

N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 1/21/2020	Patient Initials A,M,O	Age 40	Gender female
Race/Ethnicity African American	Occupation Nurse	Marital Status Married	Allergies Ibuprofen
Code Status Full code	Height 5 ft 2 inches (157.5 cm)	Weight 186 lbs (84.4 kg)	Father of Baby Involved Yes

Medical History (5 Points)

Prenatal History: G2 P0, has fibroids currently, patient is a Jehovah's witness and does not accept blood products.

Past Medical History: Leiomyoma.

Past Surgical History: Appendectomy, exploratory surgery of the abdomen.

Family History: None on file.

Social History (tobacco/alcohol/drugs): Tobacco: denies use. Alcohol: denies use. Drugs: denies use.

Living Situation: Lives at home with husband.

Education Level: College.

Admission Assessment

Chief Complaint (2 points): Pregnancy/ delivery

Presentation to Labor & Delivery (10 points): Patient is a 40 year old female that presented to the labor and delivery floor with her husband. Patient ambulated into the hospital and was drove by her husband. Patient arrived to the floor for induction of labor for AMA. Patient currently has fibroids and is 39 weeks pregnant. Patients due date is 1/21/2020. Patient is currently taking prenatal vitamins and aspirin 81 mg at home. Patients past medical history includes leiomyomas.

Patient does not have any notable family history. Patients contractions are occurring every 3-5 minutes and are lasting 40-60 seconds. Patients cervix was dilated 0.5 cm upon admission but after administering cytotec and cervidil she is now dilated 1 cm. Patient is a Jehovah's witness and does not accept blood products. Patient has informed her nurse that she would like a C-section instead of a natural birth. The nursing midwife informed the nurse that if she has not dilated more in 24 hours they will most likely go through with the C-section.

Diagnosis

Primary Diagnosis on Admission (2 points): Induction of labor

Secondary Diagnosis (if applicable): Delivery of infant

Stage of Labor

Stage of Labor Write Up, APA format (20 points) This should include the progression of cervical effacement & dilation as well as pain management techniques:

The four stages of labor consist of dilation, expulsive, placental, and restorative (Ricci, 2017). The first stage of labor is the longest stage, it begins with the first true contraction and ends with full dilation of the cervix. Stage two of labor begins when the cervix is fully dilated and ends with the birth of the newborn. This stage can last from minutes to hours. During this stage, contractions typically occur every 2-3 minutes and last 60-90 seconds and are strong by palpation. The third stage starts after the newborn is born and ends with the separation and birth of the placenta. The placenta is usually expelled in 5-30 minutes after the newborn is born. If the newborn is stable touching, holding, and skin-to-skin contact occur during this stage to help bond the mother and newborn (Ricci, 2017). The fourth stage lasts from 1-4 hours after birth. During this period the mothers body begins to stabilize.

Cervical effacement and dilation progress during the stages of labor. During the first stage of labor in the latent phase cervical effacement occurs and the cervix dilates from 0 to 3

cm. During this stage, contractions usually occur every 5-10 minutes and last 30-45 seconds and is mild by palpation (Ricci, 2017). Cervical effacement is 0% to 40% during this stage. During the active phase the cervix dilates from 4 to 7 cm with 40% to 80% effacement. During the transition phase dilation progresses from 8 cm to 10 cm with effacement of 80% to 100% (Ricci, 2017). The second stage of labor begins when the cervix is completely dilated at 10 cm and is at 100% effacement.

“Pain during labor is a universal experience, although the intensity of the pain may vary” (Ricci, p. 498, 2017). The techniques used to manage the pain of labor vary according to every woman. Nonpharmacologic measures can be taken to help manage the patients pain. Some examples of this include continuous labor support, hydrotherapy, hypnosis, ambulation, maternal position changes, TENS, acupuncture, guided imagery, therapeutic touch, massaging, and breathing techniques (Ricci, 2017). Nurses try to use nonpharmacologic measures before moving to pharmacologic interventions. Nonpharmacological measures are simple, safe, and inexpensive to use. If nonpharmacological measures do not work pharmacological interventions can be taken. This includes systemic analgesia and regional or local anesthesia.

My client was in the early labor of the first stage while I was there. My patient’s contractions were 4-6 minutes apart lasting 90 seconds. She was 20% effaced and dilated at 1 cm. Her contraction intensity was mild by palpation. Her cervical characteristics were mid-position and presented as vertex.

