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N432 Care Plan #1 (Labor)

Lakeview College of Nursing

September 11th, 2019

N432 Care Plan

Demographics (3 points)

Date of Admission & Time of Admission	Patient Initials	Age	Gender
9/10/2019 @ 1133	B.W.	23	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
caucasian	unemployed	married	NKA
Code Status	**Height**	**Weight**	**Father of Baby involved**
Full code	165 cm	86.2 kg	yes

Medical History (5 Points)

Prenatal History:

Gravida- 1

Preterm- 0

Abortions/Miscarriage- 0

Living children- 0

This is patients first pregnancy.

Past Medical History: Patient has no past medical history.

Past Surgical History: Patient has no past surgical history.

Family History: Patient's family history is unknown.

Social History (tobacco/alcohol/drugs):

Patient states she has smoked less than 100 cigarettes in lifetime and currently does not smoke. She denies use of alcohol. Patient denies any substance use.

Living Situation:

Patient comes from home with her husband. Father of the child is involved in the child's life.

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Education Level:

Patient has a high school education. Developmental level is normal. Normal cognitive level.

Admission Assessment (12 points)

Chief Complaint (2 points):

Patient admitted today with "contractions at 39.3 weeks pregnant."

Presentation to Labor & Delivery (10 points):.

Patient admitted with complaint that contractions are occurring "between 1-4 minutes regularly." Pain is felt throughout abdomen and patients back. Fetal movement was present upon assessment. Patient had a normal bloody show. Patient noted water had broke at home and that fluid was "green". Fluid sample was taken to be cultured. Patient had spotting of blood before admission as well as once admitted. Patient states contractions started happening "in the middle of the day but recently started to become very close together." She has tried breathing techniques to help with pain, and states that those helped while she was still at home. Patient stated pain and pressure were very intense especially when contractions were present and knew she wanted to get an epidural when possible. Patient was calm and eager to deliver her baby.

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points):.

Spontaneous labor at 39.3 weeks gestation.

Secondary Diagnosis (if applicable): N/A

Stage of Labor (20 points):

Stage of Labor write up in APA format (see grading rubric) (18 points)

When I met my patient she was in stage two of labor. This stage, "begins with complete cervical dilation (10 cm) and effacement and ends with the birth of the newborn" (Kyle & Ricci, 2009, p.378). When I first entered the patient's

room she had been pushing for approximately one hour. She was fully dilated and had 100% effacement. The babies head was starting to crown and his hair was visible in the birthing canal. Her contractions were lasting around 50 seconds each and were about every 1-2 minutes. “During this expulsive stage, the mother usually feels more in control and less irritable and agitated” (Kyle & Ricci, 2009, p.378). This patient was very much in control. She was able to understand when another contraction was coming on and would sometimes initiate the nursing team that she was ready to start pushing. She pushed hard for 10 seconds would breathe and rest for 5 seconds and then push for another 10 seconds. She did this in rounds of three to work through the full contraction. In between contractions she would relax as much as possible and rest to regain strength for the next round. There are two phases associated with the second phase of labor; the pelvic phase and the perineal phase. The pelvic phase is during the beginning of the fetus's descent into the pelvis. The phase my patient was experiencing while I was with her was the perineal phase. During this phase, “the fetal head is lower in the pelvic area and is distending the perineum” (Kyle & Ricci, 2009, p.379). In this phase the head is visibly crowning and the top of the fetus's head is visible.

