N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission	Patient Initials	Age	Gender
4/1/19	LG	28 years old	Female
Race/Ethnicity	Occupation	Marital Status	Allergies
Unknown	Waitress	Single	Diltiazem and Penicillin
Code Status	Height	Weight	Father of Baby Involved
Full code	68"	130 kg	Very involved

Medical History (5 Points)

Prenatal History:

Past Medical History:

Past Surgical History:

Family History:

Social History (tobacco/alcohol/drugs):

Living Situation:

Education Level:

Admission Assessment

Chief Complaint (2 points):

Presentation to Labor & Delivery (10 points):.

Diagnosis

Primary Diagnosis on Admission (2 points): Labor

Secondary Diagnosis (if applicable): Gestational diabetes

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):

Laboratory Data (15 points)

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

Lab	Normal Range	Prenatal Value 10/16/19	Admission Value 4/1/19	Today's Value	Reason for Abnormal Value
RBC	3.50 – 5.20	4.56	4.16	4.16	WNL
Hgb	11 – 16	14.2	12.9	12.9	WNL
Hct	34 - 47	39.9	37.9	37.9	WNL
Platelets	140 - 400	198	178	178	WNL
WBC	4 – 11	6.04	9.08	9.08	WNL
Neutrophils	3.9 – 13.1	NA	NA	NA	NA
Lymphocytes	1 – 3.6	NA	NA	NA	NA
Monocytes	4.4 – 12%	4.5	4.8	4.8	WNL
Eosinophils	< 7%	0.2	0.2	0.2	WNL
Bands	< 10^9	NA	0.2	0.2	WNL

Other Tests <mark>Highlight All Abnormal Labs</mark>—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+	WNL
Rh Factor	Positive/ Negative	NA	NA	NA	NA
Serology (RPR/VDRL)	Nonreaction	NA	NA	NA	NA
Rubella Titer	Immune	>500	NA	NA	WNL
HIV	Nondetective	Negative	NA	NA	WNL
HbSAG	Nondetached	NA	NA	NA	NA
Group Beta Strep Swab	Negative	<mark>Positive</mark>	NA	NA	

Glucose at 28 Weeks	100 – 125 when fasting	<mark>190</mark>	At 1700 – 112 and at 2100 – 100.	4/2/19: At 0730 – 110. At 1130 – 120. At 1700 – 99. At 2100 – 108.	
MSAFP (If Applicable)	0.5 – 2.5	NA	NA	NA	NA

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

Lab Test	Normal Range	Prenatal Value	Value on Admission 4/1/19	Today's Value	Reason for Abnormal
Calcium	9.0 – 10.5	NA	8.7	NA	
BUN	7 – 25	NA	7	NA	
Creatine	0.50 – 0.90	NA	0.64	NA	
TP		NA	6.7	NA	
ALB	3.5 – 5	NA	2.6	NA	
AST	0.0 – 32	NA	15	NA	
ALT	4 – 33	NA	11	NA	
Sodium	135 – 145	NA	137	NA	
Chloride	98 – 106	NA	105	NA	
CO2	21 – 31	NA	21.6	NA	
Magnesium	1.3 – 2.1	NA	1.8	NA	
Glucose	70 – 110	NA	112	4/2/19: At 0730 – 110. At 1130 – 120. At 1700	

				– 99. At 2100 – 108.	

—**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)	**Negative**	NA	NA	NA	NA

Lab Reference (APA):

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	**Strip 1:** 150 **Strip 2:** 150 **Strip 3:** 130 **Strip 4:** 150
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?**	Yes. In strip 1 there is an acceleration from 150 to 170, this acceleration lasted for 20 seconds. Moderate variability.

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?**
	Yes. In strip 1 there is a deceleration from 150 to 120 – 130, this deceleration lasted for 2 minutes.
	
	Did the nurse perform any interventions with these?
	Mom was turned onto her left side and Oxygen was stared at 3 liters per mask.
	
	Did these interventions benefit the patient or fetus?
	Was not assessed but based on the strips, the interventions helped to stabilize the patient and fetus.

Describe the contractions: Frequency: Length: Strength: Patient's Response:	Frequency: 2 min. Duration: 40 sec. Strength: Strong Patient is anxious and the contractions caused her a great amount of discomfort.

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	Vynatal/ Prenatal vitamin
Dose	2 chewable gummies
Frequency	Daily
Route	PO
Classification	Multivitamin
Mechanism of Action	Consist of multiple vitamins that are essential for fetus development (Jones & Bartlett

	Learning, 2019).
Reason Client Taking	Used to provide the additional vitamins that are needed during pregnancy.
Contraindications (2)	Low-salt diets and coadministration of two different prenatal vitamins at once. These contraindications do not pertain to my patient.
Side Effects/Adverse Reactions (2)	Upset stomach or headache may occur.
Nursing Considerations (2)	(1) Monitor for hypersensitivity reaction. (2) An overdose can cause injury to the fetus.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check minerals and H&H.
Client Teaching needs (2)	(1) Patient should take as prescribed. (2) Take with a full glass of water.

