N432 Care Plan #1

Bo Sananixai

Lakeview College of Nursing

September 18, 2019

Demographics (3 points)

Date of Admission & Time of Admission	Patient Initials	Age	Gender
09/09/19; 1400	M.N.	20-year-old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Caucasian	Unemployed	Single	No known drug allergies.
Code Status	**Height**	**Weight**	**Father of Baby involved?**
Full code	160 cm	70.1 kg	Yes

Medical History (5 Points)

Prenatal History: Patient states that she attended all of her prenatal check-ups and received the routine blood and urine tests during pregnancy. Patient denies receiving any abnormal test results. Patient denies any complications during prenatal stage.

Past Medical History: Patient states that she does not have a past medical history. No PMH is listed in her chart.

Past Surgical History: Patient states that she does not have past surgical history. No PSH is listed in her chart.

Family History: Patient states that her maternal grandmother had breast cancer and her maternal grandfather had lung cancer. Patient denies pertinent family history on paternal side.

Social History (tobacco/alcohol/drugs): Patient states that she is a former cigarette smoker with a 4-year pack history, smoking ½ pack per day, and “quit more than 30 days ago”. Patient states that she used to drink alcohol

(for approximately 2 years) on the weekends, equivalent to a six-pack of beer, until she found out she was pregnant and has since stopped. Patient states that she has also smoked marijuana occasionally in the past, equivalent to “one to three joints” per month. Patient denies using any other illicit drugs in the past or present.

Living Situation: Patient states that she currently lives at home with both of her parents.

Education Level: Patient states that the highest level of education completed is high school (12th grade).

Admission Assessment (12 points)

Chief Complaint (2 points): Patient states that she “experienced contractions every 5 minutes that lasted 60 seconds each”.

Presentation to Labor & Delivery (10 points): Patient presented to Labor & Delivery at approximately 1130 on 9/9/19 at 40 weeks gestation. Patient states that she timed her contractions and they started to get closer to each other, and eventually came to L&D when her contractions were five minutes apart from each other. Patient states that her contractions lasted approximately 60 seconds each time. Patients states that the onset of contractions began early this morning around 0600 and woke her up. Patient states that the location of the contractions began across her lower abdomen but later on radiated from her lower back to the front of her abdomen. Patient describes the contractions as “a lot of pressure and pain” from lower back to lower abdomen. Patient states that aggravating factors that worsened contractions were walking and moving. Patient admits that using “breathing techniques” helped relieve the pain some. On a numerical scale rating from 0-10, patient rates her admission pain as a “7” with 10 being the highest amount of pain. Upon assessment, patient’s vital signs were stable. Patient also complains of a “burning” sensation when urinating. A urine sample reveals that the color of urine does appear to be cloudy with a foul odor. A urinalysis confirms that the patient tests positive for a urinary tract infection. A urine culture and sensitivity has been ordered. Patient does not appear to have any vaginal bleeding or spontaneous rupture of membrane (SROM). Fetal movement was assessed and is normal.

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points): Spontaneous labor at 40 weeks.

Secondary Diagnosis (if applicable): Urinary tract infection (UTI).

Stage of Labor (20 points):

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

Mothers who give birth in a hospital are discharged as soon as they are medically stable, which can be anywhere from a few hours to a couple of days. The average hospital stay for a vaginal delivery is two days while a cesarean section is three to four days. The postpartum, or fourth stage, of labor begins immediately after a mother delivers the placenta and usually ends six weeks later. The postpartum period can be separated into two different periods which include the acute and subacute periods (Romano, Cacciatore, Giordano, & La Rosa, 2010). As a mother's body begins to transition itself back to a pre-pregnancy state, it experiences many physiologic adaptations which involve most of the body, including the reproductive, cardiovascular, urinary, and endocrine systems (Ricci, Kyle, & Carman, 2017).

The acute phase is the initial phase that can last anywhere between six to twelve hours after a mother gives birth (Romano et al., 2010). In the first 24 hours postpartum, it is normal for women to have a low-grade fever up to 100.4˚ F and a slightly elevated pulse rate within the first hour (Ricci, Kyle, & Carman, 2017). Respirations and blood pressure return to pre-pregnancy rates soon after birth. A thorough assessment of the mother during the acute phase is critical because it is associated with the most concerning health risk-postpartum hemorrhaging. Postpartum hemorrhaging can happen after vaginal or cesarean birth and is defined as blood loss greater than 500 mL after vaginal birth and 1,000 mL after cesarean delivery (Ricci, Kyle, & Carman, 2017). It is the leading cause of maternal death and happens within four hours of childbirth. To help relieve this issue, nurses will attempt to improve the uterine tone by immediately performing a fundal massage

or administering IV fluid resuscitation and uterotonic medications after childbirth (Ricci, Kyle, & Carman, 2017).

The subacute period is two to six weeks after a mother gives birth, and is the period where most mothers report at least one complication (Romano et al., 2010). As the mother's body transitions back to a non-pregnant state, she is at higher risk for complications such as deep vein thrombosis, infection, constipation, and urinary incontinence (Ricci, Kyle, & Carman, 2017). Mothers will continue to experience vaginal discharge, known as lochia, as a result of uterine involution. Uterine involution, or gradual shrinkage of the uterus, involves contraction of muscle fibers, catabolism of myometrial cells, and regeneration of the uterine epithelium (Ricci, Kyle, & Carman, 2017). During the renewal of uterine epithelium, the upper layers are sloughed off in the lochia discharge. Lochia discharge transitions from a bright red to light brown color and should stop around five to six weeks post-delivery (Ricci, Kyle, & Carman, 2017). Nurses should educate mothers that lochia at any stage should have a fleshy smell, but foul odors could be a sign of infection and should be reported. Furthermore, mothers in the postpartum stage are advised by nurses to wear adult diapers or pads until discharge subsides. Additionally, women can expect the return of their menstrual period during the subacute phase if they are not breastfeeding. Since mothers are usually discharged by the end of the postpartum stage, it is vital that new moms receive educational information on what to expect in the weeks after childbirth.