Quickly she moved into the third stage of labor which, “begins with the birth of the newborn and ends with the separation and the birth of the placenta” (Kyle & Ricci, 2009, p.379). After 32 minutes of pushing while I was in the room, the patient finally pushed the baby all the way out. He started to cry very quickly and was immediately put chest to chest with mom, wiped down, and his cord was clamped. During this time the doctor was still preparing the mother for the birth of her placenta. It took about 10 minutes for the birth of her placenta to occur. She didn't show any signs of pain or discomfort. The doctor slightly tugged on the cord and eventually the entire placenta came out. The father was allowed to cut the cord and the separation of the baby and placenta occurred. During the end of stage 2 and stage 3 this mother experienced a postpartum hemorrhage. She lost approximately 600 ml of blood. Immediately after the placenta was birthed the doctor ordered methergine and tranexamic acid to firm up the uterus and decrease the amount of blood loss. The nurse performed uterine massages to also assist in firming up the uterus. Blood flow stopped and would slowly return while the doctor stitched her up. At this point another uterine massage would be performed. This continued for about 20 minutes after the birth of the placenta and then the bleeding stopped almost completely. The nursing staff and I continued to perform routine checks to make sure the bleeding did not start again.

After this point the patient entered the fourth stage of labor. “The fourth stage begins with completion of the expulsion of the placenta and membranes and ends with the initial physiologic adjustment and stabilization of the mother” (Kyle & Ricci, 2009, p.379). During this stage postpartum has begun. In this phase it is common for the mother to be wide awake, feel calm, and be very talkative (Green, 2019). This patient wasn’t wide awake but she experienced a very calm demeanor and wanted to just lay there peacefully with her new baby. During this phase the nurse should continue to monitor the fundus of the uterus and whether its firm or boggy and the position it is in. If the fundus becomes boggy the nurse should massage it until it becomes firm. The nurse and I repeated this assessment every 15 minutes for the first hour and then every 30 minutes for the next. The normal position for the fundus to be felt is midline between the umbilicus and the pubis symphisis. This patient's fundus was slightly higher than the belly button during our first couple checks but eventually dropped below the umbilicus. Assessing the lochia, or vaginal discharge, is also an important assessment during this stage. This was done at the same time we assessed the fundus. It was important to also monitor the amount of blood in the patients pad to determine if she had started to hemorrhage again. This stage lasts anywhere from 1 to 4 hours. This concluded my time with this patient.

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

Green, J. M.D. (2019) The four stages of labor. Retrieved from https://wa.kaiserpermanente.org/healthAndWellness/index.jhtml?item=%2Fcommon%2FhealthAndWellness%2Fpregnancy%2Fbirth%2FlaborStages.html

Kyle, T., & Ricci, S.S. (2009). *Maternity and Pediatric Nursing*. 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	**3.8-5.51**	**4.09**	**4.05**	**Labs to be**	

				drawn 9/12 due to postpartum hemorrhage	
Hgb	**11.3-15.2**	**12.9**	**13.2**	**--**	
Hct	**33.2-45.3**	**36.8**	**37.8**	**--**	
Platelets	**149-493**	**220**	**182**	**--**	
WBC	**4-11.7**	**7.3**	**14.3**	**--**	**It is common for WBC counts to be increased during the last trimester of pregnancy and during labor. This should return back to normal baseline value within one week of birth. It is important to monitor WBC count for this return to normal (Van Leeuwen & Bladh, 2009, p.399).**
Neutrophils	**45.3-79**	**76.5**	**75.9**	**--**	
Lymphocytes	**11.8-45.9**	**15.8**	**18.3**	**--**	
Monocytes	**4.4-12.0**	**6.6**	**4.7**	**--**	
Eosinophils	**0.0-6.3**	**0.8**	**0.4**	**--**	
Bands	**N/A**	**N/A**	**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	Admission Value	Today's Value	Reason for Abnormal
Blood type	**A/AB/B/O**	**A+**	**--**	**--**	

Rh factor	**+ or -**	**negative(-)**	**--**	**--**	
Serology (RPR/VDRL)	**reactive/ nonreactive**	**nonreactive**	**--**	**--**	
Rubella Titer	**24-143 IU/ml**	**71.0**	**--**	**--**	
Hct & Hgb	**11.3-15.2/ 33.2%-45 .3%**	**11.5/32.7%**	**13.2/37.8 %**	**labs to be drawn 9/12**	
HIV	**active/no nreactive**	**nonreactive**	**nonreacti ve**	**--**	
HbSAG	**active/no nreactive**	**nonreactive**	**nonreacti ve**	**--**	
Group Beta Strep Swab	**negative/ positive**	**negative**	**--**	**--**	
Glucose at 28 weeks	**< 140**	**73**	**--**	**--**	
Genetic testing: if done	**M/F**	**opted out**	**opted out**	**opted out**	

