N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission **11/06/2019 0600**	**Patient Initials** **DB**	**Age** **20**	**Gender** **Female**
Race/Ethnicity **African American**	**Occupation** **Student**	**Marital Status** **Single**	**Allergies** **Sulfa**
Code Status **Full Code**	**Height** **167 cm**	**Weight** **72.6 kg**	**Father of Baby Involved** **Yes**

Medical History (5 Points)

Prenatal History: DB began prenatal care began at 8 weeks gestation. Patient is gravida 1 para 0. Patient has a history of chlamydia and thrombocytopenia during pregnancy.

Past Medical History: Patient denies.

Past Surgical History: Patient denies.

Family History: Patient denies.

Social History (tobacco/alcohol/drugs): Patient states she has never smoked cigarettes or used tobacco products. Patient states that she is a social drinker but has not had any alcohol during her pregnancy. Patient does admit to smoking marijuana before and during her pregnancy.

Living Situation: Patient lives at home with her mother.

Education Level: Patient has some college, she is a sophomore in the pre-nursing program.

Admission Assessment

Chief Complaint (2 points): Induction of Labor

Presentation to Labor & Delivery (10 points): DB presents to the hospital on 11/06 at 0600 for induction of labor due to the diagnosis of intrauterine growth restriction. No contractions were noted via palpation or EFM. DB is at 38 weeks gestation and EDC is 11/18/2019. A sterile

vaginal exam was performed and results indicated she was 40% effaced and 1 cm dilated. DB's membranes are still intact.

Diagnosis

Primary Diagnosis on Admission (2 points): Intrauterine growth restriction

Secondary Diagnosis (if applicable): Induction of Labor

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:

DB arrived at the hospital at 0600 on 11/06. The patient's EDC is 11/18/19, which means she is at term in her 38th week of gestation(Ricci et al., 2017). The patient's sterile vaginal exam showed that she was 40% effaced, 1 cm dilated and that the baby was vertex in the -2 station. Patient's membranes were intact. According to Ricci et al. (2017), the patient is currently in the latent phase of the first stage of labor due to the minimal amount of dilation and percentage of effacement, as well as her lack of contractions. During the latent phase, the mother will begin to experience regular contractions that often feel like period cramps. Patients are often talkative during this phase, which can last 9 hours for a nulliparous woman(Ricci et al., 2017). The patient was given oxytocin to initiate contractions (Holman et al., 2019). DB rated her pain as a 5/10 on the numeric pain scale and received 25mcg of Fentanyl IV push. Nursing actions during the latent phase include performing Leopold maneuver, a vaginal exam, monitor cervical dilation and effacement, encourage the client to take slow deep breaths and monitoring station and fetal position(Holman et al., 2019).

By 1200 DB began to have regular contractions as the oxytocin was gradually increased. Her pain rating was an 8/10, and comfort measures were initiated. The nurse educated on the use of backrubs, positioning, warm blankets, and breathing techniques. At 1300 DB was 90%

effaced and 5cm dilated with the baby presenting at -1 station. Based on this presentation, the patient is in the active stage of the first stage of labor due to being 5 cm dilated(Ricci et al., 2017). According to Ricci et al. (2017), women in this phase often experience more frequent and more prolonged contractions. Their discomfort worsens, and they begin to become inwardly focused in preparation for birth. After the assessment, the patient was administered an epidural as well as a bolus of LR. During the active stage of labor, the nurse is responsible for educating the patient and her support person on what and encourages the mother to be in the upright position. The mother is also helped to void at least every 2 hours(Holman et al., 2019).