The changes that occur in the cardiovascular system include a decline in cardiac output and blood volume. However, clotting factors remain increased two to three weeks after childbirth, so signs of blood clots like shortness of breath, edema, and calf pain should be monitored. Labs should show low hemoglobin and hematocrit levels in the first 24 hours due to the disruption of red blood cell production, with rising levels within two weeks. White blood cell levels will be increased for four to six days after childbirth then returns within normal range afterwards.

Although urinary changes return to normal after six weeks, women can experience difficulties with feeling the need to void. When this occurs in these women, they are at risk for incomplete emptying of the bladder, bladder distention, and urinary retention leading to a urinary tract infection (Ricci, Kyle, & Carman, 2017). Signs of urinary retention include frequently voiding less than 150 mL of urine and may require catheterization to empty the bladder to restore uterine tone. Nurses should educate mothers that there will be an increase in urine output within twelve hours of birth that can last up to a week due to low levels of antidiuretic and aldosterone hormone levels.

Lastly, in the endocrine system, levels of estrogen and progesterone decrease immediately after delivery of the placenta. Progesterone levels are undetectable three days post-delivery, and estrogen levels are at its lowest one week after birth but start to increase a couple of weeks later if mom is not breastfeeding (Ricci, Kyle, & Carman, 2017). If a mother decides not to breastfeed their baby, nurses should teach the patient that prolactin levels will also decrease within a couple of weeks.

The patient that I observed today delivered her baby vaginally. She experienced a quantitative blood loss of 400 mL which did not suggest postpartum hemorrhaging. As indicated in the patient's chart, a fundal massage was performed to help stop contractions after she delivered the placenta, and the fundal height was measured at -1 with a midline position. Upon a face-to-face assessment with the patient, she described seeing lochia discharge when she went got up to urinate, as it was bright red and appeared on her underwear pad and in the toilet with her urine. The patient is choosing to formula feed her baby, so it is expected that prolactin hormone levels will decrease in a couple of weeks and milk production in her breasts will stop.

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

References

Ricci, S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Philadelphia: Wolters Kluwer.

Romano, M., Cacciatore, A., Giordano, R., & La Rosa, B. (2010). Postpartum period: three distinct but continuous phases. *Journal of prenatal medicine*, *4*(2), 22–25.

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	4-5.5 million	3.59	4.06	N/A	Red blood cell mass increases in pregnancy, but plasma volume increases more, resulting in relative anemia (Ricci, Kyle, & Carman, 2017).
Hgb	12-16	11.7	13.1	14.8	Red blood cell mass increases in pregnancy, but plasma volume increases more, resulting in lowered hemoglobin (Ricci, Kyle, & Carman, 2017).
Hct	35-47%	32.9	37.9	27.6	Red blood cell mass increases in pregnancy, but plasma volume increases more, resulting in lowered hematocrit (Ricci, Kyle, & Carman, 2017).
Platelets	150-400 (10^2)	195	191	N/A	N/A
WBC	5-10 (10^2)	6.8	19.2	N/A	UTI infection. Higher levels of leukocytes in the bloodstream may indicate an infection (Ricci, Kyle, & Carman, 2017).
Neutrophils	55-70 %	69.2	91.8	N/A	UTI infection. Higher levels of neutrophils in the bloodstream may indicate an infection (Ricci, Kyle, &

					Carman, 2017).
Lymphocytes	20-40 %	20.4	4.3	N/A	UTI infection. Higher levels of lymphocytes in the bloodstream may indicate an infection (Ricci, Kyle, & Carman, 2017).
Monocytes	2-8 %	7.8	3.8	N/A	N/A
Eosinophils	1-4%	1.5	N/A	N/A	N/A
Bands	0	0	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	O negative	O negative	N/A	N/A	N/A
Rh factor	Negative	Positive	Positive	N/A	Patient's blood has the Rh factor protein, indicating a Rh-positive blood type (Ricci, Kyle, & Carman, 2017).
Serology (RPR/VDRL)	Non-reactive	Non-reactive	N/A	N/A	N/A
Rubella Titer	>10	15.7	N/A	N/A	N/A
Hct & Hgb	36-46% & 12-16 g/dL	25.1 & 10.2	N/A	N/A	N/A
HIV	Negative	Negative	N/A	N/A	N/A
HbSAG	Non-reactive	Non-reactive	N/A	N/A	N/A
Group Beta Strep Swab	Negative	Negative	N/A	N/A	N/A
Glucose at 28 weeks	75-80 mg	79 mg	N/A	N/A	N/A

Genetic testing: if done	Negative	N/A	N/A	N/A	N/A

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	Admission Value	Today's Value	Reason for Abnormal
Color & Clarity	Yellow/Clear	Yellow/Clear	Yellow/Cloudy	Yellow/Hazy	Urinary tract infection.
pH	4.5-8.0	6.0	7.0	N/A	N/A
Specific Gravity	1.002-1.030	1.023	1.013	N/A	N/A
Glucose	Negative	Negative	Negative	N/A	N/A
Protein	Negative	Negative	Negative	N/A	N/A
Ketones	Negative	Negative	Negative	N/A	N/A
WBC	0-5	5	25	N/A	The most common cause for WBCs in urine is a bacterial urinary tract infection (UTI) (Ricci, Kyle, & Carman, 2017).
RBC	0-4	2	1	N/A	N/A
Leukoesterase	Negative	Trace (A)	2+ (A)	N/A	The most common cause for WBCs in urine is a bacterial urinary tract infection (UTI) (Ricci, Kyle, &

					Carman, 2017).

