N432 Care Plan 3

Lakeview College of Nursing

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N432 Care Plan and Grading Rubric

Instructions: The care plan is to be typed into a WORD document and submitted to the labor & Delivery or Postpartum Drobox within 72 hours after your clinical has ended. Be sure and compare your work with the attached rubric before submitting this to the dropbox. The care plan is worth 150 points. In order to pass you must achieve at least 116 points to acquire a pass. If you do not pass, you will have one opportunity to do a newborn care plan on a different patient. You must pass the care plan in order to pass your clinical and thus your course.

Demographics (3 points)

Date of Admission & Time of Admission **10/28/19**	**Patient Initials** **VB**	**Age** **36 years old**	**Gender** **Female**
Race/Ethnicity **Caucasian**	**Occupation** **Employed at the University of Illinois.**	**Marital Status** **Married**	**Allergies** **Penicillins**
Code Status **Full**	**Height** **5'6"**	**Weight** **77.1kg**	**Father of Baby involved** **Yes**

Medical History (5 Points)

Prenatal History: No abnormal PAPs or STD's.

Past Medical History: No medical history recorded.

Past Surgical History: No surgical history recorded.

Family History: No family history recorded.

Social History (tobacco/alcohol/drugs): Former smoker quit 10 years ago. Never has used smokeless tobacco. No illicit drug use. Denies alcohol use. She is sexually active.

Living Situation: Lives with husband and their 2 other children.

Education Level: Bachelor's degree. Patient works at the University of Illinois.

Admission Assessment (12 points)

Chief Complaint (2 points): Spontaneous contractions

Presentation to Labor & Delivery (10 points):.Patient called stating she is in labor. She is scheduled for IOL tomorrow at OSF. Pt reports painful tightening in her abdomen for several hours now, and states the contractions are about 10 minutes apart, lasting 1-2 minutes. Pt states she is also having a lot of cramping, mostly happening right before the painful tightening begins. She denies fluid leakage but states she's been spotting since her appointment last Thursday when her cervix was checked. Patient reports feeling some fetal movement today, but not much. Patient was moved to the labor and delivery unit.

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points):. Spontaneous contractions

Secondary Diagnosis (if applicable):. N/A

Stage of Labor (20 points):

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

The first stage of labor consists of the entirety of the onset of contractions up until the effacement and dilation of the fetus. This is the longest stage of labor. The laboring mom began in the active phase when beginning the clinical day, then went into the transition phase, and moved into the second stage of labor with the cervix entirely dilated resulting in the birth of the fetus. A way to identify each stage is through cervical dilation and contraction times and intensity. According to Henry (2016) the active phase has moderate to more severe contractions with a frequency of 3-5 minutes and a duration of 40 to 70 seconds. The transition phase has contractions that increase in intensity that are very strong with a frequency of 2-3 minutes and duration of 45-90 seconds according to Henry (2016). Second stage of labor has full dilation according to Henry (2016) with contractions every 1-2 minutes. The contractions can be an important indicator for how much the mother is in pain. The contractions, frequency, and duration are significant signs and symptoms for each stage. Other signs and symptoms could be the rupture of membranes, mild to severe pain upon palpation of contractions, and depending on the stage the active phase the mother will be more restless but, excited, and as transition occurs the mother begins to become increasingly uncomfortable with the urge to defecate. The second stage is full of joy once the fetus has arrived but, can be the most intense aspect of labor with pushing.

The blood pressure, respirations, and pulse measurements for active phase is every 30 minute checks, and transition is every 15-30 minutes. The vital signs will increase as the stages progress. Once the fetus has arrived the mother's vital signs begin to decrease since the adrenaline wears off. Some expected findings related to my patient is a decrease in hemoglobin, hematocrit, and lymphocytes. According to American Pregnancy Association (2019) hemoglobin can be decreased in pregnancy in non-anemic patients but, anemia can develop with pregnancy due to the increased need for blood for nutrients for the infant. Hemoglobin can also be decreased due to iron-deficiency anemia which can develop during the pregnancy as well according to Web MD (2019). Leukocytes can be decreased due to a normal body response to a foreign antigen, which in this case is an embryo. According to Nair (2018) the embryo needs room to develop which in this case needs to suppress the mother's immune system in order to make room for

the embryo to develop into a fetus. Labs that can be normally drawn is a hemo panel, urinalysis, RH factor, blood type, group beta streptococcus test, and glucose drawn.