At 1500 DB's amniotic sac ruptured and revealed a large amount of bright and odorless fluid. The amniotic fluid is monitored for any infection indicators, such as a cloudy color or foul odor(Ricci et al., 2017). The exam revealed the mother was 100% effaced and 8 cm dilated with the baby presenting at 0 station and in the vertex position. DB is currently in the transition phase of the first stage of labor, the shortest phase. Contractions become more intense, more frequent, and more painful. The mother's urge to push increases significantly during this phase. Patients may also experience symptoms such as nausea, vomiting, restlessness, irritability, diaphoresis, increased amount of bloody show, and the feeling of loss of control(Ricci et al., 2017). Nursing actions during this phase include discouraging the mother from pushing until she is fully dilated, observing for perineal bulging or crowning, and encourage the client to begin to bear down(Holman et al., 2019).

DB entered the second stage of labor at 1700. She presented at 10 cm dilated with the baby at 0 station. Her contractions were consistently occurring every 2 minutes and lasting 90 seconds. The patient was instructed to begin pushing. By 1745 the baby was at +3 station and crowning. The midwife performed a perineal massage with mineral oil. Vitals signs tend to be

taken every 5 to 30 minutes, as well as the measurement of fetal heart rate is performed every 5 to 15 minutes(Holman et al., 2019). Heart rate tends to increase by about 10 to 20 bpm; blood pressure rises about 35 mmHg, and respirations increase(Ricci et al., 2017). The patient's extremities may begin to shake, and the mother will start to feel the urge to push. There is usually an increase in bloody show during this phase (Holman et al., 2019).

The baby was born at 1819, which began the third stage of labor. During this phase, vital signs are checked every 15 minutes. The mother's body will prepare to deliver the placenta, which will cause the uterus to contract. DB was also given oxytocin to help deliver the placenta and avoid hemorrhage. The nurse will instruct the mom to push once the placenta has separated. The patient should also receive pain medications during this phase(Holman et al.,2019). DB was given lidocaine topically to prepare for laceration correction. The mother was also administered ice packs to ease the pain.

Stage of Labor References (2) (APA):

Holman, H., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., McMichael, M.,Barlow, M.S.(2019). *RN maternal newborn nursing* (11th ed.). Assessment Technologies Institute.

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing (3rd ed.).* 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 4/8/19	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**3.9 – 4.98**	**4.6**	**4.48**	**N/A**	
Hgb	**12 – 15.5g/dl**	**12.6**	**12.2**	**N/A**	
Hct	**34 – 45%**	**37.5**	**36.2**	**N/A**	
Platelets	**150 - 400**	**251**	**180**	**N/A**	
WBC	**4.0 – 9.0**	**7.0**	**7.6**	**N/A**	
Neutrophils	**40 – 70%**	**58**	**68.2**	**N/A**	
Lymphocytes	**20 – 50%**	**25**	**19.9**	**N/A**	
Monocytes	**2 - 12%**	**13**	**11.7**	**N/A**	According to Ricci et al. (2017), monocytes are elevated with infection. The patient was diagnosed with Chlamydia during her first prenatal visit. Chlamydia is an infection(Ricci et al., 2017).
Eosinophils	**0- 6.3%**	**2**	**0**	**N/A**	
Bands	**0 - 6**	**N/A**	**N/A**	**N/A**	

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

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	**B**	**B**	**B**	**N/A**	
Rh Factor	**Negative**	**Negative**	**Negative**	**N/A**	
Serology (RPR/VDRL)	**Negative**	**Negative**	**Negative**	**N/A**	
Rubella Titer	**Immune**	**Immune**	**N/A**	**N/A**	

HIV	**Negative**	**Negative**	**N/A**	**N/A**	
HbSAG	**Negative**	**Negative**	**N/A**	**N/A**	
Group Beta Strep Swab	**Negative**	**Positive**	**N/A**	**N/A**	According to Ricci et al. (2017), is a natural bacteria that is found in about 50% of adults. This result resembles that the mother is a carrier. Her positive test is important to note because Group Beta Strep can be life-threatening to the baby(Ricci et al., 2017).
Glucose at 28 Weeks	**Negative**	**Negative**	**N/A**	**N/A**	
MSAFP (If Applicable)	**Negative**	**Negative**	**N/A**	**N/A**	