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

Lab Test	Normal Range	Prenatal Value	Admissio n Value	Today's Value	Reason for Abnormal
Color & Clarity	**yellow/clea r**	**N/A**	**yellow/cle ar**	**N/A**	
pH	**4.5-8.0**	**N/A**	**7.0**	**N/A**	
Specific Gravity	**1.002-1.030**	**N/A**	**1.016**	**N/A**	
Glucose	**0-15**	**N/A**	**normal**	**N/A**	
Protein	**0-20**	**N/A**	**negative**	**N/A**	

Ketones	**0-80**	**N/A**	**negative**	**N/A**	
WBC	**0-5**	**N/A**	**1**	**N/A**	
RBC	**2-5**	**N/A**	**4**	**N/A**	
Leukoesterase	**0-5**	**N/A**	**negative**	**N/A**	

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

Test	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal
Urine Culture	**N/A**	**N/A**	**N/A**	**N/A**	**Results Pending**

****No additional tests were performed on this patient.**

Other Tests	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (4 ed.). Philadelphia, PA: F.A. Davis Company.

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	**130 BPM**
Are there accelerations, if so describe them and explain what these mean i.e. how high do they go and how long do they last? **What is the variability?**	**Yes there were accelerations. Accelerations occur when the fetal heart rate rises above the baseline more than 15 BPM. These are usually a sign of fetal well being and do not require interventions (Kyle & Ricci, 2009). My patients accelerations rose 15 BPM and lasted 15 seconds.** **Variability is the measure of the fetal heart rate over a long period of time. Variability can be described in three ways; minimal or absent, moderate, or marked. Minimal variability would implicate an issue with, "uteroplacental insufficiency, cord compression, maternal hypotension, uterine hyperstimulation, abruptio placentae, or a fetal dysrhythmia" (Kyle & Ricci, 2009, p. 394). Minimal or absent variability would require interventions. Moderate variability is a positive sign and is indicative of good fetal health. "Marked variability occurs when there are more than 25 beats of fluctuation in the FHR baseline. Causes of this include cord prolapse or compression, maternal hypotension, uterine hyperstimulation, and abruptio placentae" (Kyle & Ricci, 2009, p.394-395). Some interventions would need to be provided to return the fetal heart rate**

	back to baseline. My patient had moderate variability, which is a positive sign and required no interventions.
Are there decelerations, if so describe them. **What do these mean?** **Did the nurse perform any interventions with these?** **Did these interventions benefit the patient or fetus?**	**My patient did have decelerations. Variable decelerations were experienced where the fetal heart rate would drop down to the 80s and would last 50 seconds during the mother's contractions. Variable decelerations are a drop in the fetal heart rate most commonly occurring due to cord compression. Variable decelerations are the most common decelerations in a laboring woman and are usually correctable and non threatening (Kyle & Ricci, 2009, p. 395-396). The decelerations my patient experienced were due to cord compression during contractions and pushes. The nurse administered oxygen to the patient to intervene. This allowed for the mom to increase oxygen and for baby to increase oxygen as well. This intervention was successful.**
Describe the contractions i.e. frequency, length, strength, patient's response.	**The contractions my patient experienced were strong. They occurred approximately every 1-2 minutes. They lasted about 70-90 seconds each time. Patient was able to determine when her next contraction was coming and was able to tell the nurse. She responded by pushing intensely through 3 cycles of about 10 seconds each. She would rest between contractions to try and recover.**

Resources:

Kyle, T., & Ricci, S.S. (2009). *Maternity and Pediatric Nursing*. Philadelphia, PA: Wolters Kluwer.

