

N432 Labor & Delivery Care Plan

Lakeview College of Nursing

Olivia Powell

Demographics (3 points)

Date & Time of Admission 4/1/21	Patient Initials L.S.	Age 28 years old	Gender Female
Race/Ethnicity Caucasian	Occupation Waitress	Marital Status Single	Allergies Diltiazem, Penicillin
Code Status Full	Height 68 inches (5'8)	Weight 286 lbs	Father of Baby Involved Yes

Medical History (5 Points)

Prenatal History: G1P0. The patient started prenatal care at 10 weeks. At 28 weeks, she was diagnosed with gestational diabetes. Her blood sugar is being controlled by a 2200 calorie diabetic diet. She checks her blood sugar once in the morning before breakfast and before her evening meal. LS takes Prenatal vitamin with Iron.

Past Medical History: The patient denies any medical history.

Past Surgical History: The patient had an appendectomy when she was 7 years old.

Family History: The patient reported her father has hypertension and COPD from smoking for many years. Her mother has breast cancer that required a lumpectomy and no other health problems.

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

Living Situation: LS lives with her boyfriend.

Education Level: The patient completed high school.

Admission Assessment

Chief Complaint (2 points): Pt was experiencing contractions but thought they were Braxton Hicks contractions.

Presentation to Labor & Delivery (10 points): On April 1st, a 28 -year-old female presented to OSF labor and delivery unit for contractions. The patient is 34 weeks' gestation and is due 5/13/21. She is G1P0. The patient reported that she was experiencing contractions but thought that they were just Braxton Hicks contractions. She came to the unit when the contractions did not go away with rest. Upon admission to the unit, her vital signs were as follows: T 98.7 oral, P 88, RR 18, BP 130/70. She was placed on an external fetal monitoring.

Diagnosis

Primary Diagnosis on Admission (2 points): Preterm 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 first stage of labor occurs when there are confirmed rupture of membranes, cervical dilation, and discomfort from contractions (Ricci et al., 2021). The latent and active stages are also included within the first stage of labor. When a woman is in the latent phase of labor, she will typically stay at home and just describe the contractions as menstrual cramps (Ricci et al., 2021). The active phase begins when the latent phase ends. During the active phase, the cervix will complete dilation. The contractions will increase in duration and frequency (Ricci et al., 2021). Women start to become uncomfortable, and the nursing staff can begin certain interventions. For example, a woman might ask for an epidural. The patient asked for an epidural but unfortunately, she was too far dilated and was not able to receive one.

When a woman becomes 10 cm dilated and is effaced 100%, she is now in the second stage of labor. The contractions start occurring from 1-2 minutes apart and are high intensity (Ricci et al., 2021). During the second stage of labor, pushing occurs. Women will feel the need to push which leads to the active pushing. In this stage, the patient only pushed a total of four times and delivered a boy weighting 2013 grams.

In the third stage, the newborn is delivered, and the placenta is also delivered. Once the newborn is delivered the placenta will start to progress its way out of the birthing canal (Holman et al., 2019). By initiating skin-to-skin contact it will help release oxytocin which will help stimulate placental separation and breastfeeding (Ricci et al., 2021). When the placenta starts to

separate, there will be a trickle of blood, lengthening of the umbilical cord, and the uterus will change shape (Ricci et al., 2021). After several minutes of the delivery of the infant, the patient's placenta was delivered completing the third stage of labor. The patient's vital signs were monitored every 15 minutes for one hour.

The final stage of labor is called postpartum. In this stage, the mother is stabilized, and the placenta is completely detached from the mother (Ricci et al., 2021). The mothers' vital signs, lochia, and fundus are monitored closely every 15 minutes for one hour. The mother is highly encouraged to urinate to avoid any bladder distention (Holman et al., 2019). During this stage, the mother is assessed for return of sensation after an epidural, initiating skin-skin bonding, and recovery (Ricci et al., 2021). The patient had an elevated temperature and pulse after delivery, the patient's physician ordered a complete blood count to be collected 12 hours once delivery was completed.

