N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 04/13/2022 06:00	**Patient Initials** C. H.	**Age** 32 – years – old	**Gender** Female
Race/Ethnicity Hispanic	**Occupation** 911 Operator	**Marital Status** Married	**Allergies** No known allergies
Code Status Full	**Height** 165 cm (5'5")	**Weight** 81 kg (178.5 lbs.)	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: G – 2 T – 2 P – 0 A – 0 L – 1

Past Medical History: Asthma

Past Surgical History: Client denies any past surgical history.

Family History: Client denies any family history.

Social History (tobacco/alcohol/drugs): Denies – Tobacco; Denies – alcohol; Denies – drugs

Living Situation: Lives in a home with her husband and child.

Education Level: College.

Admission Assessment

Chief Complaint (2 points): Regular contractions

Presentation to Labor & Delivery (10 points): The client is a 32 – year – old female who presented to the labor and delivery unit in active labor. The client had an artificial rupture of membranes at 07:15 with clear fluid, no order, and a moderate amount. She has pain with contractions and is rated a 2/10 on the numeric pain scale. The mother is showing signs of grimacing and moaning. The contractions are 4 – 4.5 minutes long, and the fetal heart rate shows

late decelerations causing placental insufficiency and then cord prolapse. Due to a prolapsed cord, she needs an emergency cesarean section.

Diagnosis

Primary Diagnosis on Admission (2 points): Labor

Secondary Diagnosis (if applicable): N/A

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	3.90-4.98	3.98	4.0	4.0	N/A
Hgb	12.0-16	9.8	12.7	12.7	The client could be experiencing decreased hemoglobin levels related to anemia or an expanded blood volume (Pagana et al., 2021).
Hct	36.0-47.0	31.6	38.1	38.1	Decreased levels could be related to hemodilution that can occur during pregnancy (Pagana et al., 2021).
Platelets	140-440	211	178	178	N/A
WBC	5.00-10.00	11.1	11	11	Pregnancy can cause a slight increase in white blood cells (Pagana et al., 2021).
Neutrophils	47.0-73.0	71.0	Not Completed	Not Completed	N/A
Lymphocytes	18.0-42.0	79.9	Not Completed	Not Completed	N/A
Monocytes	4.0-12.0	6.3	Not Completed	Not Completed	N/A
Eosinophils	0.0-5.0	0.09	Not Completed	Not Completed	N/A
Bands	0.0-10.0	0.11	Not Completed	Not Completed	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, O, AB	O	O	O	No abnormalities.
Rh Factor	(+), (-)	+	+	+	No abnormalities.
Serology (RPR/VDRL)	Nonreactive	Nonreactive	Nonreactive	Nonreactive	No abnormalities.
Rubella Titer	Immune or Non-immune	Immune	Immune	Immune	No abnormalities.
HIV	(+), (-)	+	+	+	No abnormalities.
HbSAG	Not detected	Not detected	Not detected	Not detected	No abnormalities.
Group Beta Strep Swab	(+), (-)	-	-	-	No abnormalities.
Glucose at 28 Weeks	< 140	116	116	116	No abnormalities.
MSAFP (If Applicable)	0.5-2.0	Not Completed	Not Completed	Not Completed	No abnormalities.

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

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
MCV	80-95	80.5	91.2	91.2	N/A
MPV	8-12	Not Completed	8.8	8.8	N/A
MCH	27-31	26.9	30	30	Decreased levels could be related to iron deficiency (Pagana et al., 2021).
MCHC	32-36	33.5	33.5	33.5	N/A
RDW	12.3-16.1	11.6	12.3	12.3	Slight decrease due to the amount of blood that is needed more during pregnancy and not having enough iron (Pagana et al., 2021).

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)	< 0.2	Not Completed	Not Completed	Not Completed	N/A

Lab Reference (1) (APA):

Pagana, K. D., Pagana T. J., & Pagana T. N. (2021). *Mosby's diagnostic & laboratory test reference* (15th ed.) Elsevier.

