N432 Labor & Delivery Care Plan

Lakeview College of Nursing

Happy Kalavadia

Demographics (3 points)

Date & Time of Admission	Patient Initials	Age	Gender
10/25/2021 09:01 am	TB	22	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Hispanic	Not working	Not married	None
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full	5'5	97.1 kg	Yes

Medical History (5 Points)

Prenatal History: Hemoglobin C trait, Bacterial Vaginosis

Past Medical History: Anemia, Obesity and asthma

Past Surgical History: Has no past history on file.

Family History: Sickle cell trait in mother and sister.

Social History (tobacco/alcohol/drugs): Patient smoked marijuana in the past but she did stopped it when she found out she was pregnant. Patient confirmed " Occasional '' use of alcohol during social events .

Living Situation: Lives by herself in home.

Education Level: High School diploma

Admission Assessment

Chief Complaint (2 points): Patient is 39 weeks pregnant and admitted to maternal fetal floor for scheduled induction of labor.

Presentation to Labor & Delivery (10 points): This 22 year old pregnant patient presented to the hospital for scheduled induction. She is 39 weeks pregnant and patient is a primigravida. She is 1 cm dilated cervix upon vaginal examination. Patient is scheduled for elective IOL(Induction of Labor) and she is eager to end the pregnancy because she is

exhausted from her pregnancy. She had epidural anesthesia at 17:00 and she is experiencing mild contractions which are 5 – 10 minutes apart. She mentioned that she used castor oil at home to induce labor, but it was unsuccessful. She was scheduled for artificial rupture of membranous by amnihook, but she ruptured her membrane spontaneously at 15:10 during vaginal examination by the provider. She is currently comfortable and does not experience pain . She is NPO and is voiding properly.

Diagnosis

Primary Diagnosis on Admission (2 points): Scheduled induction.

Secondary Diagnosis (if applicable): Spontaneous rupture of membrane at 4:00 am.

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 exists when the contractions help the cervix thin and begin to open, this is called effacement and dilation. During this stage, the cervix will open to 10 cm, and the first stage of labor can last about 12 to 13 hours for the primigravida (Ricci et al., 2021). There are three subsets of the first stage of labor: early labor, active labor, and the transition to the second stage (Ricci et al., 2021). During early labor, most of the time is spent at home. Active labor is when it is time to go to the hospital, and contractions will occur every 3 to 4 minutes (Ricci et al., 2021). The transition to the second stage is when the cervix opens from 7 to 10 cm and can be the most complicated, most painful part of labor (Ricci et al., 2021). The patient was in the first stage of labor because she was only 1 cm dilated, and the cervix was starting to open. Epidurals are given at this stage and this patient requested one to relieve her pain.

The second stage of labor occurs when the cervix is completely dilated and ends with the baby's birth (Ricci et al., 2021). The contractions push the baby down towards the birth canal, causing significant pressure. The patient should start pushing with the start of each contraction. The end of the first stage of labor is when the pushing phase starts of the second stage of labor (Greene, 2019).

The third stage of labor is after the birth of the baby. This is when the uterus continues to contract, and the placenta is pushed out (Ricci et al., 2021). The placenta usually delivers about 5-15 minutes after the baby arrives. The third stage of labor is the quickest. After the baby is born, the umbilical cord is cut after waiting for several minutes for the pulsations to stop (Greene, 2019). All women lose some blood after delivery when the placenta is pushed out (Greene, 2019). The provider checks to ensure all pieces of the placenta are intact, and there are no remaining fragments inside the uterus (Greene, 2019). After delivery of the placenta, the nurse or provider will massage the fundus to determine location and firmness. Medication is sometimes given to keep the uterus contracted (Greene, 2019).

Lastly, the fourth stage of labor is the hour or two after delivery, and the tone of the uterus is reestablished as the uterus contracts again (Ricci et al., 2021). The contractions are promoted with breastfeeding, which stimulates the production of oxytocin (Ricci et al., 2021). This is also the time of rest and recovery (Ricci et al., 2021). The baby starts breastfeeding after being skin to skin with her mother. (Ricci et al., 2021).