Current Medications (10 points total -1 point per completed med)

Home Medications (2 required)

****Patient is only on one at home medication**

Brand/Generic	**Prenatal Vitamin** **(Prenatal Vitamin, 2019)**				
Dose	**1 pill**				
Frequency	**QID**				
Route	**PO**				
Classification	**multivitamin**				
Mechanism of Action	**Absorbed in the stomach to increase the intake of vitamins and minerals essential for proper fetal development such as iron, folic acid, and other nutrients not obtained in the diet.**				
Reason Client Taking	**To promote fetal growth and health during pregnancy and to support maternal**				

	health and immunity.				
Contraindications (2)	**-allergic reaction to any ingredients** **-vitamin B12 deficiency or pernicious anemia**				
Side Effects/Adverse Reactions (2)	**-GI upset** **-constipation**				
Nursing Considerations (2)	**-This medication will pass into breast milk so consult doctor before breastfeeding** **-Can decrease the effectiveness of other drugs so separate doses into different times for full effectiveness of both medications**				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**overall CBC and BMP to understand patients baseline labs. Monitor therapeutic**				

	levels of other prescribed medications to make sure they are still effective.				
Client Teaching needs (2)	**-Take delayed release or extended release tablets whole; do not crush** **-May take with food if GI upset occurs**				

Hospital Medications (5 required)

Brand/Generic	**Fentanyl/ duragesic** **(Sanoski & Vallerand, 2013, p. 494)**	**Methylergonovine/ Methergine** **(Sanoski & Vallerand, 2013, p. 821)**	**lidocaine/ Xylocaine** **(Sanoski & Vallerand, 2013, p. 759)**	**Lactated ringers** **(Lactated Ringers, 2019)**	**tranexamic acid/ Cyklokapron** **(Tranexamic Acid, 2019)**
Dose	**200 mcg= 5ml**	**0.2mg = 1ml**	**200mg = 20 ml**	**1000ml** **125ml/hour**	**1000mg = 60ml**
Frequency	**PCA pump continuous with 15 minute lockout**	**1X**	**1X**	**continuous infusion**	**1X**
Route	**epidural**	**IM**	**subQ**	**IV**	**IV PB**

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Classification	**opioid analgesic**	**oxytocic**	**local anesthetic**	**IV hydrating fluids**	**hemostatic agent**
Mechanism of Action	**Binds to specific opioid receptors in the CNS therefore inhibiting pain pathways, altering pain perception, and increasing the pain threshold**	**directly stimulates uterine and vascular smooth muscle to cause uterine contractions**	**produces local anesthesia by inhibiting transport of ions across neuronal membranes, thereby preventing initiation and conduction of normal nerve impulses**	**contains a combination of water and electrolytes that enter through the vascular system and allow the body to absorb nutrients lacking.**	**inhibits activation of plasminogen, thereby preventing the conversion of plasminogen into plasmin. This decreases bleeding**
Reason Client Taking	**Labor pain**	**postpartum hemorrhage to aid in contracting the uterus and stopping the bleeding**	**Used to provide anesthetic therapy during 3rd degree tear postpartum.**	**Used to provide fluid and electrolytes to patient during labor when patient is not eating or drinking.**	**Used to stop bleeding in postpartum hemorrhage**
Contraindications (2)	**-hypersensitivity to the drug** **-acute or severe bronchial asthma**	**-Should not be used to induce labor** **-Do not use while breastfeeding**	**-patients with hypersensitivity to drug** **-patients with a third-degree heart block**	**-patients with fluid volume overload** **-patients with a history of CHF**	**-patients with acute intravascular clotting** **-patients with a subarachnoid hemorrhage**