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	Negative	Negative	Pending	N/A	Results pending, not available in patient's chart.

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

Lab Correlations Reference (APA):

References

Ricci, S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Philadelphia: Wolters Kluwer.

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	N/A - Unable to assess due to normal vaginal delivery.
Are there accelerations, if	N/A - Unable to assess due to normal vaginal delivery.

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?	
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?	N/A - Unable to assess due to normal vaginal delivery. However, a deceleration can be defined as “a transient fall in FHR caused by stimulation of the parasympathetic nervous system” (Ricci, Kyle, & Carman, 2017, p. 497). They are usually described by their shape, associated to a uterine contraction, and can be classified as early, late, and variable only (Ricci, Kyle, & Carman, 2017).
Describe the contractions i.e. frequency, length, strength, patient’s response.	N/A - Unable to assess due to normal vaginal delivery.

Electrical Fetal Heart Monitoring (1) (APA format):

References

Ricci, S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Philadelphia: Wolters Kluwer.

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

7 different medications must be completed

Home Medications (2 required)

Brand/Generic	Multivitamin, Prenatal	Ondansetron (Zofran)	N/A	N/A	N/A
Dose	1 tablet	4 mg	N/A	N/A	N/A
Frequency	Once daily	Every 8 hours, as needed.	N/A	N/A	N/A
Route	Orally (PO)	Orally (PO)	N/A	N/A	N/A
Classification	Multivitamin	Serotonin 5-HT3 receptor antagonists (Jones & Bartlett, 2019).	N/A	N/A	N/A
Mechanism of Action	Provides essential nutrients to help with baby's development (Jones & Bartlett, 2019).	Blocks serotonin receptors in the chemical trigger zone (CTZ) (Jones & Bartlett, 2019).	N/A	N/A	N/A
Reason Client Taking	Meet nutrient requirements for mother and baby.	Nausea, vomiting.	N/A	N/A	N/A
Contraindications (2)	1. Iron metabolism disorders 2. Diverticular disease	1. Chronic heart failure 2. Neuroleptic malignant syndrome	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	1. Constipation 2. Nausea	1. Headache 2. Rash	N/A	N/A	N/A
Nursing Considerations (2)	1. Monitor for signs of overdose such as uneven heart rate, confusion, and muscle weakness. 2. Monitor for signs of fat-soluble vitamins such as weight loss, blood in urine, and severe back pain.	1. Monitor for cardiac arrhythmias such as QT-interval prolongation and torsade de pointes. 2. Monitor for signs of an allergic reaction such as rash, hives, fever, chills, difficulty breathing, swelling of the face, lips,	N/A	N/A	N/A

		tongue, or throat.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	1. Review labs for vitamin B12 deficiency to determine if patient has pernicious anemia. 2. Assess patient for history of alcohol abuse, liver problems, or stomach/intestinal problems.	1. Monitor cardiac status prior to administration. 2. Assess allergies. Do not give if allergic to ondansetron or similar medicines like dolasetron, granisetron, or palonosetron.	N/A	N/A	N/A
Client Teaching needs (2)	1. Do not take with milk due to decreased absorption. 2. Monitor for allergic reactions and report if experiencing rash, itching, swelling of the face, tongue, throat; severe dizziness, or trouble breathing.	1. Report symptoms of arrhythmias. 2. Stop taking and report signs of blurred vision or temporary vision loss.	N/A	N/A	N/A

Hospital Medications (5 required)

Brand/Generic	RHO (D) Immune globulin (RhoGAM)	Docusate (Colace)	Benzocaine (Orajel)	Acetaminophen (Tylenol)	Calcium Carbonate (Tums)
Dose	300 mg	100 mg	1 spray	1,000 mg	1,000 mg (2 tabs)
Frequency	Once daily.	Two times daily.	Once daily.	Every 4 hours, as needed.	Every 4 hours, as needed.
Route	Intramuscular (IM)	Oral (PO)	Oral (PO)	Oral (PO)	Oral (PO)
Classification	Immune globulins	Stool softener.	Local anesthetics.	Analgesics.	Antacids.
Mechanism of Action	Immunizing agents preventing production of	Reduces surface tension of the oil-water	Binds to sodium channels to stabilize the	Not known; thought to reduce production of	Replacement of calcium in deficiency

	antibodies against a specific blood type (Jones & Bartlett, 2019).	interface of the stool which increases water and fat to enter the stool, softening it (Jones & Bartlett, 2019).	neuronal membrane which decreases sodium ions permeability and blocks conduction of nerve impulses (Drug Bank, n.d).	prostaglandins in the brain (Drug Bank, n.d).	states.
Reason Client Taking	Prevent mom's immune response to transmission of baby's blood type during labor.	Soften stools.	Mouth sore treatment.	Pain relief.	Heartburn, indigestion.
Contraindications (2)	1. Leukemia 2. Diabetes	1. Inflammatory Bowel Disease 2. Intestinal obstruction disorders	1. Infants under 1 year of age. 2. Mothers who are breastfeeding.	1. Liver problems. 2. Caloric undernutrition.	1. Hypercalcemia 2. Renal calculi
Side Effects/Adverse Reactions (2)	1. Bloody urine 2. Pain discomfort or tenderness at injection site	1. Stomach cramps 2. Rash	1. Edema 2. Rash	1. Stomach pain 2. Clay-colored stools	1. Arrhythmias 2. Constipation
Nursing Considerations (2)	1. Bilirubin levels can be increased. 2. Monitor for hemolytic reactions including	1. Monitor for signs of allergic reaction including rash, hives, peeling skin,	1. Monitor for signs of hypersensitivity including rash, pruritis, erythema, urticaria, and	1. Assess amount, frequency, and type of drugs taken. Not intended for long term use.	1. Observe patient closely for symptoms of hypocalcemia (Jones & Bartlett,

