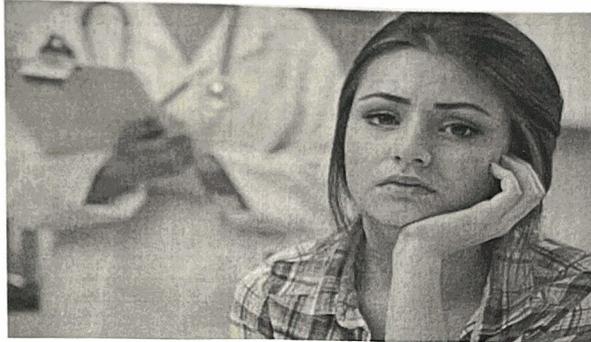


Kelsey Bierman

Labor-Vaginal Delivery

UNFOLDING Reasoning



Anne Jones, 17 years old

Primary Concept		
Pain		
Interrelated Concepts (In order of emphasis)		
1. Perfusion		
2. Stress		
3. Anxiety		
4. Reproduction		
5. Clinical Judgment		
6. Communication		
7. Collaboration		
NCLEX Client Need Categories	Percentage of Items from Each Category/Subcategory	Covered in Case Study
Safe and Effective Care Environment		
• Management of Care	17-23%	✓
• Safety and Infection Control	9-15%	
Health Promotion and Maintenance	6-12%	✓
Psychosocial Integrity	6-12%	✓
Physiological Integrity		
• Basic Care and Comfort	6-12%	✓
• Pharmacological and Parenteral Therapies	12-18%	✓
• Reduction of Risk Potential	9-15%	✓
• Physiological Adaptation	11-17%	✓

Fetal Heart Rate
Fetal Monitor

History of Present Problem:

Anne is a 17-year-old, gravida 1 para 0 who is 39 weeks gestation and admitted to the labor room for observation at 1200. She began having contractions three hours ago at 8 to 10-minute intervals with each contraction lasting 30 seconds. She states her pain is 3/10. Her membranes are intact. On admission, a vaginal exam indicates cervical dilation is 1 cm, 80% effacement, and 0 station.

After two hours of observation, her cervix is 2-3 cm/ 80% effacement/0 station and contractions are now 4-5 minutes apart, lasting 60-70 seconds and pain remains 3/10. Fetal lie is longitudinal with a cephalic presentation. You have her prenatal records from her visits to the office. She is Group Beta Strep (GBS) positive and received antibiotics at 36 weeks. Her blood type is B-

Personal/Social History:

Anne's mother is with her. Anne is not married and the father of the baby is not involved. She appears to be relaxed although she states she is a bit nervous. She wants a natural non-medicated birth and her mother will help coach her. She plans on breastfeeding for "awhile". She attended childbirth preparation classes with her mother.

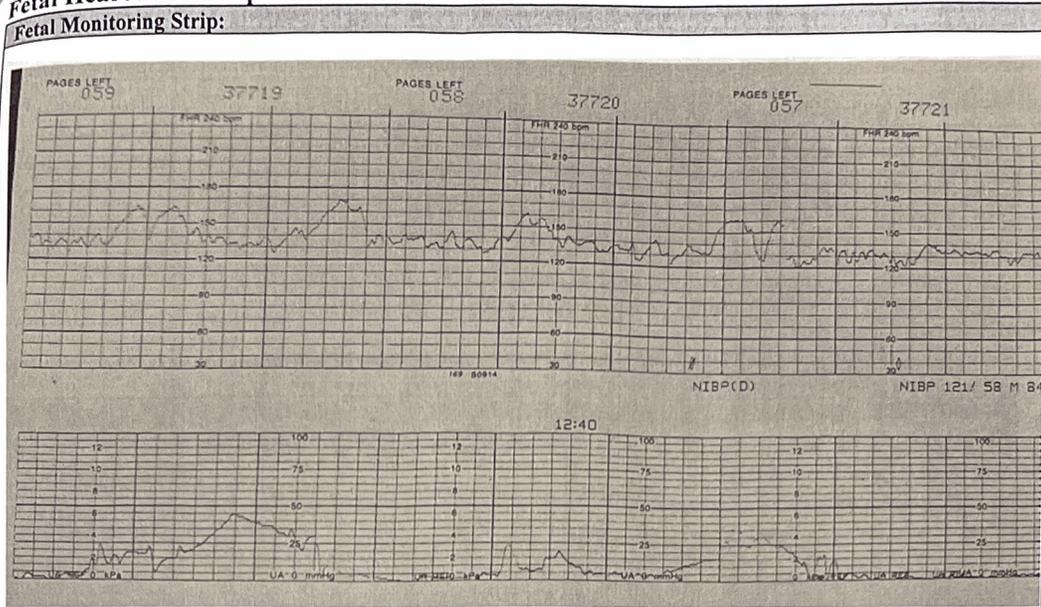
*What data from the histories are RELEVANT and must be interpreted as clinically significant by the nurse?
(Reduction of Risk Potential)*