Stage of Labor References (2) (APA):

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

Laboratory Data (15 points)

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

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.28-5.56	NA	4.5	4.5	NA
Hgb	12-17	NA	12.2	12.2	NA
Hct	33.2-45.3	NA	37.7	37.7	NA
Platelets	150-400	NA	166	166	NA
WBC	4.5-11	NA	6.0	6.0	NA
Neutrophils	45.3-79 %	NA	65.1	65.1	NA
Lymphocytes	11.8-45.9%	NA	25.3	25.3	NA
Monocytes	4.4-12 %	NA	8.7	8.7	NA
Eosinophils	0-7	NA	0.7	0.7	NA
Bands	<10%	NA	0.2	0.2	NA

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	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	A,B, AB, O	O+	O+	O+	NA
Rh Factor	+/-	positive	positive	positive	NA
Serology (RPR/VDRL)	Non reactive	Non reactive	NA	NA	NA
Rubella Titer	Immune	Immune	immune	Immune	NA
HIV	Non detected	Non detected	Non detected	Non detected	NA
HbSAG	Non detected	Non detected	Non detected	Non detected	NA
Group Beta Strep Swab	Negative	Positive 1/8/20	NA	NA	Potential for newborn infection exists.
Glucose at 28	70-110	NA	NA	NA	NA

Weeks					
MSAFP (If Applicable)	NA	NA	NA	NA	NA

Additional Admission labs **Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.**

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

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

Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Explanation of Findings
Urine protein/creatinine ratio (if applicable)	NA	NA	NA	NA	NA

Lab Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). Davis’s Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications (7 th ed.). Philadelphia, PA: F.A. Davis Company

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	150 bpm
Are there accelerations? <ul style="list-style-type: none"> • If so, describe them and explain what these mean (for example: how high do they go and how long do they last?) 	Negative for accelerations Moderate variability
What is the variability? Are there decelerations? If so, describe them and explain the following: What do these mean? <ul style="list-style-type: none"> o Did the nurse perform any interventions with these? o Did these interventions benefit the patient or fetus? 	No decelerations.
Describe the contractions:	

<p>Frequency: Length: Strength: Patient's Response:</p>	<p>Frequency: 3-5 minutes</p> <p>Length: 40-60 seconds</p> <p>Strength: not palpated</p> <p>Patients response: Some discomfort but no complaints</p>
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EFM reference (APA format):

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

**Current Medications (7 points, 1 point per completed med)
 *7 different medications must be completed***

Home Medications (2 required)

Brand/Generic	Prenatal vitamin	Aspirin 81 mg			
Dose	NA	81 mg			
Frequency	daily	Daily			
Route	oral	Oral			
Classification	Prenatal vitamin	NSAID			
Mechanism of Action	Provides additional vitamins needed during pregnancy to the mother and baby.	Inhibits the activity of the enzyme called cyclooxygenase .			
Reason Client	Pregnancy	Prevention of			

Taking		blood clots			
Contraindications (2)	Overload of iron, hemolytic anemia.	GI bleed, hemophilia.			
Side Effects/Adverse Reactions (2)	Constipation , dark stools.	Nausea, bloody or tarry stools.			
Nursing Considerations (2)	Do not give this medication with milk, instruct the patient not to take additional iron.	Monitor liver function, ensure that the patient is not on warfarin.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	BMP	CMP			
Client Teaching needs (2)	Inform the client that they can have an overdose of prenatal vitamins, inform the patient of side effects of an overdose.	Taking aspirin during late pregnancy can lead to bleeding during the delivery. You should not breast feed while taking this medication.			

Hospital Medications (5 required)

Brand/Generic	Cytotec	Cervidil	Pitocin	Hemabate	Fentanyl
Dose					

	25 mg	10 mg	30 units/500 ml	250 mcg	25 mcg
Frequency	Every 4 hours	Once	Continuous	PRN after delivery	PRN
Route	vaginal	vaginal	IV	IM	SQ
Classification	Prostaglandin	Prostaglandin	Oxytocin	Prostaglandin	opioid
Mechanism of Action	It is a prostaglandin analogue that binds to myometrial cells to cause contractions and softening of the cervix.	Stimulates the myometrial cells and regulates calcium transport.	Pitocin is a man made version of oxytocin used to stimulate contractions of the uterus. It works by increasing the concentration of calcium.	It binds to the prostaglandin receptor causing myometrial contractions causing the induction of labor and prevents hemorrhage after labor.	Binds to opioid receptor sites altering perception of emotional response to pain.
Reason Client Taking	Soften cervix	Soften cervix	Induce contractions	Hemorrhage	Pain
Contraindications (2)	Fetal distress, hyperactive uterine patterns.	Fetal distress, hypersensitivity to prostaglandins.	Placenta previa, fetal distress.	Pelvic inflammatory disease, hepatic disease.	Hypersensitivity to the drug and its components
Side Effects/Adverse Reactions (2)	Diarrhea, headache	Fever, nausea	Vomiting, more intense and frequent contractions.	Diarrhea, nausea.	Blurred vision, agitation
Nursing Considerations (2)	Assess dilation of the cervix periodically when on this medication,	Notify provider of signs of hemorrhage right away, monitor the cervix	Discontinue the medication if hyperactivity of the uterus is	Notify the provider immediately if signs of hemorrhage occur. Administer	Do not give to the patient during labor, do not give during breast feeding.