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	**N/A**	**N/A**	**N/A**	**N/A**	
N/A	**N/A**	**N/A**	**N/A**	**N/A**	
N/A	**N/A**	**N/A**	**N/A**	**N/A**	
N/A	**N/A**	**N/A**	**N/A**	**N/A**	
N/A	**N/A**	**N/A**	**N/A**	**N/A**	
N/A	**N/A**	**N/A**	**N/A**	**N/A**	
N/A	**N/A**	**N/A**	**N/A**	**N/A**	
N/A	**N/A**	**N/A**	**N/A**	**N/A**	

N/A	**N/A**	**N/A**	**N/A**	**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)	**Negative**	**N/A**	**N/A**	**N/A**	**N/A**

Lab Reference (APA):

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

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	At 1000 the baseline fetal heart rate in the first strip was 120 bpm. At 1200 the baseline fetal heart rate was 150 bpm. The baseline fetal heart rate was also 150 bpm at 1600.
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?**	On the first strip there is no indication of significant accelerations and minimal variability. Minimal variability can be a result of cord compression, maternal hypotension, uterine hyperstimulation or fetal dysrhythmia (Ricci et al., 2017). On the second strip there are moderate accelerations and variability present. The accelerations are reassuring to see, and should be seen with a healthy infant (Ricci et al., 2017). The accelerations last about 30seconds and FHR achieves 170-180 bpm. The 3rd strip shows minimal

	variability and no accelerations, this strip shows decelerations.
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?**	The first strip at 1000 does not display any decelerations. The second strip at 1200 shows one variable deceleration. The FHR peaks to about 165 bpm and then as the contraction peaks the FHR drops to about 140 bpm, ending with a peak back up to 165 bpm and then back to baseline. Variable declarations are caused by cord compression(Ricci et al., 2017). The patient was given a 1000 mL bolus of LR and the epidural. At 1430 the patient reported a decrease in pain and rated it as a 1/10. This intervention benefits the mother. At 1600 the 3nd strip showed early decelerations. FHR decreases with each contraction and drops down to 100 bpm, then returns back to baseline. Early decelerations are associated with compression of the baby's head during contractions(Ricci et al., 2017). The nurse turned DB onto her left side until the decelerations resolved. This intervention benefits the mother and the baby.
Describe the contractions: **Frequency:** **Length:** **Strength:** **Patient's Response:**	At 1000 contractions occur every 5 minutes and last for 30 seconds. The strength of the contractions is mild. At 1200 contractions occur every 3 minutes and last for 1 minute. The strength of the contractions is moderate. At 1600 contractions occur about every 2 minutes and last for about 50-60 seconds. The strength of the contractions are strong.

EFM reference (APA format):

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

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

Home Medications (2 required)

Brand/Generic	Prenatal Vit -Fe Fumarate Fa	Tylenol/ Acetaminophen			
Dose	1 tab	650 mg			
Frequency	Daily	PRN			
Route	PO	PO			
Classification	Vitamin	Non-opioid analgesic			
Mechanism of Action	Provides supplementation to support the needs of the pregnant mother and the growing baby and prevent vitamin deficiency	According to Jones & Bartlett(2019), acetaminophen blocks prostaglandin production resulting in an interruption of the pain impulse.			
Reason Client Taking	Prenatal multivitamin	headaches			
Contraindications (2)	Anti-seizure medications Hypercalcemia	Hypersensitivity to acetaminophen Renal impairment			
Side Effects/Adverse Reactions (2)	Constipation Diarrhea	Anemia Hepatotoxicity			
Nursing Considerations (2)	- Do not give at the same time as antacids, bisphosphonates	-Use cautiously in patients with liver impairment			

	, levodopa, thyroid medications, or antibiotics. - Assess patient for indications of nutritional deficiency	-Monitor renal function with patient on long term therapy			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Can cause false positives on test results Calcium and iron levels	Liver function tests: ALT, AST, bilirubin, creatinine, urinalysis for blood or albumin, monitor urine color			
Client Teaching needs (2)	- Take daily to achieve full affect, take at the same time each day to help remember. - Make sure to drink with a full glass of water.	-Tablets can be crushed or swallowed whole -Educate about signs of hepatotoxicity such as bleeding, bruising, and malaise			