	hypotension, nausea, and chills (Jones & Bartlett, 2019).	wheezing, or trouble breathing (Jones & Bartlett, 2019). 2. Throat irritation has been reported with this medication (Jones & Bartlett, 2019).	edema (Jones & Bartlett, 2019). 2. Reassess for pain and comfort levels 20 minutes after application to evaluate effectiveness of treatment method.	2. May alter results of blood glucose monitoring (Jones & Bartlett, 2019).	2019). 2. Monitor for constipation (Jones & Bartlett, 2019).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	1. Monitor hemoglobin levels prior to administration due to possible decrease during hemolytic reaction (Jones & Bartlett, 2019). 2. Assess for hemolytic anemia due to contraindications (Jones & Bartlett, 2019).	1. Abdominal assessment prior to administration (Jones & Bartlett, 2019). 2. Monitor sodium levels within normal range prior to administration (Jones & Bartlett, 2019).	1. Assess if the mom is breastfeeding prior to administration (Jones & Bartlett, 2019). 2. Review current medications and ensure no drug interactions are present prior to administration.	1. Assess overall health status and alcohol usage before administering. 2. Assess level of nutrition due to high risk of hepatotoxicity in patients who are malnourished (Jones & Bartlett, 2019).	1. Assess for heartburn, indigestion, and abdominal pain. 2. Inspect abdomen; auscultate bowel sounds prior to administering (Jones & Bartlett, 2019).
Client Teaching needs (2)	1. Do not take ibuprofen while taking this medication due to increase of kidney damage (Jones & Bartlett, 2019).	1. Stop taking if diarrhea occurs, which suggests an overdose (Jones & Bartlett, 2019).	1. Apply using cotton applicator to the desired area. 2. Consult primary care provider before	1. Advise patients to take medication exactly as directed and not to take more than the recommended amount.	1. Instruct patient not to take enteric-coated tablets within 1 hour of calcium carbonate (Jones &

	2. Do not receive the rubella virus vaccine while taking this medication due to live vaccine interaction (Jones & Bartlett, 2019).	2. Call doctor if experiencing an allergic reaction including rash, itching, swelling of the face, tongue, throat; severe dizziness, or trouble breathing (Jones & Bartlett, 2019).	taking any new medications.	2. Advise patients to avoid alcohol if taking more than an occasional 1-2 doses (Jones & Bartlett, 2019).	Bartlett, 2019). 2. Do not take with foods like spinach, rhubarb, cereals, or milk. Maintain adequate vitamin D intake(Jones & Bartlett, 2019).

Medications Reference (APA): (2 points)

References

Drug Bank. (n.d.). Retrieved from https://www.drugbank.ca/drugs/DB01086

Jones & Bartlett. (2019). *2019 Nurses drug handbook*. Burlington, MA: Jones & Bartlett Learning.

Assessment (20 points)

Physical Exam (20 points)

GENERAL (0.5 point): Alertness: Alert to person, place, time, and situation. Orientation: Oriented to person, place, time, and situation. Distress: No signs of distress noted. Overall appearance: Patient appears well	Patient is A&O x4. Patient does not show signs of distress. Overall, patient appears well nourished, looks stated age, and is able to communicate her needs effectively.

nourished and looks stated age.	
INTEGUMENTARY (2 points): Skin color: Pink Character: Dry Temperature: Warm Turgor: Elastic Rashes: No rashes. Bruises: No bruises. Wounds/Incision: No wounds or incisions. Braden Score: 23 Drains present: Y☐ N ☒ Type: N/A	Patient's skin is pink, warm, and dry. Patient's skin turgor is elastic without tenting, rashes, bruises, or drains present. Patient denies any wounds or incisions. Patient is up ad lib with a Braden score of 23, suggesting that she is at a very low risk for developing pressure sores.
HEENT (0.5 point): Head/Neck: Normocephalic Ears: Auricle and tragus without lesion or tenderness bilaterally. No visible drainage. Eyes: PERRLA present bilaterally. Nose: Symmetrical. No visible lesions. Teeth: Clean and present. Oral mucosa appears pink and moist without lesions.	Patient's head is normocephalic in size and shape for patient's body. Patient's ears are normal without drainage or discharge, lesions or tenderness on tragus or auricle bilaterally. PERRLA is present bilaterally with normal pink conjunctiva and white sclera. Nose is symmetrical without bleeding or polyps. Patient's teeth are clean with normal dentition. Oral mucosa appears pink and moist without lesions or sores.
CARDIOVASCULAR (1 points): Heart sounds: S1, S2, present.	Normal S1, S2 heart sounds present upon auscultation. No murmurs, gallops, or rubs