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

Greene, J. (2019, January 3). *The four stages of labor*. The Four Stages of Labor | Kaiser Permanente Washington.

Ricci, S.S., Kyle, T., & Carman, S. (2017). ***Maternity and pediatric nursing*** **(3 rd ed.). Philadelphia, PA: 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- 5.30 million units	**3.57**	**N/A**	**4.13**	**Within normal range.**
Hgb	12.0 -15.8	**10.3**	**N/A**	**11.3**	**Patient has Iron deficiency anemia and hence has low hemoglobin levels** (Ricci et al., 2021).
Hct	36.0-97.0	**29.8**	**N/A**	**32.8**	**Patient has Iron deficiency anemia and hence has low production of hematocrit due to decreased RBC** (Ricci et al., 2021).
Platelets	140- 440 cells/ mm3	**188**	**N/A**	**159**	**Within normal range.**
WBC	4- 12 cells/mm3	**13.56**	**N/A**	**11.9**	**Can be elevated to due physiologic stress during labor and inflammation (Ricci et al., 2021).**
Neutrophils	47%- 73%	**68.0**	**N/A**	**73 %**	**Within normal range.**
Lymphocytes	18%- 42%	**24.8**	**N/A**	**20.4**	**Within normal range.**
Monocytes	4%- 12%	**5.5**	**N/A**	**5.4**	**Within normal range.**
Eosinophils	**0.0-0.50**	**1.3 %**	**N/A**	**0.8**	**Within normal range.**
Bands	N/A	**N/A**	**N/A**	**N/A**	**Within normal range.**

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, O, AB	**O+**	**N/A**	**O+**	**N/A**
Rh Factor	Positive Negative	**Positive**	**N/A**	**Positive**	**N/A**
Serology (RPR/VDRL)	Negative	**Negative**	**N/A**	**Negative**	**N/A**
Rubella Titer	Immune	**Immune**	**N/A**	**Immune**	**N/A**
HIV	Negative	**Negative**	**N/A**	**Negative**	**N/A**
HbSAG	Negative	**Negative**	**N/A**	**Negative**	**N/A**
Group Beta Strep Swab	Negative	**Negative**	**N/A**	**Negative**	**N/A**
Glucose at 28 Weeks	<140	**82**	**N/A**	**91**	**N/A**
MSAFP (If Applicable)	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
Hep B	**Detected or not detected**	**N/A**	**N/A**	**Not detected**	**N/A**
Chlamydia	**Detected or not detected**	**N/A**	**N/A**	**Not detected**	**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)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Lab Reference (1) (APA):

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing (3rd ed.).* Philadelphia, PA: 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?**	**130** **The fetal heart rate has changed from 130 to 150 after she has spontaneous rupture of membranes. She was given Terbutaline to decrease the fetal heart rate and the heart rate was returned to its baseline.**
Are there accelerations?	**There are accelerations that go up for 15 seconds and last for**

• **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?**	**30 seconds. There is moderate variability.**
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?**	**Patient had early decelerations. The intervention performed was turning the patient on her side and it benefited the fetus.**
Describe the contractions at the beginning of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	**Contractions were 5 -10 minutes apart and lasted for 60-120 seconds. Patient states she can feel her contractions and rates them a 0/10 on the pain scale due to her epidural anesthesia. Contractions are being monitored with an external device so strength can only be measured by palpation. Strength is undetermined.**
Describe the contractions at the end of your clinical day: **Frequency:** **Length:** **Strength:**	**Contractions were 3-5 minutes apart and lasted for 60-120 seconds. Patient states she can feel her contractions and rates**

Patient's Response:	**them a 0/10 on the pain scale due to her epidural anesthesia. Contractions are being monitored with an external device so strength can only be measured by palpation. Strength is undetermined.**

EFM reference (1 required) (APA format):

