N432 Labor & Delivery Care Plan

Lakeview College of Nursing

Abby Sellek

Demographics (3 points)

Date & Time of Admission 7/2/2020	**Patient Initials KM**	**Age 33**	**Gender Female**
Race/Ethnicity Caucasian	**Occupation Receptionist**	**Marital Status Married**	**Allergies Seasonal allergies**
Code Status Full	**Height 5'6"**	**Weight 176 lbs**	**Father of Baby Involved**

Medical History (5 Points)

Prenatal History: Patient had first prenatal visit on 12/18/19 with Dr. Burns. She started prenatal vitamins, received influenza vaccine, and started initial prenatal screenings.

Past Medical History: Ovarian Cyst

Past Surgical History: Ovarian Cyst Removal

Family History: Mother: Hypertension, Father: liver disease

Social History (tobacco/alcohol/drugs): No alcohol, drug, or tobacco use.

Living Situation: Patient lives at home with husband.

Education Level: Highschool diploma

Admission Assessment

Chief Complaint (2 points): Induction of labor

Presentation to Labor & Delivery (10 points):. The patient presented to the labor and delivery unit today for an induction following a prenatal visit with Dr. Burns. The patient was stable and accompanied by her spouse. She rated her pain as a 0/10. She denied bleeding, discharge, or fluid leakage. The patient is 37 weeks and 4 days gestation with good fetal movement and a baseline heart rate of 120 bpm.

Diagnosis

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

Secondary Diagnosis (if applicable):. Intrauterine growth restriction

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:

A cervical assessment was performed at 1340. The patient was noted to be 1 cm dilated with 20% effacement. The patient is in the latent phase of labor. During the latent phase of labor, the patient's cervix is dilated from 0-3 cm and 0-40% effaced (Ricci et al., 2017). Contractions during this stage occur every 5-10 minutes and are mild in strength. During this phase, vital signs are expected to be within normal range or may be slightly elevated due to pain from contractions. A Cytotec was placed at this time. Cytotec is utilized to ripen the cervix during a labor induction (Ricci et al., 2017). This is administered every 4 hours, per the physician's orders, until the patient is 3cm dilated. The patient stated she was feeling pressure in her pelvis but was not feeling pain yet. She rated her pain as 0/10.

At 1730 the physician performed a cervical check. The patient was noted to be 1.5 cm dilated and 30% effaced. The patient stated she felt pressure in her lower abdomen but was comfortable. The patient was repositioned and encouraged to perform breathing and relaxation techniques during contractions.

At 2000, the nurse performed a cervical check and the patient was 2.5 cm dilated and 30% effaced. The patient is still in the first stage, latent phase of labor. This phase typically lasts 9 hours long but can last longer for some (ATI Nursing, 2019). During this phase, the patient will feel pressure and experience mild to moderate contractions and pain. The membrane is typically still intact, and the fetus is located at -2 station. The patient is progressing and will enter the

active phase of labor once she is 4 cm dilated (Ricci et al., 2017). The A Cytotec was placed at this time to continue to soften the cervix. She rated her pain as a 5/10. The patient requested IV pain medication and was repositioned.

Stage of Labor References (2) (APA):

ATI Nursing Education. (2019). *RN maternal newborn nursing* (11th ed.). Assessment Technologies Institute, LLC.

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	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**4.40-5.80 mcL**	**4.26**	**4.37**	**Same as admission values**	
Hgb	**12.0-15.8 g/dL**	**12.9**	**13.1**	**N/A**	
Hct	**38.0-50%**	**38.3**	**38.2**	**N/A**	
Platelets	**140-440 mcL**	**200**	**164**	**N/A**	
WBC	**4.40-5.80 mcL**	**5.62**	**5.4**	**N/A**	
Neutrophils	**40-68%**	**61.5**	**66.5**	**N/A**	
Lymphocytes	**18-49%**	**19.9**	**19**	**N/A**	
Monocytes	**3.0-13.0%**	**4.6**	**6.5**	**N/A**	
Eosinophils	**0.0-8.0%**	**1**	**0.6**	**N/A**	
Bands	**0.0-1.0%**	**0.2**	**0.4**	**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	**N/A**	**A**	**A**	**Same as admission values.**	
Rh Factor	**N/A**	**+**	**+**	**N/A**	
Serology (RPR/VDRL)	**Nonreactive**	**Nonreactive**	**N/A**	**N/A**	
Rubella Titer	**Immune**	**Immune**	**N/A**	**N/A**	
HIV	**Negative**	**Negative**	**N/A**	**N/A**	
HbSAG	**Not detected**	**Not detected**	**N/A**	**N/A**	
Group Beta Strep Swab	**Negative**	**Negative**	**N/A**	**N/A**	
Glucose at 28 Weeks	**< 140**	**170 mg/dL**	**N/A**	**N/A**	**Increased glucose levels indicate the patient may have gestational diabetes (Ricci et al., 2017). A 3-hour blood glucose test was performed to further assess the finding. These were within normal limits, indicating negative diagnosis for gestational diabetes.**
MSAFP (If Applicable)	**<2.5 MoM**	**1.02**	**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
Clamydia	Negative	Negative	N/A	N/A	
Ghonnerea	Negative	Negative	N/A	N/A	
3 Hour Glucose	Fasting: <95 mg/dL 1 hour: <180 2 hour: <155 3 hour: <140	Fasting: 75 mg/dL 1 hour: 139 2 hour: 119 3 hour: 125	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)	<150	N/A	N/A	N/A	