Cardiac rhythm (if applicable): Normal sinus rhythm. Peripheral Pulses: Radial, 3+; Pedal 3+ Capillary refill: <3 seconds bilaterally. Neck Vein Distention: Y ☐ N ☒ Edema Y ☒ N ☐ Location of Edema: Pedals bilaterally in lower extremities; +1 grade.	present. Patient's cardiac rhythm is normal sinus. Patient's peripheral pulses are present bilaterally in upper radial and lower pedal extremities, both graded as 3+. Patient's capillary refills within 3 seconds bilaterally in upper and lower extremities. Patient does not have visible neck vein distention. Patient does appear to have +1 grade edema in both feet bilaterally.
RESPIRATORY (1 points): Accessory muscle use: Y☐ N ☒ Breath Sounds: Location, character: Lungs are clear to auscultation bilaterally in all lung fields.	Patient's lungs are clear to auscultation bilaterally in all lung fields. No crackles, wheezes, rhonchi, or rales present. Patient appears to be breathing with ease and without the use of accessory muscles.
GASTROINTESTINAL (5 points): Diet at home: Normal diet without restrictions. Current Diet: Normal diet without restrictions. Height: 160 cm Weight: 70.1 kg Auscultation Bowel sounds: Yes. Present in all four quadrants (RLQ, RUQ, LUQ, LLQ). Last BM: 1000; 9/11/19 Palpation: Pain, Mass etc.: Inspection: Distention: Normal post-partum.	Patient states that both her diet at home and current one is a normal solid diet without restrictions. Patient measures 160 cm tall and weighs 70.1 kg. Normal post-partum distention of the abdomen noted upon inspection of patient's abdomen. No scars, drains, wounds, or incisions present. Bowel sounds are present and audible in all four quadrants; right upper/lower, left upper/lower. Patient states that she was able to have a bowel movement today, 9/11/19, at approximately 1000. Patient states that the

Incisions: No visible incisions. Scars: No visible scars. Drains: No visible drains. Wounds: No visible wounds. Fundal Height & Position: (-1) umbilicus, midline.	appearance of the stool was “lumpy” and brown in color. Patient states that light and deep palpation of the abdomen is not painful; no facial grimace or guarding present during assessment. Fundal height and position are midline at (-1) umbilicus.
GENITOURINARY (5 Points): Bleeding: Yes. Color: Yellow. Character: Hazy. Quantity of urine: 625 mL Pain with urination: Y ☐ N ☒ Inspection of genitals: N/A Catheter: Y ☐ N ☒ Type: N/A Size: N/A Rupture of Membranes: Yes Time: 0504 (date: 9/10/19) Color: Clear Amount: 400 mL Odor: N/A Episiotomy/lacerations: 1st degree laceration, superior on right labia minora.	Patient states that she is still experiencing vaginal bleeding that appears in the toilet with urine. Patient does not suspect the bleeding is coming from her urinary bladder because there are drops of blood and it is not “mixed in” with urine. Patient states that the color not mixed in with the urine is “yellow” and “hazy”. Patient is also recovering from a urinary tract infection, stating that it was previously yellow and cloudy. Patient’s urine output is approximated at 625 mL. Patient denies pain with urination. Patient denies presence of urinary catheter. Patient’s membrane ruptured at 0504 (9/10/19) and was approximately 400 mL, clear in color. Patient experienced a laceration during vaginal delivery of baby on the right superior of labia minora, rated as 1st degree.

MUSCULOSKELETAL (2 points): ADL Assistance: Y☐ N ☒ Fall Risk: Y ☐ N☒ Fall Score: Morse Fall Scale 15; Low risk. Activity/Mobility Status: Independent (up ad lib) ☒ Needs assistance with equipment ☐ Needs support to stand and walk☐	Patient does not require assistance with activities of daily living. Patient is up ad lib and is able to shower herself without equipment or support to stand and walk. She is not categorized as a fall risk. Patient's Morse fall scale rating is a 15, indicating low fall risk.
NEUROLOGICAL (1 points): MAEW: Y ☒ N☐ PERRLA: Y ☒ N☐ Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐ Orientation: Oriented to person, place, time, and situation. Mental Status: Patient appears alert and oriented, able to answer questions with ease. Patient denies experiencing depression. Speech: Speaks clearly, fluently, and logically. Sensory: Patient is able to detect sensation in upper and lower extremities bilaterally. LOC: Glasgow coma scale 15; normal. DTRs: 2+ in kneecaps bilaterally.	Patient is able to move all extremities well. PERRLA present upon assessment with penlight. Patient also has 5/5 musculoskeletal strength bilaterally in upper and lower extremities. Patient is oriented to person, place, time, and situation. Patient's mental status is unaltered and is able to answer questions with ease and denies depression. Speech is clear, fluent, logical and comprehensible. Patient's sensory level is intact in back of hands, fingertips, and feet bilaterally. Patient's level of consciousness using a Glasgow coma scale is 15; suggesting normal a level that is unaltered. Deep tendon reflexes tested in bilateral kneecaps are responsive, with a 2+ rating.

PSYCHOSOCIAL/CULTURAL (1 points): Coping method(s): Patient states that she enjoys getting on social media as a coping method. Developmental level: Patient's developmental level appears equal to developmental stage and age. Religion & what it means to pt.: Patient denies any religious affiliations and importance. Personal/Family Data (Think about home environment, family structure, and available family support): Patient states that she has a good family structure and full family support in arrival of new baby. Patient states that the father of the baby is also present and excited.	Patient states that "getting on social media" on her phone helps her to cope with difficult situations. Patient's developmental level appears equal to her developmental age and states that her highest level of education is high school. Patient denies any religious affiliations and importance. Patient states that she has a good support structure and is happy that both of her parents have been very supportive of her pregnancy. Patient's boyfriend/father of baby is present and has been excited to welcome baby into the world. Patient denies experiencing signs of depression such as feeling sad, losing interest activities, or self-esteem issues.
DELIVERY INFO: (1 point) (For Postpartum client) Delivery Date: 09/10/19 Time: 0540 Type (vaginal/cesarean): Vaginal, spontaneous. Quantitative Blood Loss: 500 mL	Patient's baby boy was delivered on 9/10/19 at 0540. Patient had a normal, spontaneous vaginal delivery at 40 weeks gestation with a quantitative blood loss of approximately 500 mL. Patient's baby boy tolerated the birth process well, and scored 8/9 on Apgar. Baby boy weighs 2,432

