Medications

- Calcium Carbonate (TUMS)
  - Pharmacological Class: Calcium Salts
  - Therapeutic Class: Antacids
  - Patient is taking this medication to help with feelings of nauseousness and vomiting
  - Key Nursing Assessments: Check IV site frequently (calcium causes necrosis) and monitor serum calcium to make sure it stays at therapeutic level
- Carboprost Tromethamine (Hemabate)
  - Pharmacological Class: Uterotonic Agents
  - Therapeutic Class: Oxytocic
  - Patient is taking this medication to stimulate uterine contractions
  - Key Nursing Assessments: Assess the patients' vital signs and assess for uterine contractions
- Fentanyl (Duragesic)
  - Pharmacological Class: Opioid
  - Therapeutic Class: Opioid Analgesic
  - Patient is taking this medication to help with pain impulse
  - Key Nursing Assessments: Assess for pain and for feeling in the lower extremities
- Ropivacaine (Naropin)
  - Pharmacological Class: Local Anesthetics
  - Therapeutic Class:
- Ondansetron HCL (Zofran)
  - Pharmacological Class: Selective Serotonin receptor antagonist
  - Therapeutic Class: Antiemetic
  - Why is the client taking the med: For nausea and vomiting
  - Key Nursing Assessments: Assess for dizziness and drowsiness and guard against falls

elivery Concept map template

Demographic Data

Admitting diagnosis: Spontaneous Rupture of Membranes

Secondary diagnosis: Postdates (40 weeks and 6 days)

Age of client: 25 years old

Weight in kgs: 93 kg

Allergies: No known allergies

Date of admission: 2/28/2024

Support person present: Yes (Father of children)

Presentation to Labor and Delivery

Patient came to the Labor and Delivery floor for a spontaneous rupture of membranes which started the night before. During this time, she began to feel the start of uterine contractions in her back and lower abdomen. These contractions were about 3 -5 minutes apart. She was also having some pain that lasted up until she received her epidural. Some aggravating factors that the patient said was movement of the baby that exacerbated the symptoms. The epidural helped relieve some of the pain that she was feeling along with breathing techniques that she had learned from her prenatal education courses. When asked about her pain using a scale of 0-10, she rated her pain as a 0, after the epidural was placed and before delivery.

Electronic Fetal Heart Monitoring: (At the beginning and the end of shift.)

Baseline EFH: Beginning: 140; End: 140

Variability: Beginning: Moderate; End: Moderate

Accelerations: Yes at beginning and end; 15x15

Decelerations: No decelerations at beginning and end

Contractions: Moderate by palpation

-frequency: Beginning: 2-3 minutes; End: 1 ½ - 2 minutes

-length: Beginning: 80-90 seconds; End: 70 seconds

-strength: N/a (Patient had an external monitor

-patient's response: Beginning: Resting comfortable with epidural; End: Patient is in active labor.

N432 Labor and Delivery Concept map template

Stages of Labor

Stage 1

The first stage of labor is characterized by cha… …er the baby (Ricci et. Al, 2021). In this stage, the cervix changes to allow for safe pas… …dilation, where the cervix opens to about 10 cm, for delivery of an average/normal size… …s that the cervix softens for the baby to …latent phase, the cervix will steadily dilate

Prenatal & Current Lab Values/Diagnostics

WBC: 8.48; 9.31
RBC: 4.46; 4.25
HGB: 12.6; 12.0
HCT: 38.4: 36.4
MCV: 86.1; 85.6
MCH: 28.3; 28.2
MCHC: 32.8; 33.0
RDW: 12.7; 16.2 Normal Range: 12.0-15.0%; High levels can indicate nutrient deficiency
RDW-SD: 40.9; 51.2
Platelets: 229; 166
MPV: 10.3; 10.7
SEG: 70.4; 66.8
Lymphocytes 22.4; 21.7
Monocytes: 6.5; 9.5
Eosinophils: 0.4; 0.4
Basophils: 0.1; 0.2
ABSAG: Nonreactive
Rubella: 4
RPR: Nonreactive

Medical History

Prenatal History: G3T1P0A1L1

Previous Medical History: No significant past medical history

Surgical History: Adenoidectomy, Hand tendon surgery (right hand – 11/30/2018

Family History: Father: hypertension, alcohol/drug use, gout; Mother: Cervical Stenosis; Sister: Asthma; Maternal Grandmother: Osteoporosis; Paternal Grandmother: Heart; Paternal Grandfather: Diabetes

Social History: Patient is single but lives co-habituates with the father of her children; Highest level of education is 12 years; Patient reports never smoking, formerly used vapes; Does not currently drink alcohol or use drugs; past drug use was cannabis 6 times a week)

Active Orders

- Diet – Clear liquid; this is to help with nausea and vomiting and also to prevent aspiration
- Code – Full Code; In case anything goes wrong, the medical professionals know to try to resuscitate the mother
- Continuous Fetal Monitoring; This is to monitor fetal distress and make sure that the baby is doing well inside the womb
- Record Intake and Output; To monitor for hyper/hypovolemia
- Reposition @ nurses discretion; To ensure patient comfort along with prevention of pressure ulcers. Repositioning the mother can also help with the comfort of the baby inside the womb
- Monitor Epidural (Fentanyl & Ropivacaine); This is to ensure that no neurological deficits occur while the patient is receiving this medication