Side Effects/Adverse Reactions (2)	**-slow and shallow respirations** **-sedation**	**-dizziness** **-hypertension**	**-stinging/burning** **-contact dermatitis**	**-rapid infusion can cause local pain and venous irritation** **-edema due to retention of fluid**	**-hypotension** **-thrombosis**
Nursing Considerations (2)	**-grapefruit can increase the level in the blood and cause toxicity** **-Can cause CNS depression**	**-grapefruit juice may increase levels and cause toxicity, monitor for this** **-monitor bleeding for slowing down or increasing amounts**	**-monitor site of administration to determine reaction to medication** **-monitor degree of numbness to determine the effectiveness of medication**	**-auscultate lung sounds to determine fluid volume overload** **-monitor electrolyte labs to determine deficits or too much of something**	**-monitor for increased blood coagulation especially in lower extremities** **-assess dizziness and monitor patient when ambulating**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Assess baseline VS to determine is drastic changes in heart rate, respirations, or blood pressure occurs. Monitor respiration rate throughout use as well as other VS.**	**Monitor BP, heart rate and uterine response frequently during admin. Notify provider if uterus becomes relaxed or bleeding reoccurs.**	**Assess baseline VS to determine drastic changes in heart rate, BP, or respirations Obtain baseline BMP to monitor serum electrolyte balances**	**Obtain baseline BMP to monitor electrolyte levels. Assess baseline VS to determine lung sounds, respirations, heart rate, and blood pressure.**	**Obtain baseline CBC to compare blood coagulation factors to. Monitor VS from baseline to determine drop in BP, HR, or respirations.**

Client Teaching needs (2)	**-instruct patient to push PCA pump whenever pain is increased and more relief is needed** **-instruct them that there is a lockout method and they cannot overdose on this drug**	**-advise patient that this medication may cause menstrual like cramping** **-notify provider if bleeding does not stop**	**-May cause drowsiness and dizziness so call for help when ambulating** **-vaginal area may be numb for a period of time so monitor for leakage of fluids such as blood in case patient cannot feel it.**	**-Notify provider if shortness of breath occurs** **-Notify provider if there is pain at the IV site**	**-Educate patient that dizziness may be a side effect and to take their time when getting up or moving around** **-Notify provider if vision loss occurs**

Medications Reference (APA): (2 points)

Lactated Ringers. (2019). Retrieved from https://www.rxlist.com/lactated-ringers-drug.htm#description.

Prenatal Vitamin. (2019). Retrieved from https://www.webmd.com/drugs/2/drug-19981-280/prenatal-vitamin-oral/multivitamins-w-iron-includes-prenatal-vitamins-oral/details.

Sanoski, C.A., & Vallerand, A.H. (2013). *Davis's Drug Guide For Nurses*. (14th ed.). Philadelphia. F.A. Davis company

Tranexamic Acid. (2019). Retrieved from https://fadavispt.mhmedical.com/content.aspx?bookid=1873&sectionid=139028940.

<u>Assessment (20 points)</u>

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Physical Exam (20 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient is AO X 4. She has clear speech and can form words and sentences properly. She was calm and composed during her labor and showed no emergent signs of distress. Her overall appearance showed visible pain but she was managing it well with breathing techniques as well as proper rest periods.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	**Patients skin is PWD. She was diaphoretic during labor but recovered and skin was mostly dry. Patient has normal skin turgor and elasticity AEB no skin tenting. Patient had a slight fever at the end of labor and postpartum which was treated with tylenol. Patients reports not feeling overheated. No noted rashes. No noted bruises. No wounds or incisions. Patient was stitched up after vaginal birth therefore I will continue to assess the vagina for complications with stitches. Braden score is 22. No skin risk. Patient has no drains present.**
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is normocephalic. No obvious trauma or abnormalities noted. PERRLA noted. EOM intact. Normal ear exam, no discharge or tenderness. Nares is normal, septum is midline, mucosa is normal, no drainage noted, no tenderness noted. Lips, tongue, gums and teeth are normal. Moist normal mucosa.**
CARDIOVASCULAR (1 points): **Heart sounds:**	**Patient has RRR. S1 & S2 noted. No murmurs, rubs, or gallops noted. Radial and pedal pulses assessed (see notes for grades). Cap refill < 3**

