blood loss.	The client underwent a cesarean section with a quantitative blood loss of 829 mL. Furthermore, the client has a prenatal history of anemia and a decreased hematocrit level, which places postpartum complications at an even higher risk that could lead to bleeding. Lastly, the client had a previous cesarean section, and the possibility of a cesarean scar defect further increases her risk.	1) Monitor vital signs Q15mins for the first 2 hours and Q1hr every hour for abnormal values that could indicate bleeding **Rationale:** Early bleeding compensatory mechanisms alter respiration, pulse, and blood pressure, and subtle changes can be detected early on (Phelps, 2020). 2.Administer 20 units of Pitocin in 500 mL of normal saline via continuous infusion. **Rationale:** Pitocin (oxytocin) acts as a uterotonic drug by stimulating the uterus to contract and expel remaining blood fragments, reducing the chances of postpartum hemorrhaging (Swearingen & Wright, 2019).	The patient's vital signs remained within the expected ranges for the immediate postpartum period. The patient understood the rationale for frequent vital sign checks The patient stated she did not feel any pain; however, she does feel some cramps and contractions from the Pitocin infusion. The client expelled some clots that were Rubra in color.
2. Risk for infection related to cesarean section procedure as evidenced by increased	Due to the hemodilution expected in pregnancy, the mother already has an increased	**1)** Monitor WBC count every (Q8hrs) or as ordered. Report elevations or depressions immediately to the provider. **Rationale:** Markedly decreased WBC count may indicate decreased	The patient tolerated the blood draws fine and understood the rationale for them. The client's WBC count did not increase throughout our clinical care.

white blood cell count, decreased hemoglobin, and hematocrit values.	WBC count and decreased hematocrit and hemoglobin levels (Jarvis & Nelson-Piercy, 2020). The mother just underwent an invasive procedure. There is always the risk for pathogens to enter the body and cause infection. The decreased hematocrit and hemoglobin levels could lead to inadequate oxygenation of the tissues to the lower transverse area, therefore fostering bacterial growth leading to infection.	production, and increased may indicate a possible infection (Phelps, 2020). **2.** Assess the abdominal site (Q4hrs) for abnormalities such as edema, erythema, purulent drainage, and wound dehiscence; all are potential signs of infections. **Rationale:** Early identification of erythema, purulent drainage, wound dehiscence, and edema assist in avoiding further severe infections such as sepsis (Swearingen & Wright, 2018).	The patient understood the skin checks and eventually explained the sign and symptoms back to the nurse. Goal met.
3. Interrupted family process related to the change in family routine functioning as evidenced by the increase of responsibility that comes	This is the family's second child; they currently have an 11-year-old. The introduction of a new family member can stress everyone in the household, therefore	**1.** Teach the family to communicate clearly and honestly to increase their ability to express thoughts and feelings positively **Rationale:** Harboring feelings, emotions, thoughts, and concerns can lead to misunderstanding and resentment (Phelps, 2020).	The patient and her husband understood that the addition of a newborn into the household might cause some role strain with their 11-year-old. They stated they openly communicate with their child about the newborn. Goal met.

with a newborn.	interrupting their already established process until the family acclimates to the new member.	**2.** As appropriate, make referrals to social services or community agencies to provide the family with access to additional coping resources. **Rationale:** When there is an addition to the family, it is vital to have access to parenting, psychological counseling, or social services (Phelps, 2020).	The patient plans to establish monthly parenting sessions since their last newborn has been a while.
4. Readiness for enhanced parenting related to the addition of a newborn as evidenced by this being the father's first child, and the 11-year gap between the child at home and newborn.	The couple is parenting an 11-year-old; being that it has been 11 years, the mother is likely deficient in knowledge caring for a newborn. This is the father's first known child, which places him at a knowledge deficit, and he is ready for enhanced parenting.	**1.** Offer parents an opportunity to express their doubts or convictions about the adequacy of their parenting skills. **Rationale:** An open and receptive attitude provides an atmosphere for increased trust and enhanced learning (Phelps, 2020). **2.** Explore parents' perception of social support and community resources available to the family. **Rationale:** Social support and community resources provide guidance and positive reinforcement for parenting techniques (Phelps, 2020).	The parents expressed confidence and positivity as they move forward with the new responsibilities that come along with an addition to their family. The parents verbalized that they know the community resources they could utilize when need be.

Here are my options for C section/labor and delivery nursing diagnosis:

Other References (APA)

Jarvis, S., & Nelson-Piercy, C. (2020). Common symptoms and signs during pregnancy. *Obstetrics, Gynecology & Reproductive Medicine*, *30*(10), 321–325. https://doi.org/10.1016/j.ogrm.2020.07.005

Phelps, L. L. (2020). *Sparks & Taylor's nursing diagnosis reference manual*. Wolters Kluwer.

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource medical-surgical, pediatric, maternity, and Psychiatric-Mental Health*. Elsevier.