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing (3rd ed.).* Philadelphia, PA: 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	**Amoxicillin/Amoxil**	**Ferrous sulfate/ Feosol**			
Dose	**500 mg**	**325 mg**			
Frequency	**Once capsule twice a day**	**Once tablet two times a day**			
Route	**Oral**	**Oral**			
Classification	**Antibiotic**	**Vitamins and Minerals**			
Mechanism of Action	**It inhibits the cell wall synthesis thus killing the bacteria due to its bactericidal properties.**	**It increases the production of RBC and causes increased hemoglobin and hematocrit levels in the blood.**			
Reason Client Taking	**Patient had UTI infection during her pregnancy .**	**Patient had iron deficiency anemia.**			
Contraindications	**Diarrhea**	**GI ulcer**			

(2)	**Renal impairment**	**Hemochromatosis**			
Side Effects/Adverse Reactions (2)	**Blood in the urine Gastric acidity**	**Constipation Bloating**			
Nursing Considerations (2)	**Patient should drink plenty of fluids to prevent toxicity.** **It is important to complete full course of antibiotics treatment.**	**Patient should increase their daily fiber intake to prevent constipation.** **Patient should take with medication with vitamin C to enhance its absorption.**			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**CBC levels especially WBC.**	**Hemoglobin and hematocrit levels.**			
Client Teaching needs (2)	**Take at the antibiotic at the same time to be more effective.** **Take antibiotic after meals to prevent gastric acidity.**	**Tell patient to increase their fluid intake to prevent constipation .** **Avoid taking antibiotics within 2 hours before or after taking ferrous sulfate.**			

Hospital Medications (5 required)

Brand/Generic	**Acetaminophen / Tylenol**	**Calcium carbonate / Tums**	**Lactated Ringers/ 5% dextrose**	**Fentanyl Citrate/ (Fentora)**	**Ropivacaine (Naropin)**	**Oxytocin (Pitocin)**

Dose	650 mg	1000mg	125 ml/hr	50 mcg	24 mg/hr	30 units in LR 500 ml
Frequency	Every 8 hours PRN	Every 8 hours PRN	Continuous	Q2h PRN	Continuous	Continuous
Route	Oral	Oral	IV	IV	IVPB	IV
Classification	Analgesic and antipyretic	Vitamins and Minerals	Alkalinizing agent	Opioid analgesic	Amide local anesthesia.	Oxytocic
Mechanism of Action	It inhibits the prostaglandin in the body which helps in relieving pain.	It prevents gastric acidity , reflux and nausea by increasing bicarbonate and pepsid secretion.	Replaces lost fluids and electrolytes during labor	Binds to opioid receptor sites in the CNS, altering perception of and emotional response to pain by inhibiting ascending pain pathway.	Causes reversible inhibition of sodium ion influx, and therapy blocks impulse conduction at nerve fibers.	Increases concentration of calcium inside muscle cells to increase uterine contraction.
Reason Client Taking	Pain due to uterine contractions.	Gastric acidity	Hydration during labor and fluid replacement.	To relieve severe pain due to no response to less potent drugs.	Pain relief	Induction of labor.
Contraindications (2)	Hepatic impairment Renal impairment	GI ulcer Bleeding	Renal failure and CHF.	Hypersensitivity to fentanyl. Opioid nontolerance. Intermittent pain.	Infection or inflammation at injection site.	Fetal intolerance and placenta previa.
Side Effects/Adverse Reactions (2)	Urticaria Bleeding	Urticaria Bleeding	Hyperkalemia and hypercalcemia.	Seizures, asystole, bradycardia, hypotension, and apnea.	Nausea or vomiting.	Weight gain and hirsutism.
Nursing Considerations (2)	Monitor fetal heart rate. Monitor the	Monitor fetal heart rate.	Administer prior to delivery.	Use cautiously in patients at risk for	Monitor for signs of metabolic acidosis.	Monitor fetal heart rate.

	patient for vaginal bleeding.	Monitor patient for bleeding.	Monitor IV site for infiltration.	opioid abuse. Know to achieve optimum pain control with the lowest possible fentanyl dose.	Monitor cardiovascular and respiratory status closely.	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Asses for pain and fever.	Asses for gastric reflux and acidity.	Electrolytes and vital signs.	Monitor heart rate. Monitor BP.	Before administration get a baseline blood pressure and heart rate.	Monitor electrolytes and blood pressure. Infant is tolerating fine and is heart rate is 130 beats per minute.
Client Teaching needs (2)	Take the medication exactly as directed. Call your prodder or nurse if she has any kind of rash or difficulty breathing.	Take the medication with milk for maximal production Take the medication after meals to prevent gastric acidity.		Caution patient to avoid hazardous activities. Tell patient to increase fluid intake.	Inform patient that this drug is used to ease pain. Inform them that they may experience a headache, nausea, or vomiting.	Inform client of why she is receiving it. Notify that the medication is not harmful to fetus.