Hospital Medications (5 required)

Brand/Generic	**Pitocin/ Oxytocin**
Dose	125 mL/hr
Frequency	Labor

Route	IV fluids
Classification	Oxytocic agents
Mechanism of Action	Uterine stimulant, vasopressive and antidiuretic effects. Trigger increase in intracellular calcium levels which increase contraction rate.
Reason Client Taking	Patient is in labor and this is aiding in her contraction rate.
Contraindications (2)	Fetal distress and hyperactive uterus.
Side Effects/Adverse Reactions (2)	Neonatal seizures and neonatal jaundice can occur.
Nursing Considerations (2)	If uterine hyperactivity occurs, discontinue immediately. Restricting fluid intake may be warranted.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Fetal presentation and pelvic adequacy.
Client Teaching needs (2)	Educate the patient that this drug is used to start labor. This is also used to help contraction of the uterus when

	expelling the placenta.

Medications Reference (APA):

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is AOx4 Patient was anxious and had difficult relaxing between her contractions.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** 2; WNL, patient is not at risk for skin breakdown. **Drains present: Y☐ N ☐** **Type:**	 Intact; pink Warm and dry Oral: 36.4 C Elastic; <3 No skin breakdown present. No drains or ports were present on this patient
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Not assessed.
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 but based on report. No chest pain, palpations or syncope Regular rate and rhythm S1&S2 noted No noted murmurs, gallops or rubs 3+ bilaterally LE <3 bilaterally UE

RESPIRATORY (1 points): **Accessory muscle use:** Y☐ N☐ **Breath Sounds: Location, character**	Not assessed.

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:
	2200 calorie ADA diet
	68"
	130 kg
	The rest were not assessed
	
	Uterus U/U

GENITOURINARY (5 Points):
Bleeding:
Color:
Character:
Quantity of urine:
Pain with urination: Y☐ N☐
Inspection of genitals:
Catheter: Y☐ N☐
    Type:
    Size:
Rupture of Membranes:
Time: 0510
Color: unknown
Amount: unknown
Odor: unknown
Episiotomy/Lacerations:
	After placenta: 350 mL
	Not assessed
	
	SROM

MUSCULOSKELETAL (2 points): **ADL Assistance:** Y☐ N☐ **Fall Risk:** Y☐ N☐ **Fall Score:** 30 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Not assessed.
NEUROLOGICAL (1 points): **MAEW:** Y☐ N☐ **PERLA:** Y☐ N☐ **Strength Equal:** Y☐ N☐ **if no -**	Not assessed.

Legs ☐ **Arms** ☐ **Both** ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **Deep Tendon Reflexes:**	
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):**	Not assessed.
DELIVERY INFO: (1 point) **Delivery Date:** 4/3/19 **Time:** 0828 **Type (vaginal/cesarean):** vaginal **Quantitative Blood Loss:** 350 ml <mark>Male</mark> **or Female** **Apgars:** 1 min:6 8 min: 5 **Weight:** 2013 grams **Feeding Method:** breastfeeding	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	NA	NA	NA	NA	NA
Admission to Labor/Delivery	98 bpm	132/85	16	98.4 F	100%
During your care	100 bpm	122/75	16	97.8 F	98%

Vital Sign Trends: Patient vital signs were stable before, during and after labor.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
Not assessed					
Not assessed					

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Not assessed **Location of IV:** Not assessed **Date on IV:** 4/1/19 **Patency of IV:** Not assessed **Signs of erythema, drainage, etc.:** Not assessed **IV dressing assessment:** Not assessed	LR at 100ml/hour Pitocin at 125ml/hr and 150ml/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Not noted	Blood: 350 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.
Fundus massage if indicated. "N".	Every 15 minutes after birth ,every 30 minutes during the second hour and then 4 – 8 hours until discharge.	This intervention is used to aid in the firming of the uterus.
Vital signs "N".		Monitor vital signs every 30 min for the first hr. and then every hr. for 2 hrs. and then every 8 hrs.

Encourage ambulation. "N"	Hourly	This intervention is to decrease mom's risk for blood clots. Patient was up and lib and was able to walk to the bathroom, shower and move around the room.

Nursing Diagnosis (30 points)
Must be NANDA approved nursing diagnosis and listed in order of priority
Two of them <mark>must be education related</mark> i.e. the interventions must be education for the client."

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	Rational (1 pt each) Explain why the nursing diagnosis was chosen	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.	Evaluation (1 pt each) • How did the patient/ family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1.		**1.** **Rationale** **2.** **Rationale**	
2.		**1.** **Rationale** **2.** **Rationale**	
3.		**1.** **Rationale** **2.** **Rationale**	
4.		**1.** **Rationale** **2.** **Rationale**	

Other References (APA)