	monitor for hepatic impairment .	continuously.	occurring. Stop the medication if fetal distress occurs.	an antiemetic before administering this medication.	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	CMP, dilation	Monitor the cervix and dilation.	Assess the character and frequency of contractions. Monitor the mothers and baby’s heart rate continuously.	Monitor vaginal discharge, monitor contractions, monitor vital signs.	Monitor respiratory rate.
Client Teaching needs (2)	Inform the client that diarrhea is a side effect, also inform the client that this medication is used to soften the cervix.	Inform the client of the side effects of this medication. Inform the client that the nurse will be checking cervical dilation continuously after administering this medication.	Advise the patient to expect contractions to occur more frequently after this medication is administered.	Explain the purpose of vaginal examinations to the patient, inform the patient to notify the provider if experiencing fever, chills, or foul smelling discharge.	Avoid alcohol and other CNS depressants

Medications Reference (APA):

2018 Nurses drug handbook (17th ed.). (2018). Burlington, MA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

<p>GENERAL (0.5 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Patient is A&O x4. She is oriented to place, time, date and situation. Patient is experiencing mild discomfort but has no complaints. Patient is clean, healthy, and positive.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: 23 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Patients skin is a good color and has normal skin turgor. The patient’s temperature is 98.1. The patient has no rashes, bruises, or wounds or incisions. Patient does not have any drains present. Patients Braden score is a 23.</p>
<p>HEENT (0.5 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Patients head is midline with no deviations. Assessment of the patient’s ears, nose, and teeth was not performed. Patient has PEERLA noted.</p>
<p>CARDIOVASCULAR (1 point): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema: lower legs and feet.</p>	<p>Patients heart rhythm is normal. Patients heart rate was at 105. Assessment of the patient’s heart sounds, peripheral pulses and capillary refill were not performed. Patient had no neck vein distention. Patient had edema in her lower legs and feet.</p>
<p>RESPIRATORY (1 points):</p>	<p>Patients respiratory rate was normal at 16.</p>

<p>Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Assessment of the patients breath sounds was not performed.</p>
<p>GASTROINTESTINAL (5 points): Diet at Home: Current Diet: Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds:</p>	<p>Patients diet at home is normal. Patient is currently not allowed food or liquids besides water and ice chips because of the possibility of her getting a C-section. Patients height is 5 feet 2 inches. Patients weight is 186 lbs. Assessment of the patient’s bowel sounds and abdomen was not performed.</p>
<p>GENITOURINARY (5 Points): Bleeding: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input type="checkbox"/> Type: Size: Rupture of Membranes: Time: Color: Amount: Odor: Episiotomy/Lacerations:</p>	<p>Patient had a catheter balloon inserted into her vagina to help her dilate. Patient had no rupture of membrane. Patients assessment of urine was not performed or charted.</p>
<p>MUSCULOSKELETAL (2 points): ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: 0 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Patient did not use ADL assistance. Patient was not a fall risk. Patient was up independently and did not need support to walk.</p>
<p>NEUROLOGICAL (1 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/></p>	<p>Patient was orientated to time, place, date, and situation. Patients mental status was normal for her age. Patients speech was clear. Patients deep tendon reflexes were not assessed.</p>

<p>Orientation: Mental Status: Speech: Sensory: LOC: Deep Tendon Reflexes:</p>	
<p>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):</p>	<p>Patient’s developmental level is normal for her age. Patient is a Jehovah’s witness and does not accept blood products. Patients husband and friend was at the hospital with her for support.</p>
<p>DELIVERY INFO: (1 point) Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:</p>	<p>Patient did not deliver while I was at clinical.</p>

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	NA	NA	NA	NA	NA
Admission to Labor/Delivery	89	112/68	16	97.9 temporal	100%
During your care	105	135/84	16	98.1 temporal	100%

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
9:15 am	1-10	Abdomen and back	6	cramping	Relaxation, repositioning, rest
12:40 pm	1-10	Abdomen and back	6	cramping	Relaxation, repositioning, rest