Stage 2

In the second stage of labor, the patient is completely dilated and effaced at the beginning and the phase ends with the birth of the newborn baby (Ricci et al, 2021). This stage is characterized by the process of fetal engagement, which describes the descent of the fetus into the pelvic inlet. In the stage "contractions occur every 2 to 3 minutes, last 60 to 90 seconds, and are described as strong by palpation" (Ricci et al, 2023, p. 457). During this stage, the patient's contractions were about 1 ½ to 2 minutes apart and lasted about 70 seconds. The patient did state that she began to feel pressure and a feeling of needing to defecate when the baby reached the pelvic floor. The nurse that was precepting explained to her that this was the feeling of wanting to push the baby out and that she would need to focus on where the pressure was felt because that was where she would need to push. She also seemed hyper-focused on getting the baby out. These findings are normal, as evidenced by this statement, "The mother is focused on the work of pushing. The maternal urge to push is generally felt when there is direct contact of the fetus to the pelvic floor" (Ricci et al, 2021, p. 457). This stage lasted about an hour for this pregnancy, which was her second, but it's stated that this stage can last up to 3 hours and 2 hours in subsequent pregnancies (Ricci et al). Once the baby has been delivered out, then the mother moves into the 3rd stage of labor. Some nursing interventions that were provided were helping to clean the vomit and helping to reposition the patient during pushing to help ease some labor pains during this stage of labor.

Stage 3

"The third stage of labor begins with the birth of the newborn and ends with the separation and birth of the placenta" (Ricci et al, 2021, p. 458). This stage lasted about 5 minutes for the patient, which is a normal finding. "After separation of the placenta from the uterine wall, continued uterine contractions cause the placenta to be expelled within 2- 30 minutes unless there is gentle external traction to assist (Ricci et al, 2021, p. 460). When the newborn was born, it was placed on the mother's chest right after. This is done to "promote a positive transition from intrauterine to extrauterine life" (Ricci et al, 2021, p. 458). In this stage, the uterus continues to contract in order to have expulsion of the placenta (Ricci et al, 2021). The nurse showed me that this was evident based on the fundal check which showed that the uterus was still firm at the umbilicus. This fundal check is a nursing assessment that is used to ensure that the patient isn't hemorrhaging. A few minutes later, the placenta was expelled and the side that was presenting was the shiny gray side, which is called the Schultz mechanism (Ricci et al). The doctor in the room pushed just above the symphysis slightly to help with the keep the uterus in the place while the placenta was delivered. The doctor also checked to see if there were any tears that happened during delivery, which there weren't. Some interventions that were provided by nurse and student in this stage included cleaning blood and examining the placenta.

Nursing Diagnosis 1 Risk for pain related to birth of macrosomic infant as evidenced by delivery of baby over 9 lbs (Komatsu et al, 2020).	Nursing Diagnosis 2 Risk for post-partum hemorrhage related to larger placental area in utero as evidenced by quantitative blood loss near 1,000 ccs (Mayo Clinic, 2022).	Nursing Diagnosis 3 Risk for imbalanced nutrition related diet restriction during labor as evidenced by clear liquids during labor
Rationale for the Nursing Diagnosis The patient delivered a child over 9 lbs. Delivery a bigger baby can cause pain for a mother because she isn't equipped to deliver such a big baby.	Rationale for the Nursing Diagnosis She delivered a 9 lb baby which means that she needed a larger placental area to provide adequate nutrients to her baby.	Rationale for the Nursing Diagnosis The patient was unable to eat regular food throughout her delivery
Interventions Intervention 1: Administer pain medication (Komatsu et al, 2020). Rationale: This will help the mother bear some of the pain involved with delivering a bigger baby Intervention 2: Put the mother on bed rest Rationale: This will allow the mother to rest her	Interventions Intervention 1: Palpate the fundus to assess location Rationale: Check the location of the fundal in relation to the abdomen because fundal displacement can mean a high risk for hemorrhage; Also if the fundus is form it shows	Interventions Intervention 1: Initiate regular diet protocols Rationale: This will allow the mother to regain some of the nutrients that she missed out on while she was unable to eat regular foods Intervention 2: Monitor intake and output Rationale: This will help indicate that bowel and

body and let the body recuperate naturally.	**that contraction is happening the way that it should be** **Intervention 2: Check for blood flow to see if it is heavy or light** **Rationale: This will allow the nurse or provider to get a picture of what is going on inside the body; if the mother is hemorrhaging or if she is ok.**	**urinary functions are still intact after the dietary restrictions**
Evaluation of Interventions **Patient received pain medication before clinical time ended and it seemed that she tolerated the medication well.**	**Evaluation of Interventions** **The provider checked the blood flow of the patient to make sure that blood loss was normal and that she wasn't hemorrhaging. The patient cooperated with this assessment.**	**Evaluation of Interventions** **Patient was very happy to hear that she would be able to eat normal food**

References (3):

Komatsu, R., Ando, K., & Flood, P. D. (2020, March). *Factors associated with persistent pain after childbirth: A narrative review*. British journal of anesthesia. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7187795/

Mayo Foundation for Medical Education and Research. (2022, June). *Obstetrics and gynecology*. Mayo Clinic. https://www.mayoclinic.org/medical-professionals/obstetrics-gynecology/news/postpartum-hemorrhage-risks-and-current-management/mac-20533920

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