RELEVANT Data from Present Problem:	Clinical Significance:
<ul style="list-style-type: none"> → G1P0 @ 39-week → Cervix dilated from 1cm to 2-3cm in 2 hours → Pain 3/10 → B- blood type → Contractions @ 8-10 min intervals lasting 30 sec to contractions at 4-5 min intervals lasting 60-70sec 	<ul style="list-style-type: none"> → Determines Pre-term, or full-term birt and pregnancy history → Could indicate early labor → Helps determine stage of labor → Mom may need medication to stop the production of antibodies against fetal blood. → This indicates the progression of labor
RELEVANT Data from Social History:	Clinical Significance:
<ul style="list-style-type: none"> → Father of baby is not involved → Natural non-medicated birth → Plans to breastfeeding → Attended childbirth preparation classes 	<ul style="list-style-type: none"> → Client will be a single mom. Client may need access to community resources. → Must honor the patients birthing plan. → Provide proper education on how to breastfeed consult lactation specialist. → Client shows initiative to educate herself

Anne is placed on a fetal monitor and the nurse collects the following strip:

om for
:it each
vaginal

Fetal Heart Rate Strip Assessment:
Fetal Monitoring Strip:



Interpretation:

Category 1 tracing

Clinical Significance:

Strip shows acceleration, fetal heart rate baseline 140 with moderate variability

Patient Care Begins:

Current VS:		P-Q-R-S-T Pain Assessment:	
T: 98.6 F/37.0 C (oral)		Provoking/Palliative:	Began 3 hours ago
P: 76 (regular)		Quality:	Cramping that comes and goes, lasting 40 sec after 1 hour 60-70 sec.
R: 18 (regular)		Region/Radiation:	Uterus
BP: 125/80		Severity:	3/10
O2 sat: 98		Timing:	8-10 min then 4-5 mins

*What VS data are RELEVANT and must be interpreted as clinically significant by the nurse?
(Reduction of Risk Potential/Health Promotion and Maintenance)*

RELEVANT VS Data:	Clinical Significance:
Mat on 3hr ago Cramping comes and goes, lasting 40 sec after 1hr 60-70 sec in the uterus. 3/10. 8-10min 4-5 min	The patient is experiencing expected pain related to active labor.

ital Signs eye
Limit vaginal

Current Assessment:	
General Appearance:	Calm, body relaxed, no grimacing, appears to be slightly anxious.
Respiratory:	Breath sounds clear with equal aeration bilaterally ant/post, non-labored respiratory effort
Cardiac:	Pink, warm & dry, slight ankle edema, heart sounds regular with no abnormal beats, pulses strong, equal with palpation at radial, brisk cap refill
Neuro:	Alert and oriented to person, place, time, and situation (x4)
HEENT:	Normal cephalic
Chest:	Breasts tender on palpation, areola darkened and occasional veins present
Abdomen:	Soft; no masses, uterus palpable above umbilicus, mild indenting with palpation, fetus is in LOA position by palpation
Extremities:	Mild spider varicose veins on medial aspect of left leg, deep tendon reflexes 2+
Vaginal Exam:	Small amount clear mucous, 1cm/80%/0, membranes intact