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

Home Medications (2 required)

Brand/Generic	Prenatal Vitamin	Albuterol sulfate / ProAir HFA			
Dose	200 mg	2.5 mg			
Frequency	Daily	PRN 2 puffs			
Route	PO	Inhaled			
Classification	Vitamin and mineral combination / Nutritional supplement	Adrenergic / Bronchodilator			
Mechanism of Action	Adds additional nutrients through a supplement that is to be digested and	Stimulates ATP and CAMP to relax the bronchial smooth muscles			

	absorbed in the gastrointestinal tract (*Prenatal Vitamins*, 2022).	(*Nurse's Drug Handbook*, 2021).			
Reason Client Taking	Aids in fetal development by adding additional supplements to the diet.	Exercise induced asthma.			
Contraindications (2)	Allergies to vitamins or its components and hemolytic anemia.	Beta blockers and diuretic use.			
Side Effects/Adverse Reactions (2)	Black tarry stools or unpleasant taste.	Tachycardia and shakiness.			
Nursing Considerations (2)	Monitor the client for overdose. Have the client take with a full glass of water.	Monitor the clients' heart rate and heart sounds. Monitor respiratory status.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor electrolyte levels.	Monitor potassium levels.			
Client Teaching needs (2)	Educate the client to not take more than the maximum dosage in 24 hours. Monitor the client for overdose.	Educate the client on how to use an inhaler properly. Educate the client to wait one full minute before next inhalation.			

Hospital Medications Related to labor (5 required)

Brand/Generic	Terbutaline sulfate / Bethaire	Nalbuphine hydrochloride / Nubain	Lactated Ringers	Oxytocin / Pitocin	Fentanyl – ropivacaine / Sublimaze – Naropin
Dose	0.25 mg	10 mg	500 ml	30 units / 500 ml	10 ml/hr.
Frequency	Once	Q 1 – 2 hours PRN	Continuous	Continuous	Continuous
Route	SQ	IVPB	IV bolus	IV	Epidural
Classification	Beta adrenergic receptor antagonist / Bronchodilator	Opioid / Opioid analgesic	Alkalizing agent / Intravenous nutrition	Oxytocic / Labor inducer	Opiate anesthetic / opioid antagonist Amide local anesthesia
Mechanism of Action	Relaxing smooth muscles, increasing bronchial airflow and bronchospasms (*Nurse's Drug Handbook*, 2021).	Stimulates receptors that alter emotional response and the perception of pain (*Nurse's Drug Handbook*, 2021).	Restores electrolyte imbalance and fluid imbalance. Medication promotes diuresis (*Lactated ringer*, 2022).	Stimulates uterine contractions of the smooth muscle (*Oxytocin*, 2022).	These two drugs combined create nerve block and pain relief.
Reason Client Taking	Slow down contractions and relax the uterus prior to cesarean section.	For severe pain or discomfort with uterine contractions.	For non-reassuring fetal heart pattern.	Prevent hemorrhage and bleeding.	Emergency delivery by Cesarean section.
Contraindications (2)	Hypersensitivity to terbutaline and sympathomimetic amines.	Do not give with diazepam or pentobarbit	Hypersensitivity to this medication or sodium lactate.	Placenta previa and hepatic impairment.	Hepatic impairment or renal impairment.

		al. Acute or severe bronchial asthma.			
Side Effects/Adverse Reactions (2)	Irregular heartbeat and muscle spasms.	Hypotension and respiratory depression.	Oliguria and back pain.	Hypertension and excessive bleeding after birth.	Respiratory depression and ventricular tachycardia.
Nursing Considerations (2)	Monitor for toxicity. Monitor the clients' contractions.	Monitor for signs and symptoms of respiratory depression. Always keep naloxone in the room. Monitor for neonatal opioid withdrawal symptom.	Make sure the air is fully evacuated prior to administration due to possible air embolism. Monitor the clients for sodium and fluid retention.	Monitor the client for respiratory difficulties. Monitor the client hypertension.	Monitor the clients DTRs after procedure. Monitor the client's epidural site for patency and infection.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor for irregular heartbeat; assess baseline heart sounds.	Monitor respirations and oxygen saturation.	Monitor for increased potassium levels.	Monitor FHR and maternal heart rate / blood pressure.	Double nurse verification prior to administering / assess the client's baseline respirations and oxygen saturation.
Client Teaching needs (2)	Educate the client to monitor for worsening symptoms and contact the provider immediately. Educate the client that she	Educate the client to be assisted when taking this medication due to the CNS effects. Educate the	Educate the client to report any allergic reactions. Educate the client to monitor the IV site for infection	Educate the client that this medication will cause contractions that can be uncomfortable and painful.	Educate the client that an epidural is performed by a specially trained healthcare provider

	may have tremors or nervousness with the medication.	client that they need to contact the healthcare provider immediately if they have difficulty breathing or any changes.	such as redness or irritation.	Educate the client to report breathing difficulties.	(*Ropivacaine*, 2022). Educate the client to notify the provider if she is experiencing oliguria or urinary retention (*Fentanyl*, 2022).