Male or Female: Male Apgar's: 8/9 Weight: 2,432 grams Feeding Method: Bottle, formula.	grams and is being formula fed through a bottle.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	64 bpm	124/75 mmHg	18 breaths/min	36.7˚ C	99% saturation
Labor/Delivery	160 bpm	135/84 mmHg	N/A	37.1˚ C	100% saturation
Postpartum	75 bpm	99/54 mmHg	17 breaths/min	36.4˚ C	100% saturation

Vital Sign Trends:

The vital sign trends displayed above show that most of the readings were within a normal range, except for the mother's pulse rate during labor/delivery. In the prenatal phase, it starts low at 64 beats per minute, then rises during to 160 bpm the labor/delivery stage, and drops back down within normal range of 75 beats per minute. Blood pressure trends show that the patient's prenatal value was slightly elevated above the normal of 120/80 mmHg. However, we can see that it rises as expected during labor/delivery to 135/84 mmHg but drops back to a level within reasonable limits of 99/54 mmHg. The patient's respiratory rate was not assessed during the labor/delivery period but remained within the range (18,17 breaths/min) from prenatal to postpartum without significant deviations. The patient's temperature shows a positive trend from the prenatal visit to time of

labor/delivery, but returns within normal limits in the postpartum stage. The peripheral capillary oxygen saturation for this patient trended upward from 99% saturation at the prenatal visit and remained the same at 100% saturation from labor/delivery to the postpartum stage.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	0-10 numerical pain scale.	Lower back	4	Dull, stabbing.	Patient refuses intervention at this time.
1100	0-10 numerical pain scale.	Lower back	6	Dull, stabbing.	Acetaminophen administered.

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: 09/09/19 Patency of IV: Patency verified with 10 mL of 0.9% normal saline flush at 0800. Signs of erythema, drainage, etc.: N/A IV dressing assessment: Clean, dry, and intact.	Patient currently has a 20-gauge IV placed on right hand dated 09/09/19. IV is patent and saline locked. Patency verified with 10 mL of 0.9% normal saline flush at 0800. No signs of erythema, redness, tenderness or drainage at IV site. IV dressing is clean without blood or other stains, dry, and intact.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
558 mL	625 mL

Interventions (12 points)

Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. Peri care

- I would teach the information by first explaining how to do it, then give the patient a pamphlet that outlines the steps discussed. I would then leave room for her to ask any questions, including anything that needs further clarification.
- The expected outcome would be that the new mom understands how to care for her peri area and can teach back the methods discussed.

2. Avoid stimulation to breasts

- I would teach the information by first explaining the importance on why stimulation to the breasts should be avoided since the patient is not breastfeeding. Next, I would go through the pamphlet with her that outlines activities to avoid until her milk dries up.
- The expected outcome would be that the new mom understands which activities to avoid and is able to teach back the activities to avoid prolonged milk production.

Nursing Interventions (6 points)

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

Nursing Interventions:

- Assess and document patient's pain level and intensity using the numerical 0-10 pain rating scale, with 0 being no pain and 10 being the worst possible pain.

- Rationale: Measuring pain enables the nurse to assess the amount of pain the patient is experiencing and establishes a baseline to test effective treatment methods.

- Administer pain medication as ordered, as needed.
  - Rationale: Improve the patient's comfort level by reducing pain.
- Reposition the patient.
  - Rationale: Nonpharmacological intervention to decrease pressure on pain receptors.
- Reassess and evaluate the patient's response to each pain reduction method used. Ask the patient which interventions worked best for them.
  - Rationale: Reassessing and reevaluating the patient's response to each method used helps to understand effective treatment methods.
- Educate patient about the prescription medications they will take at home, including how, when, and how much to take.
  - Rationale: Patient teaching regarding medications is vital since they will soon be discharged and need to know how, when, and how much to take.

Medical Treatments: Acetaminophen (Tylenol) 1,000 mg, PO (by mouth), every 4 hours as needed for pain.

Nursing Diagnosis (15 points)

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

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. Acute pain related to vaginal laceration,	This nursing diagnosis was chosen because the mother has	1.Administer analgesic medication as ordered as needed to promote comfort	• The client responded positively to the

epidural injection, and hemorrhoids as evidenced by pain ratings between 4-6, reports of “dull, stabbing” pain located in the lower back, and facial grimacing during position changes.	expressed increased pain levels during the assessment. Managing pain is helpful in aiding the recovery process of postpartum mothers (Swearingen, 2016).	(Ricci, Kyle, & Carman, 2017). 2. Suggest frequent use of Sitz bath to reduce hemorrhoid pain and to promote healing, hygiene, and comfort (Ricci, Kyle, & Carman, 2017).	nurse’s actions. • The client has reached a tolerable pain level. The outcome goal has been reached.
2. At risk for bleeding related to postpartum hemorrhaging and vaginal delivery as evidenced by filling underwear pad and toilet with bright red lochia, first-degree laceration on superior labia minora, and reports of “feeling constipated”.	This nursing diagnosis was chosen because the mother is still at risk for postpartum hemorrhaging for up to 12 weeks after discharge and should be educated to monitor for signs and symptoms of it.	1. Assess patients for signs and symptoms of increased bleeding and potential problems that may lead to increases in bleeding. (Swearingen, 2016). 2.Educate patients to prevent bleeding and recognize signs of bleeding that need to be reported immediately to a health care professional. (Swearingen, 2016).	• The client responded positively to the nurse’s actions. • The client understands preventative methods to decrease the risk of excessive bleeding, as well as the signs and symptoms to monitor for and report to health care providers immediately.