What assessment data are RELEVANT and must be interpreted as clinically significant by the nurse?
(Reduction of Risk Potential/Health Promotion and Maintenance)

RELEVANT Assessment Data:	Clinical Significance:
→ 1cm/80%/0 → slight ankle edema → LOA position	→ Monitor patient for further cervical changes to determine phase of labor → Monitor for worsening edema could indicate pre-eclampsia/third spacing of fluid. → LOA position is an acceptable position for laboring.

Clinical Reasoning Begins...

1. Interpreting relevant clinical data, what is the primary concern? What primary health-related concepts does this primary problem represent? (Management of Care/Physiologic Adaptation)

Problem:	Pathophysiology of Problem in OWN Words:	Primary Concept:
Labor	Labor involves changes within the myometrium, decidua, and cervix that occur gradually, culminating in the rapid changes of active labor that ends with the expulsions of the products of conception.	Reproduction

Collaborative Care: Medical Management (Pharmacologic and Parenteral Therapies)

Care Provider Orders:	Rationale:	Expected Outcome:
Admit to Labor and Delivery	Patient is progressing in labor	Spontaneous vaginal delivery
Intermittent fetal heart monitoring ambulating as tolerated	Patient has uncomplicated pregnancy. The fetal heart strip is category 1. Patient desires natural unmedicated child birth.	No acute distress of fetus as evidenced by no audible decelerations.
Ampicillin 2 g IVPB when in active labor and 1 g every 4 hours while in labor	Patient is GBS pos. Goal is to prevent infant from contracting GBS during labor	Prevention of GBS sepsis of newborn.

Vital Signs every hour	To ensure vitals remain stable	VS remain stable throughout delivery
Limit vaginal exams.	To prevent infection	Patient doesn't contract an infection during labor
May ambulate as tolerated	To allow gravity to aid the progression of labor	labor will progress

PRIORITY Setting: Which Orders Do You Implement First and Why? (Management of Care)

Care Provider Orders:	Order of Priority:	Rationale:
<ul style="list-style-type: none"> Establish peripheral IV Ampicillin 2 g IVPB now x1 and 1 g every 4 hours while in labor Intermittent fetal heart monitoring ambulating as tolerated 	Intermittent fetal heart rate monitoring ambulating as tolerated Est. peripheral IV Ampicillin 2 g IVPB now	To ensure that the fetus is stable Need to est. IV to initiate IV antibiotics The patient is GBS positive. Antibiotics will prevent GBS sepsis of the neonate.

Collaborative Care: Nursing

2. What body system(s) will you assess most thoroughly based on the primary/priority concern?
 (Reduction of Risk Potential/Physiologic Adaptation)

PRIORITY Body System:	PRIORITY Nursing Assessments:
Reproductive Uterus	Ensure contractions are strong enough to progress cervical dilation. Ensure contractions are not too close together or too long. Ensure uterus relaxing completely between contractions.

3. What nursing priority (ies) will guide your plan of care? (Management of Care)

Nursing PRIORITY:	Acute Pain	
PRIORITY Nursing Interventions:	Rationale:	Expected Outcome:
→ Since patient wants an un-medicated labor, promote relaxation techniques such as visual imagery, movement, water, + massage. → Promote deep breathing by inhaling through the nose and exhaling through the mouth	These are non-pharmacological pain management techniques to help with labor pains. Helps promote relaxation + better tolerate the pain of labor	Patient will utilize non-pharmacological pain techniques to manage her pain. Client will verbalize minimize discomfort