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 Location of IV: Metacarpal vein peripherally in right and left arm Date on IV: 1/21/2020 Signs of erythema, drainage, etc.: None IV dressing assessment: dry and intact	Hep lock. Patients IV flushed easily.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Not charted	Not charted

Nursing Interventions and Medical Treatments during Labor & Delivery (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with “N” after you list them, identify medical treatments with “T” after you list them.)	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.
Flushed patients IV	Once	To make sure the IV was patent
Watched nurse insert Cytotect into patients cervix	Once	To soften the patients cervix
Watched the nurse midwife insert a catheter balloon into the	Once	To help the patient dilate.

patients cervix		
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Nursing Diagnosis (30 points)

Must be NANDA approved nursing diagnosis and listed in order of priority
Two of them must be education related i.e. the interventions must be education for the client.”

<p>Nursing Diagnosis (2 pt each) Identify problems that are specific to this patient. Include full nursing diagnosis with “related to” and “as evidenced by” components</p>	<p>Rational (1 pt each) Explain why the nursing diagnosis was chosen</p>	<p>Intervention/Rational (2 per dx) (1 pt each) Interventions should be specific and individualized for his patient. Be sure to include a time interval such as Assess vital signs q 12 hours.” List a rationale for each intervention and using APA format, cite the source for your rationale.</p>	<p>Evaluation (1 pt each)</p> <ul style="list-style-type: none"> How did the patient/ family respond to the nurse’s actions? Client response, status of goals and outcomes, modifications to plan.
<p>1. Risk for bleeding related to Leiomyoma as evidenced by weak uterine contractions</p>	<p>This nursing diagnosis was chosen because my patient is at a high risk for bleeding due to AMA, and Leiomyoma. Since she does not accept blood products she is also at a higher risk for hemorrhage.</p>	<p>1. Asses maternal vital signs for signs of shock. Rationale in pregnant woman signs of shock manifest after 25% to 30% blood loss. 2. Monitor labs such as CBC’s, PTT and PT. Rationale Hgb and Hct will be lower in the pregnant patient due to hemodilution and their values will guide fluid replacement therapy.</p>	<p>The patient has not given birth yet so these interventions have not taken place. The goal of these interventions is to return the patients blood volume to a normal level within 2-3 hours of birth.</p>

<p>2. Acute pain related to uterine contractions as evidenced by patients increasing contractions.</p>	<p>This nursing diagnosis was chosen because my patient is reporting mild pain with her contractions.</p>	<p>1. Encourage the patient to verbalize her level of acceptable pain using a valid pain scale. Rationale documentation and understanding of the patient’s individual acceptable pain level enables the nurse to work with the patient in providing adequate pain relief. 2. Change the woman’s position frequently Rationale Frequent position changes assist in comfort and should be based on the patient’s comfort level, preference, safety and privacy.</p>	<p>Patient is responding well to the evaluation of pain. Patients pain is currently at a 6 on a scale of 1-10. Patient changes her position frequently to help with her pain and responded well to the nurses encouraging her to do so.</p>
<p>3. Anxiety related to induction of labor as evidenced by a high risk pregnancy.</p>	<p>This nursing diagnosis was chosen because my patient is a high risk pregnancy and is experiencing some anxiety about a natural labor.</p>	<p>1. Review the stages of labor as they occur, reassuring the family of normal expectations and behaviors. Rationale Explaining in lay terms the labor process and what to expect enhances the patients coping skills and decreases anxiety. 2. Educate the client on the medications she is receiving and why she is receiving them. Rationale Explaining the medications the patient is receiving can help reduce anxiety because she can understand why they are giving her the medications.</p>	<p>The patient responded well to the medications she was given. The patient was informed of what all the medication were and what they will do to her body. The patient was aware that she was in the first stage of labor. Patient was having anxiety about having a natural birth and expressed wanting to have a C-section.</p>
<p>4. Knowledge deficit related to induction of labor as evidenced by anxiety.</p>	<p>This nursing diagnosis was chosen because the patient was having anxiety about induction of</p>	<p>1. Educate the patient on what induction of labor is. Rationale Explaining to the patient what induction of labor is and why she needs it can help her understand what is going on.</p>	<p>The patient responded well to the nurse’s explanation of induction of labor. The nurse also informed her of all the medications she was receiving and what they</p>

	labor and needed more education about the process.	2. Educate the patient on the medications being given for induction of labor and what they will do to her body. Rationale explaining the medications she is giving will help her better understand what induction of labor does.	did to her cervix and her contractions.
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Other References (APA)