The assessment can include cervical dilation checks to be able to see if the patient is progressing, monitoring for effacement, assess the client to see if she is in true labor and to see if the membranes have ruptured as well as documenting the color and amount of amniotic fluid, monitor fetal heart rate, palpate the bladder regularly, and assess the client's temperature every 4 hours according to Henry (2019). The active phase interventions are promoting rest and relaxation through measure of comfort such as raising the head of the bed, frequent rotation of positions, encouraging deep breathing, and providing non-pharmacological measures of pain relief which can also be the treatment. Once the cervix has dilated to about 8cm the client moves into the transition phase where the mom begins to feel more uncomfortable. According to Henry (2019) the care during this phase includes encouraging voiding every 2 hours, make sure the client is not pushing before the necessary time, keeping the client as comfortable as possible, and observe for crowning. Once the presenting part is apparent and the cervix is fully dilated and effaced the mother is ready to begin pushing into the second phase of labor, birth. The treatment of the first stages of labor are usually with an epidural, fentanyl which is the pain relief my client used, and non-pharmacological techniques. The second stage of labor's treatment is usually a higher dose pain medication such as fentanyl, hydrocodone, or morphine. The nursing interventions according to Henry (2019) during the second stage is checking vitals every 5 to 30 minutes according to hospital protocol, assessing for uterine contractions for extraction of the placenta, determine the degree of the pushing efforts made by the client which could have resulted in a laceration, and checking the fetal heart rate with vitals every 15 minutes after birth.

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

American Pregnancy Association. (2019). Pregnancy Concerns. In *Anemia During Pregnancy*. Retrieved from https://americanpregnancy.org/pregnancy-concerns/anemia-during-pregnancy/

Henry, N. et.al. (2016). *RN Maternal Newborn Nursing* (10.0th ed., pp. 93-94). N.p.: ATI Nursing.

Nair, A. (2018). Low Lymphocytes during Pregnancy – Should You Be Worried?. In *first cry parenting*. Retrieved from https://parenting.firstcry.com/articles/low-lymphocytes-during-pregnancy-should-you-be-worried/

Web MD. (2019). Anemia in Pregnancy. In *Web MD*. Retrieved from https://www.webmd.com/baby/guide/anemia-in-pregnancy#1

Laboratory Data (15 points)

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

- **No admission values were drawn**

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value

RBC	**3.80-5.30**	**3.92**	**N/A**	**3.67**	**The decrease in RBC during labor is from potential anemia. According to American Pregnancy Association (2019) this happens because of the increased amount of blood produced to provide essential nutrients for the baby.**
Hgb	**12-15.8**	**12.5**	**N/A**	**12.1**	
Hct	**36-47**	**36.1**	**N/A**	**35.5**	**If the patient was not originally anemic before pregnancy, it is extremely common to develop anemia during the pregnancy. According to Web MD (2019) iron-deficiency anemia is the most common cause of the recent decrease of hematocrit. This level is very close to the normal range as well which could be a normal finding.**
Platelets	**140-440**	**167**	**N/A**	**186**	
WBC	**4-12**	**10**	**n/A**	**9.00**	
Neutrophils	**47-73**	**70**	**N/A**	**72**	
Lymphocytes	**18-42**	**14**	**N/A**	**13.0**	**According to Nair (2018) the immune system suppresses itself in response to the embryo. When the immune system decreases it allows for the embryo to grow properly and become a fetus.**
Monocytes	**4-12**	**6.8**	**N/A**	**6.6**	
Eosinophils	**0-5**	**0**	**N/A**	**0**	
Bands	**0-1%**	**0**	**N/A**	**0**	

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, B, AB, O**	**O**	**O**	**O**	

Rh factor	**Positive**	**Positive**	**Positive**	**Positive**	
Serology (RPR/VDRL)	**Non-reactive**	**Non-reactive**	**Non-reactive**	**Non-reactive**	
Rubella Titer	**Immune**	**Immune**	**Immune**	**Immune**	
Hct & Hgb	**N/A**	**N/A**	**N/A**	**N/A**	
HIV	**Negative**	**Negative**	**Negative**	**negative**	
HbSAG	**N/A**	**N/A**	**N/A**	**N/A**	
Group Beta Strep Swab	**Negative**	**Positive**	**Positive**	**Positive**	**Normal flora changes. This is a normal occurrence for a mom that can be treated with antibiotics before delivery.**
Glucose at 28 weeks	**70-99**	**N/A**	**N/A**	**N/A**	
Genetic testing: if done	**N/A**	**Not done**	**Not done**	**Not done**	

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

N/A, no Urinalysis collected.