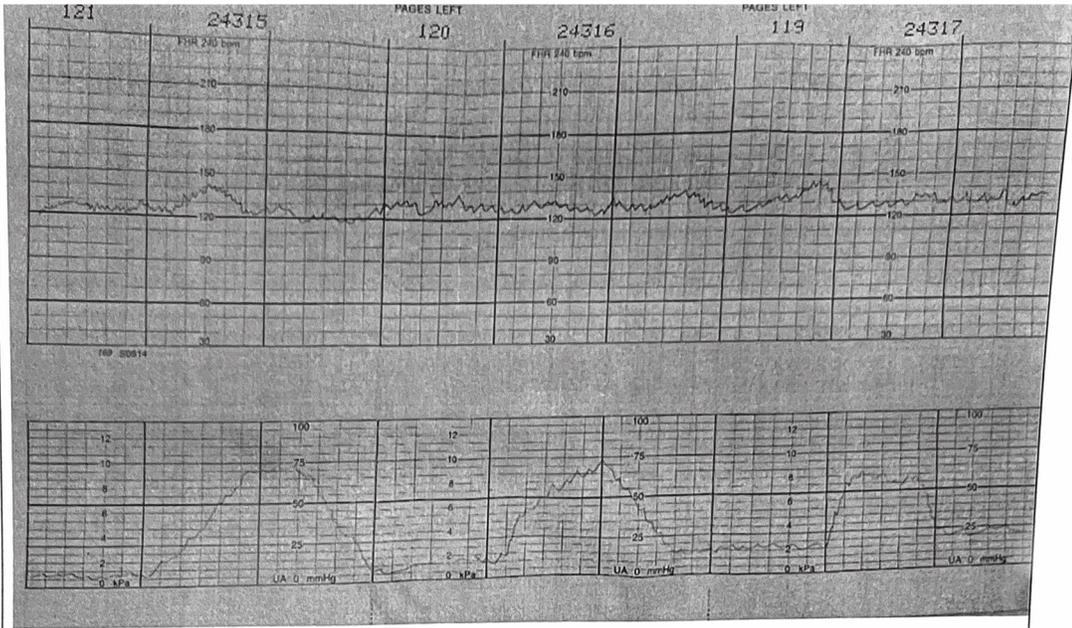
4. What psychosocial/holistic care **PRIORITIES** need to be addressed for this patient?

(Psychosocial Integrity/Basic Care and Comfort)

Psychosocial PRIORITIES:	Risk for anxiety	
PRIORITY Nursing Interventions:	Rationale:	Expected Outcome:
<p>CARE/COMFORT: <i>Caring/compassion as a nurse</i> Provide an opportunity for conversation.</p> <p><i>Physical comfort measures</i> Demonstrate breathing and relaxing techniques Provide comfort measures</p>	<p>This presents the client with the opportunity to express her excitement about herself, the pregnancy, and her baby. This will help to distract the patient.</p> <p>This can help to reduce anxiety and provides coping strategies.</p>	<p>The client will use the breathing techniques AEB her demonstrating the technique.</p> <p>Client will appear relaxed appropriate for labor AEB conversating with HCPs.</p>
<p>EMOTIONAL (How to develop a therapeutic relationship): <i>Discuss the following principles needed as conditions essential for a therapeutic relationship:</i></p> <ul style="list-style-type: none"> • Rapport • Trust • Respect • Genuineness • Empathy 	<p>Encourage the client to verbalize her feelings, concerns and fears. This will help the client to become less anxious and will allow her continue with the labor process more comfortably.</p>	<p>Client will report that her anxiety is well managed AEB verbal confirmation</p>

Four hours later... (1600)

Anne is breathing through the contractions and her mother is at her side. She has put on the call light because she thinks her water broke. You as the nurse, go in and assess. Her contractions are now every three minutes and moderate in intensity with palpation. You perform a vaginal exam and note clear fluid that has no odor, she is 6 cm dilated, 90% effacement, and +1 station. Vertex presentation and fetal position is LOA with good flexion of the head. You notice the following FHR on the strip.