Other References (APA):

Ricci, S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Philadelphia: Wolters Kluwer.

Swearingen, P. L. (2016). *ALL-IN-ONE NURSING CARE PLANNING RESOURCE: Medical-surgical, pediatric, maternity, and ... psychiatric-mental health* (4th ed.). St. Louis, MO: Mosby.

N305 Care Plan Grading Rubric: Labor Student Name:

Demographics	3 points	1.5 points	0 points	Points
Demographics • Date of admission • Patient initials • Age • Gender • Race/Ethnicity • Occupation • Marital Status • Father of baby involvement • Allergies • Code Status • Height • Weight	Includes complete information regarding the patient. Each section is filled out appropriately with correct labeling.	Two or more of the key components are not filled in correctly.	5 or more of the key components are not filled in correctly and therefore no points were awarded for this section	
Medical History	**5 points**	**2.5 points**	**0 points**	**Points**
Prenatal History Past Medical History • All previous medical diagnosis should be listed Past Surgical History • All previous surgeries should be listed Family History • Considering paternal and maternal Social History • Smoking (packs per day, for how may year) • Alcohol (how much alcohol	Includes each section completed correctly with a detailed list of pertinent medical history, surgical history, family history and social history. If patient is unable to give a detailed history, look in the EMR	1 or more of the key components is missing detailed information.	More than two of the key components are not filled in correctly	

consumed and for how many years) • Drugs (how often and drug of choice) Living situation Education level • If applicable to learning barriers	and chart.			

Admission Assessment -Chief Complaint	2 points	1 point	0 points	Points
Chief complaint • Identifiable with a couple words of what the patient came in complaining of	Chief complaint is correctly identified.	Chief complaint not completely understood.	No chief complaint listed.	
Admission Assessment- History	**10 points**	**6-10 points**	**0-5 points**	**Points**
Presentation to Labor & Delivery • Information is identified in regards to why the patient came to the hospital • Utilization of OLD CARTS as appropriate • Written in a paragraph form with no less than 5 sentences • Information was not copied directly from the chart and no evidence of plagiarism • Information specifically stated by the patient using their own words is in quotations • Plagiarism will receive a 0	Every key component of the admission history is filled in correctly with information. It is written in a paragraph form, in the student's own words. There is no evidence of plagiarism identified. This is developed in a paragraph format with no less than 5 sentences.	Two or more of the key components are missing in the admission history. The admission history is lacking important information to help determine what has happened to the patient.	4 or more components are missing in the admission history. Paragraph is not well developed and it is difficult to understand what the patient is seeking care for. There is evidence of plagiarism noted in the HPI.	

Primary Diagnosis	2 points	1 point	0 points	Points
Primary Diagnosis • The main reason the patient was admitted Secondary Diagnosis • If the patient has more than one reason, they are being admitted	All key components are filled in correctly. The student was able to identify the correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.	One of the key components is missing or not understood correctly.	Student did not complete this section and there is concern for lack of understanding the diagnosis.	

Stage of Labor	20 points	14-10 points	9-5 points	4-0 points	Points
Stage of Labor • Professionally written essay in APA format outlined all aspects of the stage of labor the client is in during the student's care • information is well written and no less than 1 page • Signs/symptoms of the stage • Expected findings related to the stage such as vital signs and laboratory findings • How the stage of labor is identified • Typical nursing interventions and treatments for the stage of labor • Assessment findings that would suggest the client is progressing to another stage • Listed clinical data that correlates to this particular client	All key components were addressed and student had a good understanding of the expectations listed. Stage of labor was thorough with a direct correlation of how this related to the client and their stage of labor was performed.	One or two key components were missing such as signs and symptoms, expected findings, correlation and treatment. Student was able to describe the stage of labor.	Three or more components were missing throughout the paper. Unable to determine if the student had a good understanding of the stage of labor and the direct correlation to the client	Section is incomplete with several key factors missing. Student did not have a good understanding of the stage of labor and how it correlated to the client. Section was not in APA format with minimum of 2 references (0 points will be	

Laboratory Data	15 points	5-14 points	4-0 points	Points
Normal Values • Should be obtained from the chart when possible as labs vary some. If not possible use laboratory guide. • Normal values should be listed for all laboratory data. Laboratory Data • Admission Values • Most recent Values (the day you saw the patient) • Prenatal Values Rational for abnormal values • Written in complete sentences with APA citations • Explanation of the laboratory abnormality in this client • For example, elevated WBC in patient with pneumonia is on antibiotics. • Minimum of 1 APA reference, no reference will result in zero points for this section	All key components have been addressed and the student shows an understanding of the laboratory norms and abnormalities. Student had 1 reference listed and is able to correlate abnormal laboratory findings to the client's particular disease process.	1 or more of the client's labs were not reported completely with normal values or patient results. Lab correlation did not completely demonstrate student's understanding of correlation.	Student did not have an understanding of laboratory values and the abnormalities. More than 2 labs were excluded. Student did not discuss the abnormal findings in APA format with a minimum of 1 reference.	
Electronic Fetal Heart Monitoring	20 points	19-10 points	0-10 points	Points
Components of EFHM: • Baseline • Accelerations • Variability • Decelerations • Contractions: frequency, duration, intensity • Correlation of EFHM to the client's diagnosis and condition. • Interventions performed • Normal values/expected values are listed • Minimum of 1 APA reference, no reference will result in zero points for this section	All key components have been addressed and the student shows an understanding of the norms and abnormalities. Student had 1 reference listed and is able to correlate abnormal findings to the client's particular disease process.	One or more of the key components is missing, yet the student is able to demonstrate an understanding of the diagnostic testing and is able to correlate the abnormal findings to the disease process.	Student did not have an understanding of EFHM and the abnormalities. Student did not have an APA reference listed.	