Hospital Medications (5 required)

Brand/ Generic	**Pitocin/ oxytocin**	**Fentora/ Fentanyl**	**PermaPen / Penicillin G**	**Naropin/ ropivacaine**	**Cytotec/ misoprostol**

Dose	1-20 mL/hr	25 mcg	2.5 million units	10 mL/hr	800 mg
Frequency	Titrated/hr	once	Q4	once	once
Route	IV	IV push	IV	Epidural	Rectal
Classification	Oxytocic	Opioid	Antibiotic	Local anesthetic	Prostaglandin analog
Mechanism of Action	Oxytocin binds to the receptors in the myometrium resulting in an increase in calcium and stimulation of the uterus to contract(Epocrates, 2020.	Fentanyl binds to opioid receptors and changes the perception and emotional response to pain by inhibiting the pain pathways(Jones & Bartlett, 2019).	Inhibits the final stage of cell wall formation by binding to proteins in the cell wall and resulting in cell wall lysis **(**Jones & Bartlett, 2019).	Ropivacaine inhibits sodium channels and inhibits nerve impulse and conduction(Epocrates, 2020).	Produces uterine contractions(Epocrates, 2020).
Reason Client Taking	To initiate/ improve uterine contractions	Pain	To treat Strep B	Epidural to relieve labor pain	Induction of labor
Contraindications (2)	Uterine hyperactivity or hypertonicity Grand multiparity	Hypersensitivity asthma	Hypersensitivity to penicillin or its components	Hypersensitivity to amide anesthetics Caution in elderly patients	Prior cesarean section Hypersensitivity
Side Effects/Adverse Reactions (2)	Uterine hypertonicity Nausea & vomiting	Bradycardia diaphoresis	Headaches stomatitis	Seizures paresthesia	Diarrhea dyspepsia
Nursing Considerations (2)	-Administer IV or IM -Doses are often titrated based upon	-Only administer the smallest dose necessary to	-Obtain tissue and fluid samples prior to	- Some anesthetics can have long lasting or delayed effects	-Store at room temperature away from heat and moisture - Administer

	the patient	achieve pain relief. -Use cautiously in patients who may be at risk for substance abuse such as family history of drug abuse.	administering first dose. -Administer penicillin at least one hour before other antibiotics	-Make sure the patient is not taking dysrhythmic medications because it can alter the effect of ropivacaine	with food and before bedtime
Key Nursing Assessment(s) /Lab(s) Prior to Administration	EFM HR	BUN Creatinine Monitor respirations	Sodium levels Diarrhea Fluid overload	Liver function test BUN, creatinine HR, RR, Oxygen saturation, BP	Monitor VS FHR
Client Teaching needs (2)	-Educate patient on signs to notify the health care personnel such as uneven heart rate, excessive bleeding, severe headache or blurred vision, confusion, or severe weakness. -Discuss other medication that are taken prior to receiving oxytocin.	- Avoid potentially hazardous activities until the CNS effects have worn off - Educate patient to increase fiber and fluid intake because fentanyl can cause constipation.	-Instruct the patient to notify the prescriber of penicillin allergies prior to taking and report any adverse reactions - Instruct patient to notify the prescriber if they have diarrhea, even after penicillin therapy ends	-Instruct to monitor for symptoms of overdose by educating on heightened adverse reactions -Avoid injury by waiting to get up until feeling has fully returned.	-Do not take longer than recommended - Call the provider if they experience severe nausea, vomiting, stomach pain or diarrhea that lasts longer than 8 days.