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

Holman, H.C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., McMichael, M.G., & Barlow, M.S. (2019). *Rn maternal newborn nursing* (11th ed.). Assessment Technologies Institute.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing*. Wolters Kluwer.

Laboratory Data (15 points)

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

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.5-5.2	4.56	4.16	N/a	
Hgb	11.0-16.0	14.2	12.9	N/a	

Hct	34.0-47	39.9	37.9	N/a	
Platelets	140-440	198	178	N/a	
WBC	4.00-11.00	6.04	9.08	N/a	
Neutrophils	47.0-73.0	N/a	N/a	N/a	
Lymphocytes	18-42	N/a	N/a	N/a	
Monocytes	4-12	4.5	4.8	N/a	
Eosinophils	0-5	0.2	0.2	N/a	
Bands	0-5	0.2	0.2	N/a	

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

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	A, B, AB, O	O	O	O	
Rh Factor	Positive or Negative	+	+	+	
Serology (RPR/VDRL)	Nonreactive	N/a	N/a	N/a	
Rubella Titer	Positive	>500	N/a	N/a	
HIV	Negative	Negative	N/a	N/a	
HbSAG	Negative	N/a	N/a	N/a	
Group Beta Strep Swab	Negative	Positive	N/a	N/a	The patient could have had sexual intercourse (Group B Strep and pregnancy, 2021).
Glucose at 28 Weeks	70-100	190	97	120	The patient was diagnosed with gestational diabetes (Ricci et al., 2021).
MSAFP (If Applicable)	0.5-5.0	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
Calcium	8.6-10.2	N/a	8.7	N/a	
Glucose	70-100	N/a	97	N/a	
BUN	8-20	N/a	7	N/a	Pregnant women's bodies break down products differently (Ricci et al., 2021).
Creatine	0.6-1.0	N/a	0.64	N/a	
TP	6.0-8.3	N/A	6.7	N/a	
ALB	3.5-5.5	N/a	2.6	N/a	The patient is positive for GBS (Group B Strep and pregnancy, 2021).
AST	5-40	N/a	15	N/a	
ALT	7-35	N/a	11	N/a	
Sodium	135-145	N/a	137	N/a	
Potassium	3.6-5.2	N/a	3.5	N/a	
Chloride	96-106	N/a	105	N/a	
CO2	23-29	N/a	21.6	N/a	The patient was in labor and was very anxious, requiring oxygen (Ricci et al., 2021).
Magnesium	1.7-2.2	N/a	1.8	N/a	
GFR	>60	N/a	>60	N/a	
Uric acid	2.7-7.3	N/a	3.3	N/a	
LD(LDH)	140-280	N/a	171	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	N/a	N/a	N/a	N/a	N/a

protein/creatinine ratio (if applicable)					
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Lab Reference (1) (APA):

Group B Strep and pregnancy. (2021, January 21). Retrieved from <https://gbss.org.uk/info-support/about-group-b-strep/what-is-group-b-strep/>

Ricci, 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
<p>What is the Baseline (BPM) EFH?</p> <p>Has it changed during your clinical day? If yes, how has it changed?</p>	<p>The baseline EFH is around 150 bpm.</p> <p>The baseline of 150 bpm was constant with a few episodes of decelerations when the patients’ contractions become more frequent.</p>
<p>Are there accelerations?</p> <ul style="list-style-type: none"> • If so, describe them and explain what these mean (for example: how high do they go and how long do they last?) <p>What is the variability?</p>	<p>There are some accelerations on strip 2 and 3. Each acceleration goes up anywhere from 5 to 10 bpm for around 10-15 seconds right before each contraction.</p> <p>On strip 1, there is minimal variability. Strips 2-4 show moderate variability.</p>
<p>Are there decelerations? If so, describe them and explain the following: What do these mean?</p> <ul style="list-style-type: none"> o Did the nurse perform any 	<p>On strips 2-4 there are minimal decelerations. Each time a contraction occurs, a deceleration happens.</p> <p>The first intervention that occurred was turning the patient on her left side. The next intervention was to apply oxygen at 3L.</p>