Lab Test	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal
Color & Clarity					
pH					
Specific Gravity					
Glucose					
Protein					
Ketones					
WBC					

RBC					
Leukoesterase					

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**	

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

Lab Correlations Reference (APA): American Pregnancy Association. (2019). Pregnancy Concerns. In *Anemia During Pregnancy*. Retrieved from https://americanpregnancy.org/pregnancy-concerns/anemia-during-pregnancy/

Nair, A. (2018). Low Lymphocytes during Pregnancy – Should You Be Worried?. In *first cry parenting*. Retrieved from https://parenting.firstcry.com/articles/low-lymphocytes-during-pregnancy-should-you-be-worried/

Web MD. (2019). Anemia in Pregnancy. In *Web MD*. Retrieved from https://www.webmd.com/baby/guide/anemia-in-pregnancy#1

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	**135. Normal Range**

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?**	**Accelerations lasting at least 15 seconds; greater than/ equal to 15bpm. This signifies fetal movement with contractions that is normal.** **Moderate variability** **Reference: Ricci, S., Kyle, T. and Carmen, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Philadelphia: Lippincott, Williams & Wilkins. SBN: 978-1-60913-747-2.**
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?**	**No decelerations present.** **No interventions to be performed at this time.**
Describe the contractions i.e. frequency, length, strength, patient's response.	**Method: TOCO; palpation. Contractions last 2-4 minutes, contraction duration is 60-90 seconds. Contractions are moderate by palpation. Uterine resting tone is soft by palpation. Patient is tolerating the contractions well with the epidural and changing positions frequently. Patient verbalized she is relaxed with interventions.**

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

7 different medications must be completed

Home Medications (2 required)

Brand/Generic	**Calcium carbonate (TUMS)**	**ondansetron (ZOFRAN)**			
Dose	**1,000mg**	**4mg**			
Frequency	**Every 8 hours PRN**	**Every 6 hoursPRN**			
Route	**Oral**	**Oral**			
Classification	**Antacid**	**Antiemetics**			

Mechanism of Action	**Replacement of calcium in deficiency states. Control of hyperphosphatemia in end-stage renal disease without promoting aluminum absorption. Essential for nervous, muscular, skeletal problems, maintain cell membrane and capillary permeability.**	**Blocks the effects of serotonin at 5-HT3 receptor sites (selective antagonist) located in vagal nerve terminals and the chemoreceptor trigger zone in the CNS.**			
Reason Client Taking	**Heartburn/ indigestion**	**Nausea**			
Contraindications (2)	**Hypercalcemia, renal calculi, and V-fib.**	**Hypersensitivity, and Congenital long QT syndrome.**			
Side Effects/Adverse Reactions (2)	**Constipation, and arrhythmias.**	**Serotonin syndrome, and torsade de pointes**			
Nursing Considerations (2)	**Observe patient closely for symptoms of hypocalcemia notify physician if these symptoms**	**Monitor ECG, Monitor signs and symptoms of serotonin syndrome and assess for rash.**			

	occur. Monitor patient on digitalis glycosides for signs of toxicity.				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor serum calcium, chloride, sodium, potassium, magnesium, albumin, and PTH.**	**Monitor serum bilirubin, AST, and ALT levels.**			
Client Teaching needs (2)	**Instruct patients not to take-enteric coated tablets within 1hr of calcium carbonate; this will result in premature dissolution. Do not administer concurrently with foods containing large amounts of oxalic acid.**	**Instruct patient to take as directed. Advise patient to notify of signs and symptoms of rash occur, or serotonin syndrome occur, as well as irregular heart beats.**			

Hospital Medications (5 required)