Medications Reference (APA):

Epocrates(2020). Retrieved on June 26, 2020 from https://online.epocrates.com/drugs

Jones & Bartlett Learning. (2019). *2019 Nurses Drug Handbook.* Jones & Bartlett Learning, LLC.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented x4. Patient does not appear to be in distress but states she has some pain. Overall patient appears anxious and excited.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type: N/A**	Skin color is appropriate for ethnical background. Skin is pink, warm, dry and intact, Turgor is good, no tenting present. No rashes, bruises, or wounds present. Braden score is 21.

HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head appears symmetric and normocephalic. Trachea is midline. Ears are intact with no visible signs of discharge. Eyes are symmetric. PERRLA. Nose is midline with no deviated septum, polyps, or epistaxis. Patient appears to have good oral hygiene, teeth clean and intact. .
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: N/A**	S1 and S2 heard upon auscultation. Regular rate and rhythm. No murmurs or gallops present. Pedal and radial pulses are strong bilaterally, 3+. Capillary refill is less than 3 seconds in all extremities.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Lungs are clear to auscultation in all lobes. No crackles, rhonchi or wheezes present.
GASTROINTESTINAL (5 points): **Diet at Home:** **Current Diet:** **Height: 167 cm** **Weight: 72.6 kg** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	Patient has a regular diet at home and during her stay at the hospital. Patient is 167 cm tall and weighs 72.6 kg. DB has active bowel sounds in all four quadrants. Patient states her last bowel movement was yesterday(11/05). Abdomen is soft upon palpation. No distention, incisions, scars, drains, or wounds present.
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: indwelling** **Size: 16 gauge** **Rupture of Membranes:** **Time:**	Patient did not have blood present in her urine. Urine was clear and yellow. Total quantity of urine was 1545 mL. Genitalia is red and tender. Patient had a 16 gauge Foley catheter in place. Membranes ruptured at 1500. The color was clear, the amount was large and it was odorless. Patient has a 2nd degree midline laceration.

Color: **Amount:** **Odor:** **Episiotomy/Lacerations:**	
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score: 40** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☒ **Needs support to stand and walk** ☐	Patient is independent, however the epidural and IV lines made her a fall risk. Fall score is 40.
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:**	Patient is able to move all extremities well and had equal strength bilaterally. Patient is alert and oriented x4. Sensory is intact except for her lower extremities after the epidural. Patient's speech is clear and easy to understand. DTRs intact.
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 appears to be coping well. Developmental level seems appropriate for her age. Patient states she is Christian and believes in God and fate. DB has the support of her boyfriend and father of the infant as well as the support of her mother. DB lives at home with her mother.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	Delivery Date is 11/06/2019 at 1819. Patient had a vaginal delivery. Patient lost 650 mL of blood. The infant is female. Her apgar score at 1 minute was 6 and at 5 minutes was 8. The infant weighs 3005 grams. DB is breast feeding.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**84**	**128/65**	**18**	**98.8 F oral**	**100% RA**
Admission to Labor/Delivery	**98**	**132/85**	**16**	**98.4F oral**	**100% RA**
During your care	**92**	**132/84**	**18**	**99.3 F oral**	**97% RA**

Vital Sign Trends: Vital signs remained stable, heart rate and temperature increased from first prenatal visit. This is to be expected as the mother's body prepares for the stress of birth (Ricci et al., 2017).

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0600	**0-10 Numeric Pain scale**	**Bottom**	**5/10**	**N/A**	**Fentanyl 25 mcg IV push**
1430	**0-10 Numeric Pain scale**	**Bottom**	**1/10**	**N/A**	**No interventions implemented at this time**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV:** right basilic vein **Date on IV:** 11/06/2019 **Patency of IV:** Patent, no indications of infiltration **Signs of erythema, drainage, etc.:** None	LR solution 100 mL/hr Oxytocin 1-20 mL/hr, 333 mL/hr, 166 mL.hr