<p>interventions with these?</p> <ul style="list-style-type: none"> o Did these interventions benefit the patient or fetus? 	<p>When comparing the interventions and the strips, the interventions only helped some of the time in strip 3 and 4.</p>
<p>Describe the contractions at the beginning of your clinical day: Frequency: Length: Strength: Patient's Response:</p>	<p>The patient's contractions were around every 5 minutes lasting 30-40 seconds each. The contractions intensified each time. The patient became nauseated during this period. Pt rated pain 4/10.</p>
<p>Describe the contractions at the end of your clinical day: Frequency: Length: Strength: Patient's Response:</p>	<p>The patients' contractions were strong, occurring around every 1-2 minutes, and lasting 70-80 seconds. Pt rated pain 10/10.</p>

EFM reference (1 required) (APA format):

Ricci, S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

**Current Medications (7 points, 1 point per completed med)
 *7 different medications must be completed***

Home Medications (2 required)

Brand/Generic	Acetaminophen/ Tylenol	Prenatal Vitamin			
Dose	500mg	27mg (1 tablet)			
Frequency	PRN Q6 hr	Daily			
Route	Oral	Oral			
Classification	Nonopioid	Vitamin			

	analgesic				
Mechanism of Action	Inhibits cyclooxygenase to interfere with pain impulses.	Helps prevent vitamin deficiency			
Reason Client Taking	For headaches	Pt is pregnant			
Contraindications (2)	Acute liver failure, severe renal impairment	Anemia, hemochromatosis			
Side Effects/Adverse Reactions (2)	Rash, Headache	Muscle weakness, hives			
Nursing Considerations (2)	This medication should not be given for more than 4-5 days. Tylenol can cause hepatic damage.	Avoid herbal supplements. Do not take with calcium supplements or dairy products.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Liver function should be assessed before administration. Be mindful that this medication can cause false glucose readings.	Check iron levels. Ask about any other medications.			
Client Teaching needs (2)	Ensure the pt only takes as prescribed. Instruct the pt to avoid alcohol while taking.	Only chew the tablet if it is a chewable tablet. Always take with a full glass of water.			

Hospital Medications (5 required)

Brand/Generic	Zofran/ Ondansetron	Betamethasone/ Sernivo	Lactated Ringers Solution	Nifedipine/ Reglan	Vancomycin/ Firvanq
Dose	4mg	12mg	100mL/hr	Initial dose 30mg, then 10 mg	1.5mg in 100mL
Frequency	once	Once, then again at 24 hr	Continuous	Q6h	Continuous for 4 hr
Route	oral	Intramuscular	Intravenous	Oral	IV
Classification	Antiemetic	Glucocorticoid	IV solution	Calcium channel blockers	Glycopeptide antibiotics
Mechanism of Action	Blocks the process of serotonin	Binds to glucocorticoid receptors to bind to DNA to modify	Solution to replenish electrolytes and fluids	Relaxes cardiac muscles and blood vessels	Prevents bacteria from producing cell walls to grow
Reason Client Taking	Pt became nauseated.	The pt is in preterm labor.	To help with fluid and electrolyte balance	The pt is experiencing hypertension .	The pt has a positive GBS test.
Contraindications (2)	Serotonin syndrome, hypomagnesemi a	Hypersensitivit y to betamethasone, untreated infections	Severe liver disease. Severe metabolic acidosis/alkalosi s	Severe heart failure, myasthenia gravis	Kidney disease, hearing loss
Side Effects/Adverse Reactions (2)	Drowsiness, constipation	Acne, rash around the mouth	Back pain, decreased heart rate	Flushing, swollen ankles	Black, tarry stools, fever
Nursing Considerations (2)	Monitor for unbalanced gait, Be cautious that the pt could fall	Monitor for signs of peptic ulcer, assess for joint pain	Monitor for hypervolemia, for short term correction only	Assess cardiac status, closely monitor blood glucose levels	Ensure the pt's IV line is patent, plan accordingly to procedure time

Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess for drowsiness, monitor for mental status change			Monitor liver function, monitor potassium levels	
Client Teaching needs (2)	Take as prescribed, This medication can be taken with or without food	Do not use long term, The injection must be administered slowly.	Use for short term only, Do not take with products that can cause hyperkalemia	Do not breastfeed while on this medication, Tell provider of lactose problems	If medication is frozen, do not thaw in a microwave or freezer, Allow the medication to reach room temperature before administering

Medications Reference (1 required) (APA):

Jones & Bartlett Learning. (2020). *2021 Nurse’s Drug Handbook* (20th ed.). Jones & Bartlett Learning.

Prenatal multivitamins Uses, Side Effects & Warnings. (n.d.). Retrieved from <https://www.drugs.com/mtm/prenatal-multivitamins.html>

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): Alertness: Orientation: Distress: Overall appearance:	Pt is alert and orientated x3. Pt appeared to be well groomed and in no acute distress.
INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: .	Skin color is normal for race. Upon palpation, skin is warm and moist. There are not rashes, lesions, or bruising noted. Normal skin turgor. Capillary refill is less than 3 seconds. There are no rashes or wounds noted. Braden Score: 21

<p>Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	
<p>HEENT (0.5 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck symmetrical. Trachea midline. No drainage, bleeding noted. Bilateral sclera white, conjunctiva pink with no drainage noted. Septum midline. No drainage or bleeding noted. Overall good dentition.</p>
<p>CARDIOVASCULAR (1 point): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>Clear S1 and S2 sounds noted. No murmurs, gallops, or rubs. Normal rhythm and rate. Peripheral pulses are 2+ bilaterally. Capillary refill less than 3 seconds.</p>
<p>RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>No labored breathing noted. Lung sounds clear bilaterally with no wheezes, crackles, or rhonchi.</p>
<p>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:</p>	<p>Carb controlled due to gestational diabetes Controlled 2200 calorie diabetic diet 5'8 286 lbs Bowel sounds present in all four quadrants. 3/31/21 Upon inspection, there is no distention, scars, incisions, or wounds noted. No drains present.</p>
<p>GENITOURINARY (2 Points): Bleeding: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>The patient voided with no pain after delivery. There was 500mL of urine that was yellow with some bloody tinge.</p>

<p>MUSCULOSKELETAL (2 points): ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>No assistance with ADL's. Fall Score: 20</p>
<p>NEUROLOGICAL (1 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC: Deep Tendon Reflexes:</p>	<p>Full ROM bilaterally in all extremities. Normal, equal strength in upper and lower extremities. Pt is alert and orientated. PERRLA. Deep tendon reflexes 2+ bilaterally. Appropriate speech for developmental level. No LOC noted during assessment.</p>
<p>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):</p>	<p>The patient enjoys communicating with her boyfriend as a coping mechanism. Developmental level is appropriate for age. Patient stated she is a Christian and religion helps her get through the tough financial times. She also stated her family lives an hour away, but they communicate every day.</p>
<p>Reproductive: (2 points) Rupture of Membranes: o Time: o Color: o 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:</p>	<p>Spontaneous 4/3/21 @ 0510 Clear Moderate Odorless No epidural or pain medication No assistive devices 1st degree Boggy & positioned to the right 350mL Rubra</p>
<p>DELIVERY INFO: (1 point) Delivery Date: Time: Type (vaginal/cesarean):</p>	<p>4/3/21 0828 Vaginal</p>

Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:	350mL Male 6 @ 1 minute, 8 @ 5 minutes 2013 g Breast and bottle feeding
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Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	78 bpm	126/66	18	98.1F	100%
Admission to Labor/Delivery	98 bpm	132/85	16	98.4 F	100%
During your care	98 bpm	134/88	18	99.0 F	100%