Medications Reference (1 required) (APA):

Loebl, S. (2020). *2020 Nurse's drug handbook*. Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The person is alert to person, time and place. She is pleased to talk to and is eager to share her pregnancy journey with student nurse .**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score: 18** **Drains present: Y☒ N ☐** **Type:**	**Skin color is usual for ethnicity.** **Skin is dry and intact.** **Temperature is normal on upper and lower extremities.** **Skin turgor is normal.** **Braden score is 18** **No wounds or rashes upon inspection.** **Patient has Foley's catheter placed after epidural .**
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is symmetrical to skull and face.** **Neck has structure, movement, and nonpalpable lymph nodes.** **Patient can see and hear without aids.** **Teeth are intact and dentition is good.** **Nose is patent and free of polyps or bleeding.**
CARDIOVASCULAR (1 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒**	. **Clear S1 and S2 were heard, no adventitious sounds.** **Pulses were 3+ normal.** **Capillary refill was less than 3 seconds.** **No edema or neck vein distention.**

Edema Y ☐ N ☒ **Location of Edema:**	
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Respirations are regular and nonlabored.** **Respiratory pattern is regular.** **Breath sounds are clear.**
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:**	**.** **Patient was on a regular diet at home and is currently NPO but can still have ice chips and sips of water when taking medications.** **Height is 140 cm.** **Weight is 97.1 kg.** **Bowel sounds are normoactive in all four quadrants.** **Last bowel movement was 10/23/21.** **Abdomen shape is round due to pregnancy, no abnormal distention.** **Normal obstetric abdominal assessment overall.** **No drains, wounds or scars.** **No incisions, scars, or wounds seen.**
GENITOURINARY (2 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: Foley** **Size: 10**	**Patient has no bleeding.** **Genitals are normal.** **Urine is clear and yellow, no odor, no episiotomy/lacerations.** **Foley's catheter present.** **Patient had SROM @ 1510.** **The fluid was clear with moderate amount and no odor.**
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☒** **Fall Score: 22** **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**Patient is currently independent and able to ambulate by herself. But she might be low fall risk later due to her epidural . She might need support and assistance while ambulating.**
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:**	**Oriented to person, place, time, and situation.** **Normal cognition with ability to follow commands.** **Memory intact when having discussion.** **Speech is clear.** **Level of consciousness is alert, awake and**

Speech: **Sensory:** **LOC:** **Deep Tendon Reflexes:**	**answers questions appropriately.** **DTR are 3+**
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):**	**Patient's exhibits coping by listening to music and sleeping. She has good support of her boyfriend. Her religion is not determined. Her parents are not in contact with her . Her boyfriend is supportive and is caring in nature. Currently patient is coping well.**
Reproductive: (2 points) **Rupture of Membranes:** o **Time:** 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:**	**Patient had spontaneous rupture of membranous at 4:00 pm when the provider was examining the vagina as he wanted to rupture by help of amnihook. The color of the fluid was white with not odor and the amount was about 5 ml.** **Patient had chosen epidural anesthesia for her pain.** **Fundus height is below the uterus and the position is LOA.** **Patient has not delivered yet and hence no lochia and bleeding present.**
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	**Baby not delivered yet.**

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**95**	**115/77**	**18**	**98.2**	**100% room**

					air
Admission to Labor/Delivery	**83**	**119/65**	**16**	**98.2**	**100% room air**
During your care	**88**	**139/69**	**16**	**97.2**	**100% room air**

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

Patient vital signs are within the expected ranges. BP ranges from 115/77-139/69, RR remains at 18, pulse ranges from 76-82, temperature ranges from 98.3-98.6, and O2 remains at 100% on room air (RA).