Interpretation:

Category 1 tracing, FHR baseline 125, moderate variability + accelerations

Clinical Significance:

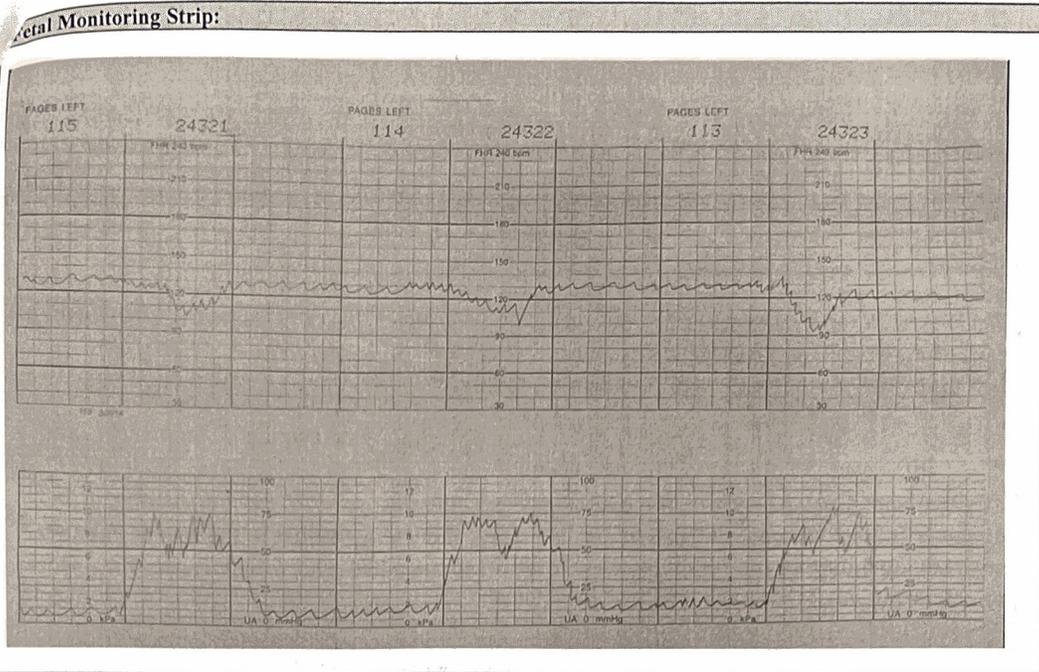
The fetus neurologically intact

Current VS:	Most Recent:	Current PQRST:	
T: 98.8 F/37.1 C (oral)	T: 98.6 F/37.0 C (oral)	Provoking/Palliative:	
P: 86 (regular)	P: 76 (regular)	Quality:	"Squeezing, tightening"
R: 22 (regular)	R: 18 (regular)	Region/Radiation:	abdomen
BP: 130/80	BP: 125/80	Severity:	6/10
O2 sat: 98% room air	O2 sat: 98% room air	Timing:	Every 3-4 mins

1. What data is RELEVANT and must be interpreted as clinically significant by the nurse?
(Reduction of Risk Potential/Health Promotion and Maintenance)

RELEVANT VS Data:	Clinical Significance:
Pain: "Squeezing, tightening" in abdomen, 6/10, every 3-4min	Anne is progressing in labor
RELEVANT Assessment Data:	Clinical Significance:
Clear fluid, no odor, Gcm intact, 90% effaced, +1 station, Vertex, LOA.	Possible rupture of membranes, labor is progressing normally prepare for delivery. Baby remains in good delivery position.

are need to be



Interpretation:
 FHR baseline 125, no accelerations, and early decelerations

Clinical Significance:
 baby is preparing for delivery.

Half an hour later (2030)...

Anne delivers a healthy male infant at 2032. Placenta delivered at 2045. No pain medication was given. Pitocin 30 units/500 mL IV was began after the delivery of the placenta. Infant Apgars were 8 and 9.

Weight: 7 lbs 0 oz (3.2 kg) 20 (50.8 cm) inches long. Skin-to-skin contact with baby initiated and her baby boy attempted to breastfeed and latched on for 5 minutes on right side. Anne is smiling and holding and talking to her baby. Her uterus is firm, one finger width below the umbilicus and midline. Lochia moderate rubra. Mid-line episiotomy is well approximated, slightly bruised and area swollen. Ice pack applied to perineum. Anne was able to void 400 mL clear, yellow urine after delivery. She has finished recovery and is being transferred to the postpartum unit.