IV dressing assessment: clean, dry, intact	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Cytotec 800 mg rectal **Lidocaine 1 mL subcutaneous** **Fentanyl 25 mcg IV** **Penicillin G 10 million units** **Ropivacaine and fentanyl 400 mL** **LR 13,000 mL** **Oxytocin 952 mL**	**Voided 645 mL** **Foley 900 mL** **Blood loss 650 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.
Comfort measures such as back rubs, positioning with the peanut ball, warm blankets and breathing techniques (N)	Throughout the labor process	DB was rating her pain as an 8/10. Prior to administering more pain medications the nurse wanted to try non-pharmacologic treatment. The patient had recently received fentanyl, the nurse wanted to give the medication more time to take effect.
Turned the patient onto her left side(N)	Once	DB was turned onto her let side to resolve the decelerations that appeared on the FHR monitor.
Infant was placed on mother's chest directly after birth(N)	Once	Skin to skin contact regulates baby's temperature and vital signs(Ricci et al., 2017).

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) 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. Acute pain related to cervical dilation as evidenced by patient rating her pain as an 8/10 on the numeric pain scale.	This nursing diagnosis was chosen because of the impact pain can have on an individual. Pain can be debilitating.	**1.**Administer analgesics as prescribed. **Rationale:** Opioid analgesics are often used in patients experiencing moderate to severe pain(Ricci et al., 2017). **2.** Use other comfort measures that involve the senses. **Rationale:** Massage and pressure stimulate A-delta and C fibers, which relax muscles and decrease tension(Ricci et al., 2017).	The patient responded well to the analgesics. The patient was eager to attempt the comfort measures but did not find them as effective. Will continue to monitor pain levels and provide patient centered interventions.
2. Anxiety related to unfamiliar surroundings, processes, and procedures as evidenced by patient stating feeling uneasy.	Anxiety is often caused by fear of the unknown. Anxiety can also be debilitating and should be addressed to set the client at ease.	**1.** Encourage doula support for the mother **Rationale:** A study showed that women who had support from a doula had a greater chance of spontaneous vaginal delivery(Ricci et al., 2017). **2.** Review the stages of labor with the mother and the family so they are aware of expectations.	The patient was open to having a doula and asked for further information. The patient and family were appreciative of the stage of labor review. They stated feeling more confident and comfortable with what was yet to come. Will continue to educate and

		Rationale: Going through the stages of labor with the other and the family can help reduce anxiety(Ricci et al., 2017).	answer questions.
3. Need for health teaching related to unfamiliarity with effects of postpartum wound infection as evidenced by patient asking how to care for her laceration.	It is important to educate patients on the risks of infection to prevent complications.	**1.** Teach the patient how to identify signs and symptoms of infection. **Rationale**: Postpartum infections are a common result of maternal complications and death(Ricci et al., 2017). **2.** Explain treatment interventions such as daily wound care and antibiotic treatment**.** **Rationale:** Nurses educate mothers on the proper wound care such as cleaning with a mild soap and water to prevent the buildup of bacteria(Ricci et al., 2017).	The patient was receptive to the education about infection prevention and signs and symptoms of infection. The patient stated confidence in being able to prevent the possibility of infection. Will continue to educate and provide resources.
4. Need for health teaching related to lack of prenatal class attendance as evidenced by patient stating she missed appointments due to her busy schedule	It is vital to attend prenatal classes to better prepare and feel comfortable with the birthing process.	**1.** Assess patient and family understanding of birth process. **Rationale:** Having a baseline of patient knowledge lets the nurse know exactly where education is needed(Rici et al., 2017). **2.** Assess which plans or questions the mother has in regard to pain management during labor. **Rationale:** It is important to know the mother's pain plan because the administration of analgesics is heavily dependent upon the timing(Ricci et al., 2017).	The patient was embarrassed to admit her lack of attendance to the prenatal classes. She was reassured and has been asking questions as she thinks of them. Patient seems appreciative and confident in her plan of care. Will continue to educate and provide insight.

Other References (APA)

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

Swearingen, P. L., & Wright, J.D (2019). *All-in-one nursing care planning resource*. Elsevier.