N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 1/29/2020 8:00am	**Patient Initials** MJ	**Age** 31 Years old	**Gender** Female
Race/Ethnicity White	**Occupation** House Wife	**Marital Status** Married	**Allergies** NKA
Code Status Full	**Height** 5'4" (162.6 cm)	**Weight** 160 lb. (72.6 kg)	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: No complication during pregnancy, received prenatal care by physician at Christie clinic.

Past Medical History: Anemia and Sinus tachycardia

Past Surgical History: Wisdom teeth

Family History: Hypertension- (father and mother)

Social History (tobacco/alcohol/drugs): Denies smoking, smokeless tobacco, no alcohol or drugs.

Living Situation: In a home with husband and 2 kids.

Education Level: High School

Admission Assessment

Chief Complaint (2 points): Labor induction

Presentation to Labor & Delivery (10 points):.Induction 39 week 6 days

Diagnosis

Primary Diagnosis on Admission (2 points):.Labor Induction

Secondary Diagnosis (if applicable):.N/A

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

The patient was brought in for a social induction of her third child. Patients Pitocin was stated shortly after admission around 10am. Epidural was placed shortly after that, along with a catheter. At the start of my shift, the patient was 4cm dilated and 80% effaced with inconsistent contractions. After allowing the mom some rest and keeping an eye on her contractions, the nurse checked her cervix again with no change. By 15:30 patient was asking about having her water broken to move the process along. With the contractions becoming more and more inconsistent and the Pitocin running at 18, the nurse felt it was best to call the doctor. The physician agreed to come in and possibly break the water if the baby had moved down. By 16:15 the physician broke the patients water. At that point it was noticed that the water was a green/brown color telling the medical team there was meconium in the amniotic fluid. This putting the baby at risk, the physician then requested the neonatologist be at delivery. Around 17:15 the patient called out saying she was feeling pressure, the nurse checked the patient she was dilated to 10cm and 100%, station of -2. The physician was called in, surgical techs were asked to set up a sterile field. Patient began pushing around 17:40, patient was in little pain with epidural and utilized lamaze breathing techniques. Patients foley catheter was removed at 18:00, baby was delivered by 18:13 and placenta by 18:17. Baby did not suffer any issues due to meconium, neonatologist was not needed for delivery.

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	4-6 mcl		3.8		
Hgb	11.3-15.2 g/dL		11.2		
Hct	33.2-45.3%		34		
Platelets	149-393 k/mcl		192		
WBC	4.0-11.7 k/mcl		9.82		
Neutrophils	45.3-79.0%		47.56		
Lymphocytes	11.8-45.9%		11.21		
Monocytes	4.4-12.0%		4.82		
Eosinophils	0-6.3%		0.13		
Bands			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	Value on Admission	Today's Value	Reason for Abnormal
Blood Type			O		
Rh Factor			negative		
Serology (RPR/VDRL)	non reactive	non reactive			
Rubella Titer	non detected	non detected			
HIV	non detected	non detected			
HbSAG	Negative	Negative			
Group Beta Strep Swab	Negative	Negative			

Glucose at 28 Weeks	Negative	Negative			
MSAFP (If Applicable)		130			

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
N/A					

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)		N/A			

Lab Reference (APA):

Henry, N.J.E., Mcmicheal, M., Johnson, J., DiStasi, Ball, B.S., Holman, C., Lemon, T. (2016).

*Rn adult medical surgical nursing: review module.*Assessment Technologies Institute.

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment N/A
What is the Baseline (BPM) EFH?	 N/A
Are there accelerations? ● **If so, describe them and explain what these mean (for example: how high do they go and how long do they last?)** **What is the variability?**	 N/A
Are there decelerations? If so, describe them and explain the following: What do these mean? o **Did the nurse perform any interventions with these?** o **Did these interventions benefit the patient or fetus?**	 N/A N/A
Describe the contractions: **Frequency:** **Length:** **Strength:** **Patient's Response:**	 N/A

EFM reference (APA format):

Current Medications (7 points, 1 point per completed med)
7 <u>different</u> medications must be completed

Home Medications (2 required)

Brand/Generic	Prenatal Vitamins				
Dose					
Frequency					
Route					
Classification					
Mechanism of Action					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Nursing Considerations (2)					
Key Nursing Assessment(s)/Lab(s) Prior to Administration					
Client Teaching needs (2)					

Hospital Medications (5 required)

Brand/Generic	Acetaminophen/ Tylenol	Calcium carbonate/ TUMS	Carboprost/ Hemabate	fentaNYL/ suldimaze	Ondansetron/ Zofran-ODT
Dose	975 mg	1,000 mg	250 mcg	50 mcg	4 mg
Frequency	PRN every 4 hours	PRN every 8 hours	PRN every 15 mins	PRN every 2 hours	PRN every 6 hours
Route	Oral	Oral	Intramuscular	Subcutaneous	Oral
Classification	analgesics	antacid	gynecologic bleeding	anesthesia	
Mechanism of Action	antipyretic effect via direct action on the hypothalamic heat-regulating center.	Essential component and participant in physiologic systems and reactions	stimulates smooth muscle and uterine contractions	Binds to various opioid receptors, producing analgesia and sedation	selectively antagonizes serotonin 5-HT3 receptors
Reason Client Taking	Mild pain	heartburn indigestion	bleeding	severe pain	nause
Contraindications (2)	Hepatic impairment, hypovolemia	Hypercalcemia, and dehydration	symptomatic CAD, caution if anemia	caution if seizure disorder, or hypovolemia	congenital long QT syndrome, bradycardia
Side Effects/Adverse Reactions (2)	renal tubular necrosis, headache	hypercalcemia, nephrolithiasis	uterine rupture, hemorrhage	Monitor for respiratory depression, hypotension	bradyarrhythmias, ECG if electrolyte abnormalities
Nursing Considerations (2)	caution if malnutrition or renal impairment	caution if renal impairment or hyperparathyroidism	No routine tests, monitor vitals and signs for excess bleeding.	Vital signs continuously and ECG	Monitor vitals
Key Nursing Assessment(s)/Lab(s	Monitor liver	Monitor kidney	Monitor vitals.	Cardiac rhythm at	Cardiac rhythm at