RELEVANT Assessment Data:	Clinical Significance:
I=F (0) U=1 Placenta delivered 13 min after birth Apgar 8 & 9 baby re-latched	The uterus is contracting no bladder distention Placenta delivered no complication noted. healthy neonate Establish breast feeding within golden hour

Caring about this patient. What is the priority?

Current VS:	P-Q-R-S-T Pain Assessment:	
T: 98.6 F/37.0 C (oral)	Provoking/Palliative:	sitting
P: 74 (regular)	Quality:	throbbing
R: 18 (regular)	Region/Radiation:	perineum
BP: 122/78	Severity:	3/10
O2 sat: 98% room air	Timing:	constant

What VS data are RELEVANT and must be interpreted as clinically significant by the nurse?
 (Reduction of Risk Potential/Health Promotion and Maintenance)

RELEVANT VS Data:	Clinical Significance:
Pain assessment	Observe perineum to monitor for abnormal swelling or hematoma formation.

Effective and concise handoffs are essential to excellent care and, if not done well, can adversely impact the care of this patient. You have done an excellent job to this point; now finish strong and give the following SBAR report to the nurse who will be caring for this patient: (Management of Care)

Situation:	
Name/age:	Anne, 17 yo. NSVD @ 2052 male neonate, Aug 8 and 9.
BRIEF summary of primary problem:	70% G1P1 at 39 weeks. Midline episiotomy with moderate swelling and bruising. Moderate lochia rubra, voided 100mls after delivery. Currently on Pitocin drip as ordered. Placenta delivery @ 2015.
Day of delivery:	
Background:	
Primary problem/diagnosis:	Father not involved, main support system is mom.
RELEVANT past medical history:	Natural un-medicated labor. Patient is B-, GBS positive received antibiotics @ 36 weeks. No other prenatal labs available.
RELEVANT background data:	
Assessment:	
Most recent vital signs:	T: 98.6 F, P: 74 (regular), R: 18 (regular), BP: 122/78
RELEVANT body system nursing assessment data:	O2 sat: 98% on room air. Fundus firm U-1. Moderate lochia rubra. Breast feeding established feed 5min on right-side, latched well. Positive bonding with neonate. Perineum bruised with swelling. Patient rated pain 3/10. Pain is throbbing and constant.
RELEVANT lab values:	No pain medication administered at this time.
TREND of any abnormal clinical data (stable-increasing/decreasing):	
How have you advanced the plan of care?	
Patient response:	
INTERPRETATION of current clinical status (stable/unstable/worsening):	
Recommendation:	
Suggestions to advance the plan of care:	Consult case management. Provide postpartum education. Give Rhogam.

What Patient is Experiencing:	How to Engage:
<p>The mom is experiencing joy delivering her first child. The mom also may be experiencing fear/anxiety about how to properly care for the newborn due to age and the fact that she is a first-time mom.</p>	<p>let her know that you are proud of how she handled labor. let her know that if she has any questions or concerns she can always ask me. Tell the patient that she can speak with the charge nurse if I'm not on the unit.</p>

Use Reflection to THINK Like a Nurse

What did you learn that you can apply to future patients you care for? Reflect on your current strengths and weaknesses this case study identified. What is your plan to make any weakness a future strength?

What Did You Learn?	What did you do well in this case study?
<p>I learned more about the stages of labor, how to assist a mother using non-pharmacologic pain management, and what need to be monitored postpartum.</p>	<p>I feel like I did a good job following her birth plan by giving her multiple options for non-pharmacologic pain management.</p>
What could have been done better?	What is your plan to make any weakness a future strength?
<p>I could have used more practice with fetal heart rate strips because I am not confident in my ability to interpret them.</p>	<p>I will study FHR strips until I do feel confident in my interpretation. I plan to achieve this by doing multiple practice strips.</p>