S1, S2, S3, S4, murmur etc. **Cardiac rhythm (if applicable):** NSR **Peripheral Pulses:** 3+ radial pulses palpated bilaterally/ 2+ pedal pulses palpated bilaterally **Capillary refill:** < 3 seconds **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	**seconds bilaterally on hands and toes. No noted edema. No noted neck vein distention.**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**Lungs CTA bilaterally in all lobes. Respirations are unlabored. No tenderness or deformity on chest wall. Patient was receiving supplemental O2 during labor to assist with variable decelerations in FHR but was discontinued after birth. Patient breathing room air at this time. No oxygen use at home. Trachea midline, no deviations.**
GASTROINTESTINAL (5 points): **Diet at home:** Normal diet **Current Diet:** Normal diet **Height:** 165 cm **Weight:** 86.2 kg **Auscultation Bowel sounds:** active bowel sounds heard in all four quadrants **Last BM:** N/A **Palpation: Pain, Mass etc.:** **Inspection:** Rounded **Distention:** N/A **Incisions:** None **Scars:** None	**Normal bowel sounds heard in all 4 quadrants. Patient has no scars, wounds, drains, or incisions on the abdomen. Her abdomen is tender upon palpation. Patient appears to be in pain when palpating fundal height but doesn't complain of pain. Fundal height is approximately 1 cm below umbilicus at my last check. Fundus is in midline between umbilicus and pubis symphisis. Abdomen is normal and round. No distention noted. No noted masses.**

Drains: None **Wounds:** None **Fundal Height & Position:** 1 cm below umbilicus midline between umbilicus and pubis symphysis	
GENITOURINARY (5 Points): **Bleeding:** yes- light spotting **Color:** yellow/clear **Character:** normal **Quantity of urine:** 150ml **Pain with urination: Y ☐ N ☐** **Inspection of genitals:** no noted abnormalities, wounds, or blisters **Catheter: Y ☐ N ☐** **Type:** **Size:** **Rupture of Membranes:** Spontaneously at home **Time:** approx 1030 pm **Color:** greenish color **Amount:** patient states it was a large amount **Odor:** no noted odor **Episiotomy/lacerations:** patient had third degree tear during birth	**Patient was straight cathed at 0400 to remove 150 ml urine. Urine was clear/yellow during UA upon admission. Patient states no pain while urinating. Patient has no catheter in place. No genital abnormalities noted. Patient states her water broke last night at approximately 2230 before she came to the hospital. Patient states that the fluid had a green color to it. Patient denies any odor to the fluid. Fluid was obtained and will be cultured. Patient states she had a normal bloody show and has had light spotting since then. No episiotomy performed. During labor patient experienced a third degree tear between her vagina and rectum. Doctor stitched up the laceration and used local anesthesia (lidocaine) to numb the vaginal area. Upon completion of stitches vagina had already started to decrease swelling. During birth patient experienced postpartum hemorrhage and lost about 600ml of blood. Slow trickle continues to flow. Will monitor blood loss closely.**
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** 30 - low risk	**Patient has no noted deformities or joint abnormalities. She has normal ROM in all extremities bilaterally. She can ambulate on her own to the bathroom or in the halls, however should be monitored closely postpartum to make sure she is stable. Patient did experience blood loss so should take ambulation slowly. No edema noted. No cyanosis noted. Patient is weak and**

Activity/Mobility Status: **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**exhausted postpartum. Strength rated 5/5 in all extremities bilaterally. Patient needs time to rest and relax to regain strength.**
NEUROLOGICAL (1 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** AO X 4 **Mental Status:** **Speech:** **Sensory:** **LOC:** **DTRs:**	**Patient is AO X 4. She is weak and exhausted postpartum. Patients sensations are intact. Patients grips are equal bilaterally. Equal strength in upper and lower extremities. Patient has normal developmental level. Normal cognitive level. Her mental status is normal. Speech is clear. She is fully conscious and understand commands and questions. DTRs intact.**
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 is in good mood. She is very tired and exhausted but very happy and pleasant. She is hands on with her baby and shows interest in learning how to breastfeed, hold him, and have skin to skin. Her husband is with her and assisted her throughout the entire birthing process. She stated she has sisters with kids of their own and will receive a lot of help from them and her parents. Patient does not express any religious beliefs. She will go home with her husband and their baby to their home. She feels safe in her relationship and in her home. She shows a normal developmental level and an interest in learning how to take care of her new baby.**

DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date:** 9/11/2019 **Time:** 0732 **Type (vaginal/cesarean):** vaginal **Quantitative Blood Loss:** 600 ml **Male or Female:** Male **Apgars:** 9/10 10/10 **Weight:** 9lb 13oz **Feeding Method:** breastfeeding	**Baby was delivered on 9/11/2019 at 0732. Baby was a male. He was delivered via vaginal birth. Mother experienced approximately 600 ml loss of blood during labor. He weighed 9 pounds 13 oz. Mother will breastfeed him. Apgar at 1min = 9/10. apgar at 2min=10/10.**

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**78 BPM**	**124/86 mmHg**	**16 breaths/min**	**37.4 C**	**N/A**
Labor/Delivery	**90 BPM**	**114/78 mm Hg**	**18 breaths/min**	**37.8 C**	**97%**
Postpartum	**76 BPM**	**122/82 mmHg**	**16 breaths/min**	**37.6 C**	**97%**

Vital Sign Trends:

During labor her vital signs started to trend in the direction of a patient who is experiencing hemorrhage. Her heart rate increased in order to make up for the blood loss, her blood pressure started to tank due to blood loss and her respirations

started to increase in order to perfuse the rest of her body with oxygen. She was given medications to assist with the hemorrhage and after these medications were given her vital signs started to trend back to her normal baseline. This patient's baseline temperature is slightly higher than the normal temperature and increased even more during labor. She was given tylenol postpartum and this worked in decreasing her slight fever. Overall this patient was very healthy and didnt have very drastic changes in her vital signs.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0805	**numeric**	**headache/back ache**	**4/10**	**throbbing**	**Tylenol administered**
1045	**numeric**	**no actual perceived pain**	**0/10**	**N/A**	**no intervention needed**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV:Right antecubital fossa** **Date on IV: 9/10/2019** **Patency of IV: IV is patent. Fluids running. no infiltration or phlebitis noted.** **Signs of erythema, drainage, etc.: No redness, swelling, drainage, or pain on palpation** **IV dressing assessment: Transparent dressing in place. Dry and intact.**	**Patient receiving Lactated ringers at 125ml/hour**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

N/A patient was pushing **(administered LR at end of my shift therefore not counted)**	**150 ml at 4AM when patient was straight cathed**

Interventions (12 points)

Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. Vitamin K administration to the newborn is a teaching topic I would focus on. Vitamin K is a fat soluble vitamin that aids in the ability of the blood to clot. Administration of vitamin K should be done after a baby is born due to the fact that, "it takes about a week for the newborn to produce enough vitamin K to prevent vitamin K deficiency bleeding" (Kyle & Ricci, 2009, p.504). Without vitamin K babies can be at a higher risk of bleeding out if even minor cuts or scrapes occur. After feeding is introduced to the newborn their own intestinal microorganisms begin to grow and the production of vitamin K starts to take place on its own. It is crucial to educate new parents on the importance of vitamin K and the risks of not giving this to their newborn. Along with me explaining the importance of this shot I can offer to provide the new parents with pamphlets of information so they can further educate themselves and make a decision that is best for everyone. The desired outcome would be that the parents would choose to get their child the shot and the nurse would admin the vitamin K to the newborn child.
2. Breastfeeding is a topic that I would focus on educating my patients on as well. Advantages of breastfeeding can be great for the mom and the baby. Some advantages for the newborn include; strong immune system development, stimulated growth of positive bacteria in the GI tract, provides passive immunity from mother, promotes mother-infant bonding, provides protection against food allergies, and promotes better tooth and jaw development (Kyle & Ricci, 2009). Some advantages of breastfeeding for the mother include; facilitating in postpartum weight loss, stimulates uterine contractions to control bleeding, lowers risks of breast cancer and