Brand/Generic	**carboprost (Hemabate) injection**	**ePHEDrine syringe**	**clindamycin in D5W (Cleocin)**	**oxytocin (Pitocin)**	**fentanyl (Sublimaze)**
Dose	**250mcg**	**10mg**	**900mg**	**30units/500m**	**50mcg**

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Frequency	**Every 15 minutes PRN**	**Every 5 minutes PRN**	**Every 6 hours**	**Continuous**	**Every 2 hours PRN**
Route	**Intramuscular**	**Intravenous**	**Intravenous**	**Intravenous**	**Subcutaneous**
Classification	**Oxytocic**	**Vasopressors**	**Anti Acne agents, lincosamides**	**Oxytocic**	**Opioid analgesics**
Mechanism of Action	**Causes uterine contractions by directly stimulating the myometrium.**	**Stimulates a1, b1, and b2 receptors leading to vasoconstriction and an increased cardiac output, both of which contribute to an increased blood pressure.**	**Interferes with bacterial protein synthesis, active propionibacterium acnes.**	**Stimulates uterine smooth muscle, producing uterine contractions similar to those in spontaneous labor. Has vasopressin and antidiuretic effects.**	**Binds to opiate receptors in the CNS, altering the response to and perception of pain. Produces CNS depression.**
Reason Client Taking	**Bleeding**	**Severe hypotension**	**Positive GBS**	**Induce labor**	**Pain**
Contraindications (2)	**Hypersensitivity, acute pelvic inflammatory disease, and active pulmonary, renal, or hepatic disease.**	**None.**	**Exposure to sunlight, ultraviolet lights, sunlamps and weather extremes, and sunburn. Regional enteritis, ulcerative colitis or history of antibiotic-associated**	**Hypersensitivity and anticipated nonvaginal delivery.**	**Hypersensitivity, and known intolerance.**

			colitis.		
Side Effects/Adverse Reactions (2)	**Uterine rupture, and anaphylaxis**	**Dizziness, restlessness, bradycardia and nausea**	**Colitis, photosensitivity, and burning.**	**Coma, seizures, intracranial hemorrhage and asphyxia.**	**Apnea and laryngospasm.**
Nursing Considerations (2)	**Monitor for signs and symptoms of anaphylaxis, and assess for nausea, vomiting, or diarrhea.**	**Monitor BP continuously during administration, and monitor for signs of bradycardia monitor HR.**	**Assess skin lesions periodically during therapy. And assess for rash.**	**Fetal maturity, presentation, and pelvic adequacy should be assessed prior to administration of oxytocin for induction of labor, and monitor BP and pulse.**	**Monitor respiratory rate and BP frequently throughout therapy. The respiratory depressant effects of fentanyl may last longer than the analgesic effects.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor CBC for electrolytes.**	**None.**	**None.**	**Monitor electrolytes.**	**Monitor serum amylase and lipase.**
Client Teaching needs (2)	**Explain purpose of vaginal examinations, and instruct patient to notify health care professional immediately if fever, chills, foul smelling vaginal discharge or lower**	**Advise patient to notify health care professional if pregnant or breastfeeding before surgery, and monitor for signs of dehydration.**	**Instruct patient on correct procedure for application. Use no more than a pea size amount. Advise patient to use sunscreen daily.**	**Advise patient to expect contractions similar to menstrual cramps after administration has started. Monitor for dehydration.**	**Discuss the use of anesthetic agents and the sensations to expect with the patient before surgery, explain pain assessment scale to patient,**

	abdominal pain and increased bleeding occurs.				**and medication causes dizziness and drowsiness.**

Medications Reference (APA): (2 points): Davis, F. (2019). Up-to-Date Drug Information. In *Davis's Drug Guide Online*. Retrieved from https://www.drugguide.com/ddo/

Assessment (20 points)

Physical Exam (20 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The patient was alert, orientated, with no apparent signs of distress. The overall appearance was calm, relaxed and excited for the upcoming event of her baby being born.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score: 23** **Drains present: Y☐ N☐** **Type:**	**The patient's skin was warm, pink, and dry. No apparent signs of rashes, bruises, wounds, or incisions, The temperature was normal of 98.1 with rapid turgor representing the patient is hydrated. The braden score was 23. No drains were present.**

HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is normocephalic. Neck is supple. No acute deformities. No present signs of discharge from the ears or the eyes. PERRLA noted. Nose is midline with no deviation or drainage. Good dentition.**
CARDIOVASCULAR (1 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐ Edema Y ☐ N ☐** **Location of Edema:**	**S1 and S2 heard upon auscultation. No presence of S3, S4, or signs of a murmur. Cardiac rate and rhythm was regular. Strong peripheral pulses. Normal capillary refill within 3 seconds. No JVD or edema noted.**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**No adventitious sounds heard upon auscultation. Normal rate and pattern noted. No signs of crackles, wheezes or rhonchi. No use of accessory muscles.**
GASTROINTESTINAL (5 points): **Diet at home: Normal diet** **Current Diet: Clear liquids** **Height: 5'6"** **Weight: 170lbs** **Auscultation Bowel sounds: Hyperactive bowels** **Last BM: 10/28**	**Clear liquid diet has been implemented due to anticipation of labor. The patient is 5'6", weighing 170lbs. Hyperactive bowel sounds noted with last BM on 10/28. No presence of pain or a mass noted upon palpation. No distention indicated upon inspection nor incisions, scars, drains, or wounds. The fundal height cannot be recorded due to impending labor. This can only be seen after labor.**

Palpation: Pain, Mass etc.: **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Fundal Height & Position: N/A Pt in labor.**	
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine: 100mL** **Pain with urination: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type: indwelling single lumen catheter latex** **Size:16** **Rupture of Membranes: N/A the mom had not had her membranes ruptured during the clinical day.** **Time:** **Color:** **Amount:** **Odor:** **Episiotomy/lacerations:**	**Voids spontaneously without difficulty through an indwelling catheter, size 16. No bleeding noted within the urine. Color is straw-like yellow, with no stones, or pain noted. Quantity of urine is 100mL. The rupture of membranes had not taken place during the clinical experience.**
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☐**	**Extremities are strong bilaterally with no indication of a fall risk resulting in a score of 0. ROM are intact. No ADL assistance needed. Patient is up and lib, independent. No acute**

Fall Risk: Y ☐ N☐ **Fall Score: 0** **Activity/Mobility Status: up and lib** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**deformities.**
NEUROLOGICAL (1 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **DTRs:**	**MAEW and PERLA noted. Strength is equal bilaterally. Patient is alert and oriented to time, place, and location. The patient has a stable mental status. Patient expresses excitement for her baby to arrive. Speech is clear. Sensory and LOC is intact. No decrease in LOC. DTR's noted 2+.**
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):**	**The patient expressed excitement from the impending delivery. She has a good supportive family. She lives with her family including her kids and husband. The patient had an appropriate developmental level and high educational level. The patient is Christian which is very important for her way of coping. She copes well with her faith and family as her major core coping methods.**
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date:** **Time:**	**N/A the mom did not deliver during the clinical day.**

N432 Care Plan and Grading Rubric

Type (vaginal/cesarean): **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**80**	**110/70**	**16**	**98.0**	**96**
Labor/Delivery	**83**	**117/75**	**18**	**98.1**	**94**
Postpartum	**Patient has not delivered**				

Vital Sign Trends: The vitals remained stable throughout the clinical day in comparison to the prenatal set of vitals. The BP is being watched due to potential hypotension. There was no significant change.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1022	**6.5/10**	**Abdomen**	**Slightly untolerable**	**Cramping**	**Epidural**
1500	**4/10**	**Abdomen**	**Tolerable**	**Cramping**	**Turn on opposite side**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV: Metacarpal vein on top of the left hand** **Date on IV: 10/28/2019** **Patency of IV: Flushes without difficulty** **Signs of erythema, drainage, etc.: No signs of erythema or drainage.** **IV dressing assessment: Dry and intact.**	Lactated Ringers 125 mL/hr Intravenous Continuous

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
0mL	**100mL urine output**

Interventions (12 points)

Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. **Medications are an essential component of labor and delivery. The teaching component discussed concerns the use of oxytocic medications such as pitocin in which the patient has been administered. The choice of teaching about this medication helps to alleviate some stress with knowing what the mother is taking as well as what it is doing for the process of labor. Explaining to the mother through a discussion, question and answer form is key for teaching methods. The medication is used to induce labor which is essential for stage one of labor. The mother expressed interest in the medication and asked how long for this medication to work. The expected outcome was for the mother to know the medication of pitocin, what it is used for, and have all of her questions answered to alleviate stress and promote feelings of relaxation and know this medication can also be used after labor. This will not be included in discharge medications.**

2. **Breathing techniques are critical for the mother in order to cope with contractions as well as labor and delivery of the infant. Breathing techniques can range from using pursed lip breathing, taking deep breaths, and using distraction techniques to reduce pain. These methods are demonstrated through action where the client follows the steps and imitates the nurse's actions. The expected outcome is reduction of pain through proper breathing and distraction techniques. These can be used after discharge when feeling stressed but, no further discharge information is needed per teaching method.**

Nursing Interventions (6 points)

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

Nursing Interventions: Nursing interventions to relieve pain would be using therapeutic techniques as well as non-pharmacological interventions. Some of these interventions include heat/cold compresses, massage, breathing techniques, ambulation, praying with the client if this is apart of their religion and culture, using music therapy, guided imagery or decreasing stimulation to promote comfort and relaxation. These interventions were used in order to promote relaxation and comfort since the mom was in active labor in which she asked for other forms of pain relief measures. Once discharged from the hospital the mom can use some of these techniques to control pain management.

Medical Treatments: Fentanyl was ordered in reduction of pain, and scheduled a follow up appointment 10 days after the delivery of the infant to make sure the mom is comfortable and recovering well with controlled pain management.

<u>Nursing Diagnosis (15 points)</u>

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
● Include full nursing	● Explain why		● How did the

diagnosis with "related to" and "as evidenced by" components	the nursing diagnosis was chosen	Include a short rationale as to why you chose this intervention & cite the reference appropriately	client/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to emotional and muscular tension as evidenced by distraction behavior of feelings of restlessness	**The client exhibited feelings of restlessness as the labor progressed. She was mainly excited for the baby to arrive but, switched positions frequently and tried to use alternative pain management techniques**	**1. Monitor frequency, duration, and intensity of uterine contractions. Rational: Detects progress of labor as well as checks to see if there is an abnormal uterine response.** **2. Assist the client with comfort measures such as massage, hot/cold compresses, sponge bath, or changing positions. Rational: these non-pharmacological pain relief measures can alleviate pain and stress and promote relaxation and comfort.** **Reference for both interventions: Martin, P. (2017). 36 Labor Stages, Induced and Augmented Labor Nursing Care Plans. In *Nurse Labs*. Retrieved from https://nurseslabs.com/labor-stages-labor-induced-nursing-care-plan/3/#c2**	**The goal was to alleviate pain/ control or manage it with non-pharmacological techniques. Monitoring the contactions helped the patient feel more at ease with knowing what was happening with the progress of labor. The patient also encouraged the comfort measures in alleviating pain and aiding with distraction. The patient's goal was to promote comfort during labor as much as we could. Her response as well as the husband was positive and the outcome was that these measures helped with aiding in decreasing pain. A modification to this plan would be to add in some other forms of non-pharmacological measures such as talking more with the patient.**
2. Fatigue related to discomfort/pain	**The patient was in pain due to impending labor**	**1. Encourage the patient to close their eyes, and extend**	**The goal is to conserve as much energy as possible in between contractions. The**

as evidence by verbalization of feeling fatigued due to stress and pain	**which had caused the patient to become increasingly fatigued/ lethargic.**	**their legs to relax in between contractions. Rational: This helps with promoting muscle relaxation.** **2. Assess the degree of fatigue. Rational: If the mother is too fatigued it may interfere with aiding in self-care postpartum as well as care of the infant.** **Reference for both interventions: Martin, P. (2017). 36 Labor Stages, Induced and Augmented Labor Nursing Care Plans. In *Nurse Labs*. Retrieved from https://nurseslabs.com/labor-stages-labor-induced-nursing-care-plan/3/#c2**	**outcome was the patient was more relaxed as well as conserved more energy to be less fatigued through promotion of rest periods. The mother expressed that closing her eyes and relaxing with dimly lit rooms aided in relaxation and admired the intervention. The patient expressed she is not extremely fatigued only minimally and will be able to participate in all forms of labor, and self-care postpartum as well as the care of the infant. No modifications to the plan.**

Other References (APA): Martin, P. (2017). 36 Labor Stages, Induced and Augmented Labor Nursing Care Plans. In *Nurse Labs*.