) Prior to Administration	function	function test.		baseline	baseline
Client Teaching needs (2)	Don't take with alcohol	Take by mouth, with water.	If patients feels light headed or notices signs of excessive bleeding notify the nurse.	Not to drive or drink while taking this medication.	Fine to take while driving.

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook.*

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	A&O: 4x
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:**	Patients skin is pink, soft dry and warm. Cap refill normal less than 3 seconds. Skin turgor was normal, 1 second tenting. No wounds detected. Varicose veins in lower legs and feet.

Rashes: **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N** ■ **Type:**	
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and Neck appear in normal limits. No jugular vein distention. Not assessed, allowed for the patient to sleep.
CARDIOVASCULAR (1 point): **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:**	Not assessed, allowed for the patient to sleep.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N** ■ **Breath Sounds: Location, character**	.Not assessed, allowed for the patient to sleep.
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:**	.Regular diet at home. NPO after epidural was placed. 5’4” 160 lb. No scars, drains, or wounds observed. Varicose veins detected in the lower legs.
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N** ■	Bleeding noticed during cervical exam. No lesions or open sores on genital area.

Inspection of genitals: **Catheter: Y ■ N ☐** **Type:** **Size:** **Rupture of Membranes:** **Time:** 16:15 **Color:** Thick, brown/green **Amount:** Large amount **Odor:** Slight odor **Episiotomy/Lacerations:** Laceration	
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ■ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Patient is a fall risk due to having an epidural and catheter in place. She is unable to get up at this time due to an epidural, but normally is up at ad lib with no support needed or equipment.
NEUROLOGICAL (1 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **Deep Tendon Reflexes:**	.Patients mental status seemed good for, just ready to have a baby. Patients speech was clear and easy to understand. Patient was orientated to person, place, time and situation.
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient lives at home with her husband, and two daughters. She is a housewife and mother. The patient religion is Mennonites.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:**	1/29/2020 1813 Vaginal Male Breast feed

Feeding Method:	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal					
Admission to Labor/Delivery	121	122/76	16	98.1F	98
During your care					

Vital Sign Trends:

Unable to obtain vital sign trends because there was only one set charted at the time, I was reviewing the chart.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1500	0				
1615	0				

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:**	18 gauge left top of hand. 1/29/20 10:30am IV has line attached and infusing, clean and intact. Dressing was allusive, no phlebitis or

IV dressing assessment:	infiltration present, catheter patent.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**

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.**
Pitocin (T)	Delivered through IV pump	To induce labor for social reasons.
Epidural (T)	Delivered through IV pump	For pain management.
Lamaze Breathing (N)	During the labor process.	For pain management and to help supply patient with oxygen.

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."

Nursing Diagnosis (2 pt each)	**Rational (1 pt each)**	**Intervention/Rational (2 per dx) (1 pt each)**	**Evaluation (1 pt each)**
Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	Explain why the nursing diagnosis was chosen	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	● How did the patient/ family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to

		APA format, cite the source for your rationale.	plan.
1. At risk for complications of postpartum hemorrhage related to Oxytocin induction.	Oxytocin induction/augmentation put patients at a higher for hemorrhage.	**1.** Assess vital signs every 15 mins for the first hour. **Rationale-** to watch for signs of hypovolemic shock. **2.** Monitor perineal blood loss. **Rationale-** Continuous seepage of blood with a firm uterus can indicate cervical or baginal lacerations.	Patient understands the plan and plans to be compliant.
2. At risk for infection related to foley catheter.	Foley catheters if not taken care of properly leave patients at a high risk for urinary tract infections.	**1.** Emptying the catheter regularly so that, urine doesn't backflow into the bladder. **Rationale-** allowing urine to back flow into the bladder can cause infection. **2.** Keep the tubing below the bladder. **Rationale-** Keeping the bag to high doesn't allow for the bladder to empty properly.	Patient understands the plan and will participate in the plan of care.
3. At risk for falls related to receiving an epidural.	With an epidural the patient is unable to feel their legs putting them at an increased risk for falling.	**1.** Inserting catheter so patient doesn't feel the need to try to get up **Rationale-** Patient will not need to get up to use the bathroom and possibly fall. **2.** Keep patients belongings and call light within reach. **Rationale-** The patient want feel the need to try and get up if they have everything with them. Or they can call out if needed.	Patient agreed with these measures. And was compliant with staying in bed.
4. At risk for impaired gas exchange related to patient being anemic.	Patient was anemic which can cause them to feel short of breath and tired.	**1.** Provide supplemental Oxygen if needed **Rationale-** To help with oxygen perfusion. **2.** Allow time to rest. **Rationale-** The patient might be more tired than	The patient responded to these interventions appropriately.

		normal, allowing the patient extra time to rest.	

Other References (APA)

Ladwig, G. B., & Ackley, B. J. (2011). *Mosbys Guide to Nursing Diagnosis.* Elsevier Health Sciences.