Medications Reference (1) (APA):

Drugs.com. (2022). *Lactated ringers.* https://www.drugs.com/pro/lactated-ringers.html

Drugs.com. (2022). *Prenatal multivitamins.* https://www.drugs.com/mtm/prenatal-multivitamins.html

Jones & Bartlett Learning. (2021). *2021 Nurse's drug handbook* (20th ed.). Jones & Bartlett Learning

Prescribers' Digital Reference. (2022). *Fentanyl.* https://www.pdr.net/drug-summary/Fentanyl-Citrate-fentanyl-citrate-2474.1127

Prescribers' Digital Reference. (2022). *Oxytocin*. https://www.pdr.net/drug-summary/Pitocin-oxytocin-1666

Prescribers' Digital Reference. (2022). *Ropivacaine.* *https://www.pdr.net/drug-summary/Naropin-ropivacaine-hydrochloride-2741.2710*

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	76 bpm	125 / 78 mmHg	16 rpm	98.6 F	98% Room Air

Admission to Labor/Delivery	88 bpm	138 / 82 mmHg	15 rpm	99.0 F	97% Room Air
During your care	87 bpm	140 / 84 mmHg	15 rpm	99.0 F	97% Room Air

Vital Sign Trends and pertinence to client's condition in labor: The client was under a lot of stress due to unexpected complications of the cord prolapsing and an emergency c-section. The other vitals are stable and should continue to be monitored.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
07:30	Numeric 0-10	Lower abdomen, pelvic, and lower back.	2	Achy, sharp, throbbing	Medication given for pain.
08:00	Numeric 0-10	Lower abdomen, pelvic, and lower back.	2	Achy, sharp, throbbing	Medication given for pain.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 gauge
Location of IV:	Right hand
Date on IV:	04/13/2022
Patency of IV:	Flushes easily
Signs of erythema, drainage, etc.:	No signs of edema, irritation, or erythema.
IV dressing assessment:	Dry and intact. Saline locked.

Intake and Output during your clinical day (2 points)

Intake (in mL)	Output (in mL)
½ cup of ice chips – 120 ml	850 ml of blood

	Void – unmeasured currently.

Electronic Fetal Heart Monitoring (20 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?**	145 bpm Fetal EFH has changed throughout the day. It has changed to late decelerations.
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?**	No 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, prolonged late decelerations were noted. The client had placental insufficiency due to the late decelerations, and having an artificial rupture of membranes can cause a prolapsed cord (Ricci et al., 2020). The nurse did a vaginal exam to assess cord prolapse and kept her hand in the vaginal canal to relieve cord compression. The mother was given terbutaline and put in the Trendelenburg position. The

	interventions helped, but the client will need an emergency C – section.
Describe the contractions at the beginning of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	Normal uterine contractions were observed. 4 – 4.5 minutes; 50 seconds; Moderate; client expressed pain during the contractions.
Describe the contractions at the end of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	Contractions continued at the same rate. Normal uterine contractions were observed. 4 – 4.5 minutes; 50 seconds; Moderate; client expressed pain during the contractions.

EFM reference (1) (APA format):

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

Stage of Labor (40 points)

Stage of Labor Write Up, APA format This should include what is expected during the stage(s) of labor you observed; the progression of cervical effacement & dilation; pain management techniques; and what you observed and did during your clinical day. See the grading rubric for details to be included.

This should include the following reproductive data if it occurs during your clinical day.

The first stage of labor includes three phases: latent, active, and transition. The first stage of labor and delivery lasts from the start of the contractions to the complete effacement and dilation of the cervix (Barlow et al., 2019). The latent phase is the onset of labor and can have mild to moderate contractions that occur every 5 – 30 minutes. The contractions are more regular

(3 – 5 minutes; 40 – 70 seconds), and dilation is 4 – 7 cm (Barlow et al., 2019). My client came into the labor and delivery unit during active labor. She had regular harsh contractions lasting 4 – 4.5 minutes; 50 seconds in between. The client had an artificial rupture of membranes at 07:15 that consisted of clear fluid, a moderate amount, and no odor noted. During this time, the fetal heart rate dropped with late decelerations. When performing a vaginal exam, the newborn was experiencing cord prolapse. The nurses moved her into the Trendelenburg position and gave her terbutaline. The mother will need support transitioning from a normal vaginal birth to an emergency cesarean section.