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
11:40 am	**Numeric**	**Abdomen**	**3**	**Mild but sharp pain**	**Patient requested epidural anesthesia.**
4:00 pm	**Numeric**	**Abdomen**	**0 (Patient received an epidural)**	**N/A**	**N/A**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 **Location of IV: Left arm** **Date on IV: 10/25/2021** **Patency of IV: Patent** **Signs of erythema, drainage, etc.: None** **IV dressing assessment:**	Dextrose 5% in lactated ringer. 125 ml/ hr. IV is patent and has transparent dressing.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
1403- IV **Oral – 480 (This was before epidural** **anesthesia as the patient is NPO now).**	**880 ml**

Nursing Interventions and Medical Treatments during Labor & Delivery (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them, identify medical treatments with "T" after you list them.)	**Frequency**	**Why was this intervention/ treatment provided to this patient? Please give a short rationale.**
Epidural (T)	**Once**	This was requested by patient for pain relief. Patient refused cervical check before epidural was given, therefore, her dilation is unknown currently.
Repositioning (N)	PRN	Patient was repositioned whenever her baby was having decelerations and to ensure her comfort.
EFM Monitoring	Continuous	The mother and baby were on continuous monitoring so that their condition can be monitored and ensure everything is normal.

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. **Decreased low blood perfusion related to patient complaining of dizziness and evidenced by low systolic and diastolic blood pressure .**	**Patient pressed the call light button because she felt lightheadedness, dizziness due to her low blood pressure.**	1. Patient was placed in supine position and pillows were placed under her legs so that her legs are above the heart level. **Rationale: This will help the patient's blood pressure to increase and relieve her dizziness (**Martin, 2021). 2. Patient was given fluids which would result in increased blood pressure. **Rationale: Fluids increased the blood pressure due to increased cardiac output resulting in increased venous return and blood pressure (**Martin, 2021).	**Patient's symptoms has improved as well as her blood pressure improved after these nursing interventions. Patient is comfortable now and confirmed that she does not experience dizziness.**
2. **Risk for maternal injury related to epidural as evidenced by bleeding at**	Patient requested an epidural, and it took two before they were able to get it in the	**1.** Monitor temperature and pulse. **Rationale:** Increased temperature and pulse are indicators of infection (Martin, 2021). **2.**Assess for signs of	Patient verbalizes understanding of individual risk and reasons for specific interventions. Patient follows directions to protect herself and fetus

the catheter site due to two needle sticks as provider at difficulty getting the catheter in at the correct sport. .	correct spacing in the spinal cavity.	headache. **Rationale:** Patient can develop a spinal headache due to how many times they were in the spinal cavity (Team, 2019).	from injury. Patient is free of injury and complications.
3.**Knowledge deficit related to epidural catheter as evidenced by thinking it was for urine.**	**Patient thought all catheters were for urine and asked how she is going to urinate through her epidural catheter.**	**1. Assess patient baseline knowledge and expectations during pregnancy.** **Rationale: This can help guide in establishing learning needs and set priorities (Martin, 2021).** **2.** Provide information about procedures. **Rationale: Education can facilitate maintaining control during labor, and reduce anxiety (Martin, 2021).**	**Patient verbalizes understanding of the procedure of an epidural. Patient participates in the decision-making process.**
4.**Knowledge deficit related to breastfeeding as evidence by primigravida.**	Patient is a first-time mother so she will need information on the proper techniques of breastfeeding.	**1.** Assess patient knowledge of breastfeeding. **Rationale:** Support and teaching must be individualized to the client's level of understanding (Martin, 2021). **2.** Educate mother and husband about breastfeeding techniques to improve chance of success. **Rationale:** Correct positioning and getting the infant to latch on is critical for breastfeeding to get off to a good start and	Patient will promote successful latching on through correct positioning. The patient will successfully feed the infant.

		contributes to breastfeeding success (Martin, 2021).	

Other References (APA)

Martin, P. (2021, June 11). Nursing Guides, Care Plans, NCLEX Practice Questions. Nurseslabs. https://nurseslabs.com/.