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

The patient’s blood pressure and pulse went up during labor. The patient remained stable through the time of care.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1730	Numeric	Abdomen	4/10	Contractions, tightening	Pt was repositioned to her side.
0500	Numeric	Abdomen	7/10	Contractions, tightening	Pt was administered Ondansetron as she became nauseous from the pain.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 g Location of IV: Right forearm Date on IV: 4/1/21 Patency of IV: Patent and flushable Signs of erythema, drainage, etc.: No swelling or drainage noted IV dressing assessment: Dry, clean, and intact	Lactated Ringers at 100 mL/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
LR @ 100 mL/hr 240mL water Ice chips – 100mL	500mL

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.
Turned on left side - N	Once	Pt’s BP and pulse were rising but oxygen was dropping.
Administered oxygen – T	Once	Pt’s BP and pulse were rising but oxygen was dropping.
Education on breastfeeding - N	Once	Pt needed education on breastfeeding as she has no prior knowledge.

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	Rationale	Intervention/Rationale(2	Evaluation
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<p>(1 pt each) Identify problems that are specific to this patient. Include full nursing diagnosis with “related to” and “as evidenced by” components</p>	<p>(1 pt each) Explain why the nursing diagnosis was chosen</p>	<p>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.</p>	<p>(2 pts each)</p> <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Risk for injury related to delivery of preterm infant.</p>	<p>The patient is only at 34 weeks gestation.</p>	<p>1. Administer Betamethasone IM. Rationale: With the fetus being premature, it can help speed up the fetus’s lung maturity (Martin, 2019). 2. Assess fetal heart tones. Rationale: The delivery could be very rapid making it difficult on the fetus (Martin, 2019).</p>	<p>Pt was administered Betamethasone and reacted well.</p> <p>Fetal heart tones were monitored. There were very few periods of decelerations.</p>
<p>2. Acute pain related to uterine contraction as evidenced by pt reported pain 10/10 as the contractions intensified.</p>	<p>The patient is in preterm labor.</p>	<p>1. Teach the patient relaxation techniques. Rationale: This will help the mother control her sensation of pain (Martin, 2019). 2. Monitor both fetal and maternal vital signs. Rationale: By continuous monitoring, this will show the effectiveness of the interventions performed (Ricci et al., 2021).</p>	<p>The pt was taught breathing techniques to calm down when she started to feel anxious.</p> <p>The vital signs on both mother and fetus remained stable during interventions.</p>
<p>3. Knowledge deficit related to change in responsibilities as evidenced by pt is primigravida.</p>	<p>The patient has never had a child before.</p>	<p>1. Include significant other in the teaching process. Rationale: By including the significant other, this may help eliminate any stress the mother is experiencing (Martin, 2019). 2. Review the patient’s daily routine that may be affected by having an infant. Rationale: By reviewing</p>	<p>The boyfriend of the patient was involved in teaching, and he was eager to learn.</p> <p>The patient’s daily routine was assessed, and they came up with a plan to help adjust to the infant’s needs.</p>

		the patient’s schedule, it may help the mother and significant other realize their new roles in having an infant (Martin, 2019).	
<p>4. Knowledge deficit related to breastfeeding as evidenced by pt reported she not her family members have breastfed before.</p>	<p>Patient stated her family has never breastfed any of their babies.</p>	<p>1. Assess the patient’s readiness to learn. Rationale: By determining the patient’s readiness to learn, it will determine the effectiveness of learning (Martin, 2019). 2. Provide information about how to breastfeed. Rationale: When providing information, this will allow the patient to reference back to what was taught (Ricci et al., 2021)</p>	<p>The patient was eager to learn as she would ask questions through the teaching process.</p> <p>A handout was provided to the patient and boyfriend.</p>

Other References (APA)

Martin, P. (2019, June 1). *36 labor stages, induced and augmented labor care plans.*

Nurselabs.com. <https://nurseslabs.com/labor-stages-labor-induced-nursing-care-plan/6/#f2>

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing.* Wolters Kluwer.