Plagiarism results in a zero in this section
2 APA references, essay is written in correct APA format.
10 points 1-9 points 0 points

Current Medications				

Current Medications
• Requirements of 5 inpatient hospital medications and 2 home medications—these must be 7 DIFFERENT medications
• Each medication must have brand/generic name
• Dosage, frequency, route given, class of drug and the action of the drug
• Reason client taking
• 2 contraindications must be listed
  o Must be pertinent to your patient
• 2 side effects or adverse effects
• 2 nursing considerations
• Key nursing assessment(s)/lab(s) prior to administration
  o Example: Assessing client's HR prior to administering a beta-blocker
  o Example: Reviewing client's PLT count prior to administering a low-molecular weight heparin
• 2 client teaching needs
• Minimum of 1 APA citation, no citation will result in loss of all points in the section
	All key components were listed for each of the 7 medications, along with the most common side effects, contraindications and client teachings.
	
	Student had 1 APA citation listed.
		1 point will be lost for each medication with incomplete information.	There was noted lack of effort on the student's part to complete this section or there was no APA citation listed.	

Physical Assessment	20 points	1-18 points	0 points	Points
• Completion of a head to toe assessment done on the students own and not copied from the client's chart • Fall risk assessment • Braden skin assessment • No fall risk or Braden scale will result in a zero for the section	All key components are met including a complete head to toe assessment, fall risk and Braden score.	One or more of the key components is missing from a given section. Each body system is worth points as listed on care plan	More than half of the key components are missing. Therefore, it is presumed that the student does not have a good understanding of the head to toe assessment process.	
Vital Signs	5 points		2.5 points	0 points / Points
Vital signs • 3 sets of vital signs are recorded with the appropriate labels attached • Includes a prenatal set, labor/delivery set, and postpartum set • *If client has not delivered for a postpartum set, student is to list TWO vitals from labor and delivery* • Student highlighted the abnormal vital signs • Student wrote a summary of the vital sign trends	All the key components were met for this section (with 2 sets of vital signs) and student has a good understanding of abnormal vital signs.		Only one set of vital signs were completely recorded and one of the key components were missing.	Student did not complete this section /
Pain Assessment	2 points		1 point	0 points / Points
Pain assessment • Pain assessment was addressed and	All the key components were met (2 pain assessments) for this section and		One assessment is incomplete.	Student did not complete this /

recorded twice throughout the care of this client • It was recorded appropriately and stated what pain scale was used	student has a good understanding of the pain assessment.		section	

IV Assessment	2 points	1 point	0 points	Points
IV assessment • IV assessment performed and it is charted including what size of IV and location of the IV • Noted when the IV was placed • Noting any signs of erythema or drainage • Patency is verified and recorded • Fluid type and rate is recorded or Saline lock is noted. • IV dressing assessment is recorded (clean, dry and intact)	All of the key components were addressed. Student demonstrates an understanding of an IV assessment.	One of the key components is missing.	More than 1 aspect of the IV assessment is missing or student did not complete this section.	
Intake and Output	2 points	1-0 points		Points

Intake • Measured and recorded appropriately—what the patient takes IN • Includes: oral intake, IV fluid intake, etc. Output • Measured and recorded appropriately—what the client puts OUT • Includes: urine, stool, drains/tubes, emesis, etc.	All of the key components of the intake and output were addressed. Student demonstrates an understanding of intake and output.		One of the key components of the intake and output is missing. Difficult to determine if the student has a thorough understanding of the intake and output.	
Nursing Care/Interventions	12 points		2-0 points	Points
Nursing Interventions • List the nursing interventions utilized with your client • Includes a rationale as to why the intervention is carried out or should be carried out for the client Teaching topics • List 2 priority teaching items • Includes 1 expected outcome for each teaching topic	All the key components of the summary of care (2 points) and discharge summary (2 points) were addressed. Student demonstrated an understanding of the nursing care.		One or more of the key components of the nursing care was missing, therefore it was difficult to determine if the student had a thorough understanding of the nursing care.	
Nursing Diagnosis	15 points	5-14 points	4-0 points	Points

Nursing Diagnosis • List 2 nursing diagnosis o Include full nursing diagnosis with “related to” and “as evidenced by” components • Appropriate nursing diagnosis • Appropriate rationale for each diagnosis o Explain why the nursing diagnosis was chosen • Minimum of 2 interventions for each diagnosis • Rationale for each intervention is required • Correct priority of the nursing diagnosis • Appropriate evaluation	All key components were addressed. The student demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.	One or more of the nursing diagnosis/rational/intervention sections was incomplete or not appropriate to the patient Each section is worth 3 points. Prioritization was not appropriate.	More than 2 of the nursing diagnosis sections were incomplete or inappropriate. Prioritization is dangerously inappropriate.	
Overall APA format	5 Points	1-4 Points	0 Points	Points
APA Format • The student used appropriate APA in text citations and listed all appropriate references in APA format. • Professional writing style and -sections.	APA format was completed and appropriate. Grammar was professional and	APA format was used but not correct. Several grammar errors or overall poor writing Content was difficult to understand.	No APA formats. Grammar or writing style did not demonstrate collegiate level	

		Points
Instructor Comments:	Total points awarded	
Description of Expectations	/150= %	
Revised 8/18/2019	Must achieve 116 pt =77%	