osteoporosis, and can be used as a form of contraception (Kyle & Ricci, 2009). The lactation specialist explained that when a mother attempts to breast feed her newborn child within 4 hours of birth it stimulates the hormones in her body to produce prolactin. Prolactin is a hormone that helps the mothers milk supply come in. If the mother does not attempt to breast feed within this time frame her chances of a healthy milk supply coming in decreases. After going over this information with my patient I would invite the lactation specialist to come in and assist the new mom with positioning and techniques to use for success. If the mother would like I can even supply her with pamphlets to take home and read up on with more information regarding breastfeeding. The ideal outcome of this education session would be the mother shows interest in wanting to breast feed her child and attempts to try immediately after birth.

Resources:

Kyle, T., & Ricci, S.S. (2009). *Maternity and Pediatric Nursing*. Philadelphia, PA: Wolters Kluwer.

Nursing Interventions (6 points)

Include a rationale as to why the intervention is being provided to client

Nursing Interventions: Perform fundal massages Q 15 minutes for the first hour after birth. Fundal massages will help to keep the uterus firm. By keeping the uterus firm the risk of bleeding is decreased. Because this patient already had a postpartum hemorrhage it is crucial to continue these messages on a regular schedule to inhibit her bleeding anymore.

Medical Treatments: Admin Methergine, an oxytocic drug, that also stimulates uterine contractions. With uterine contractions the uterus firms up therefore reducing the bleeding that occurs postpartum. This was an emergent prescription due to the patient experiencing a major postpartum hemorrhage of 600ml of blood.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

N432 Care Plan

Nursing Diagnosis ● Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** ● Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)** Include a short rationale as to why you chose this intervention & cite the reference appropriately	**Evaluation** ● How did the client/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. impaired gas exchange R/T diminished maternal circulation to the utero-placentalu nit AEB fetal rate deceleration during contractions **(Swearingen, 2016, p.644)**	**During contractions the FHR showed decelerations due to impaired oxygen exchange between the mother and the placenta resulting in lack of oxygen delivered to the baby.**	**1. Admin supplemental oxygen at 8-10 L/min (Swearingen, 2016, p.644)** **rationale: provide mother with increased oxygen to ensure the baby receives adequate amounts** **2. Monitor for fetal distress by continuous FHR monitoring (Swearingen, 2016, p.644)** **rationale: if the baby's oxygen supply diminished further his heart rate will increase and will show proof that interventions are needed**	**Supplemental oxygen raised the mothers oxygen saturation as well as the babies. Both responded very well to the intervention. Decelerations were not as severe after this intervention was made. We were able to determine this successful intervention due to the continuous FHR monitoring that we began after the drop in oxygen occurred.**
2. At risk for shock R/T post partum hemorrhage AEB 600 ml of blood lost during labor	**If this diagnosis is not addressed and understood then it runs the risk of becoming a very serious complication.**	**1. Assess the amount and begin measurement of continuing blood loss (Swearingen, 2016, p.644)**	**The patient was very responsive to the interventions made. She was understanding of constant vital sign checks and would answer all the questions we asked to**

(Swearingen, 2016, p.643)	**Intervening before this becomes a serious matter is a crucial part of this patients safety.**	**rationale: Knowing the amount of blood loss can alert staff to knowing if a transfusion may be necessary.** **2. Monitor accompanying vital signs for signs and symptoms of major blood loss such as hypotension, decreased pulse pressure, tachycardia, delayed cap refill, cool clammy or mottled skin, and changes in mentation. (Swearingen, 2016, p.643)** **rationale: Understanding that if any of these vital signs start to arise this is a huge warning sign that the patient is bleeding out and there needs to be a major intervention to stop the bleeding and save her life.**	**assess her mentation status. She was unaware of her major blood loss therefore the situation was handled well. She did not feel any symptoms of shock and the healthcare team did not make a big enough deal to scare the patient or cause anxiety.**

Other References (APA):

Swearingen, P. L. (2016). All-in-one: nursing care planning resource (4th ed.). St. Louis, Missouri: Elsevier