Retrieved from https://nurseslabs.com/labor-stages-labor-induced-nursing-care-plan/3/#c2

N305 Care Plan Grading Rubric: Labor Student Name:

Demographics	3 points	1.5 points	0 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**	
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 consumed and for how many years) ● Drugs (how often and drug of choice) **Living situation** **Education level** ● If applicable to learning barriers	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 and chart.	1 or more of the key components is missing detailed information.	More than two of the key components are not filled in correctly	

Admission Assessment -Chief Complaint	2 points	1 point	0 points	Po
Chief complaint ● Identifiable with a couple words of what the patient came in	Chief complaint is correctly identified.	Chief complaint not completely understood.	No chief complaint listed.	

complaining of				
Admission Assessment- History	**10 points**	**6-10 points**	**0-5 points**	**Po**
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 points**	**0 points**	**Po**
Primary Diagnosis ● The main reason the patient was	All key components are filled in correctly. The student was able to	One of the key components is missing or not understood	Student did not complete this section and there is concern for lack of	

admitted **Secondary Diagnosis** ● If the patient has more than one reason they are being admitted	identify the correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.	correctly.	understanding the diagnosis.	

Stage of Labor	20 points	14-10 points	9-5 points	4-0 p
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 ● Plagiarism results in a zero in this section ● 2 APA references, essay is written in correct APA format.	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	Sect incompl sever factors Student have a unders of the s labor an correlat cli Section in APA with m of 2 ref (0 point giv

Laboratory Data	15 points	5-14 points	4-0 points	
Normal Values ● Should be obtained from the chart when	All key components have been addressed and the student shows an understanding of	1 or more of the client's labs were not reported completely with normal values or	Student did not have an understanding of laboratory values and the abnormalities.	

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	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.	patient results. Lab correlation did not completely demonstrate student's understanding of correlation.	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**	
Components of EFHM: ● Baseline ● Accelerations ● Variability ● Decelerations ● Contractions: frequency, duration, intensity ● Correlation of	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	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	Student did not have an understanding of EFHM and the abnormalities. Student did not have an APA reference listed.	

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	the client's particular disease process.	the disease process.		
Current Medications	**10 points**	**1-9 points**	**0 points**	
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	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.	

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				
Physical Assessment	**20 points**	**1-18 points**	**0 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
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.	Stude comp s
Pain Assessment	**2 points**	**1 point**	**0**
Pain assessment ● Pain assessment was addressed and recorded twice throughout the care of this client ● It was recorded appropriately and stated what pain scale was used	All the key components were met (2 pain assessments) for this section and student has a good understanding of the pain assessment.	One assessment is incomplete.	Stude comp s

IV Assessment	2 points	1 point	0 poin
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 th 1 aspe of the assessm t is missing studer did no comple this sectio

Intake and Output	**2 points**	**1-0 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 the intake and output is missing. Difficult to determi if the student has a thorou understanding of the intak and output.	
Nursing Care/Interventions	**12 points**	**2-0 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 nursin care was missing, therefore was difficult to determine the student had a thoroug understanding of the nursi care.	
Nursing Diagnosis	**15 points**	**5-14 points**	**4-0 points**
Nursing Diagnosis ● List 2 nursing diagnosis o Include full nursing diagnosis with "related to" and "as evidence d by"	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/inter vention 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.

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				
Overall APA format	**5 Points**	**1-4 Points**	**0 Points**	
APA Format ● The student used appropriate APA in text citations and listed all appropriate references in APA format. ● Professional writing style and grammar was used in all narrative sections.	APA format was completed and appropriate. Grammar was professional and without errors	APA format was used but not correct. Several grammar errors or overall poor writing style was used. Content was difficult to understand.	No APA format. Grammar or writing style did not demonstrate collegiate level writing.	
			Points	
- Instructor Comments:	**Total points awarded**			
Description of Expectations	**/ 150=**			

	%	
Must achieve 116 pt =77%		