The second stage of labor is the delivery of the newborn. This stage consists of a fully dilated cervix to the fetus's birth (Barlow et al., 2019). Since the client is to be transferred to the OR for an emergency cesarean section, she will not have a vaginal delivery. The client will be under general anesthesia, and they will get the baby out immediately. Cesarean birth uses a surgical birth through an incision in the lower abdomen and uterine wall (Ricci et al., 2020). Many factors can lead up to having a cesarean delivery. These can include a previous cesarean birth or signs of fetal distress (Ricci et al., 2020). In this case, the client's neonate showed signs of fetal distress through a prolapsed cord. The mother delivered a healthy male that is 7 lbs—8 oz. The newborn had an Apgar score of six at one minute and eight at five minutes. The newborn will be breastfeeding.

Then the third stage following delivery, the placental will be removed by the surgeon and not through the vaginal canal. She will then have the incision closed and go back to the room for postoperative care of the newborn and mother. The fourth stage of labor is the postpartum stage. The nursing staff will be assessing vital signs every 15 minutes for the first hour, then every 30 minutes for the following hours, and every 4 hours until stable (Ricci et al., 2020). Fundal

assessments are also critical during this time to prevent postpartum hemorrhage. The fundal assessment an hour after birth should appear to be firm, at the umbilici, and leveled. The lochia should be Rubra, a moderate amount, and dark red (Ricci et al., 2020). Since the mother lost 850 ml before the cesarean birth, she will be monitored for blood loss during the surgery and possible hemorrhage.

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

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

Barlow, M., Holman, H., Johnson, J., McMichael, M, Sommer, S., Wheless, L., Wilford, K., & Williams, D. (2019). ATI: RN *Maternal newborn nursing* (11th ed.). Assessment Technologies Institute, LLC.

Nursing Diagnosis (30 points)
Must be NANDA approved nursing diagnosis and listed in order of priority
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 each of the rationales.	**Evaluation (2 pts each)** • How did the patient/ family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to labor contractions as evidenced by client rated her pain a	The client reported pain of 2 out of 10 in-between contractions and contractions in	1. Offer pain medication. **Rationale**: Giving the client Nalbuphine will ease the pain of her contractions (Ricci et al., 2020). 2. Assist with comfort	The client received pain medications right before she went to her emergency C-sections. I could not teach breathing or relaxation techniques to the mother

2/20 and is saying “ouch” or “ow” continuously.	the lower abdominal area.	measures. **Rationale**: The nurse can give relaxations techniques and breathing techniques to provide comfort (Ricci et al., 2020).	due to the emergency cord prolapse.
2. Risk for bleeding related to large amount of blood as evidenced by 850 ml of blood loss prior to procedure.	The client has lost 850 ml before the clients’ delivery through cesarean section.	1. Administration of oxytocin. **Rationale**: Administering oxytocin can stimulate contraction to prevent bleeding and hemorrhage (Ricci et al., 2020). 2. Monitor blood loss. **Rationale**: Monitor blood loss through weighing pads, sheets, and anything with blood on it (Ricci et al., 2020).	I was not able to administer medication at the time or monitor blood loss during my clinical day.
3. Knowledge deficit related to cord prolapse as evidenced by an emergency c-section.	An emergency calls for education especially if this is the first time this has happened during a pregnancy.	1. Educate the mother on why this has occurred. **Rationale**: The neonate is in destress causing a cord to prolapse from the head compressing the umbilical cord. Additionally leading the mother to have an emergency c-section (Ricci et al. 2020). 2. Educate the mother on what a cord prolapse is. **Rationale**: A prolapsed cord is when the umbilical cord can drop through the cervix first, and the baby compresses the cord causing it to prolapse (Ricci et al., 2020). When the cord prolapses, it is a medical emergency due to the lack of oxygen, which can cause fetal death.	Educating the mothing on what is happening to her and her baby is essential. Since I could not educate during my shift, the nurse should ensure the client is educated.
4. Risk for infection	Late decelerations	1. Monitor the client for signs and	During my care, I could not assess the client for

related to cord prolapse due to vaginal examination.	resulted in a vaginal exam to examine the prolapsed cord, which could lead to an infection.	symptoms of infection every 4 hours. **Rationale**: Assess the area for signs and symptoms of erythema, irritations, and edema (Ricci et al. 2020). 2. Assess the perineal only when necessary to prevent infection. **Rationale**: When giving vaginal exams, this can increase new bacteria that can lead to an infection (Ricci et al. 2020).	signs of infection. If the client has signs of infection, they should report it to their provider.

Other References (APA):