Lab Reference (APA):

Kee, J.L.F. (2017). *Pearson handbook of laboratory & diagnostic tests with nursing*

implications. Pearson.

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?	**Baseline EFH is 130 bpm. FHR within normal limits.**
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?**	**Accelerations are present and reactive with moderate variability. Accelerations last approximately 30 seconds long and increase by 20-25 bpm. Accelerations are a positive indicator of good fetal and placental perfusion (Ricci et al., 2017)**
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?**	**No decelerations present.**
Describe the contractions: **Frequency:** **Length:** **Strength:** **Patient's Response:**	**Strip 1: 1400** **Frequency: Irregular** **Length: Irritability** **Strength: Mild** **Patient's Response: The patient noted mild discomfort but no pain.**

	Strip 2: 1730 **Frequency: every 2-3 minutes** **Length: 30-50 seconds** **Strength: Mild** **Patient's Response: The patient stated she could feel contractions, was experiencing pressure, but was comfortable.** **Strip 3: 2000** **Frequency: every 2-3 minutes** **Length: 60-70 seconds** **Strength: Moderate** **Patient's Response: The patient stated she was uncomfortable and requested IV pain medication. At this time, she did not want an epidural.**

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	**cetirizine/ Zyrtec**	**prenatal vitamin/ prenatal plus**	**No additional medication prescribed.**	**No additional medication prescribed.**	**No additional medication prescribed.**
Dose	**10 mg**	**1 mg**	**N/A**	**N/A**	**N/A**
Frequency	**PRN**	**Once Daily**	**N/A**	**N/A**	**N/A**
Route	**Oral**	**Oral**	**N/A**	**N/A**	**N/A**
Classification	**Antihistamine**	**Prenatal Vitamin**	**N/A**	**N/A**	**N/A**

Mechanism of Action	**Inhibits histamines from causing inflammatory response**	**Provides essential nutrients and minerals for fetus and mother during pregnancy.**	**N/A**	**N/A**	**N/A**
Reason Client Taking	**Seasonal allergies**	**Prenatal**	**N/A**	**N/A**	**N/A**
Contraindications (2)	**Hypersensitivity** **Breastfeeding**	**Hypercalcemia** **Hyperthyroidism**	**N/A**	**N/A**	**N/A**
Side Effects/Adverse Reactions (2)	**Drowsiness** **Dry mouth**	**Diarrhea** **Nausea**	**N/A**	**N/A**	**N/A**
Nursing Considerations (2)	**This medication can pass through breastmilk and harm an infant.** **Monitor for drowsiness, decreased respiration.**	**Prenatal vitamin ingredients are often not regulated because they are considered a supplement. Administer as prescribed.**	**N/A**	**N/A**	**N/A**
Key Nursing Assessment(s)/Lab (s) Prior to Administration	**Vitals** **LOC**	**Electrolytes** **Folic acid levels**	**N/A**	**N/A**	**N/A**
Client Teaching needs (2)	**Do not perform any activities that require mental alertness until familiar with reaction to medication. Notify doctor before taking this medication if breastfeeding.**	**Take vitamin daily throughout entire pregnancy.** **Take with food to decrease stomach upset.**	**N/A**	**N/A**	**N/A**

Hospital Medications (5 required)

Brand/Generic	**misoprostol / cytotec**	**Dextrose 5% lactated ringers**	**fentanyl/ sublimaze**	**ondansetron/ zofran**	**No additional medication prescribed.**
Dose	**25 mcg quarter tablet**	**125 mL/hour**	**100 mcg**	**4 mg**	**N/A**
Frequency	**Q 4 hours**	**Continuous**	**Q 1 hour PRN**	**Q 12 hours PRN**	**N/A**
Route	**Cervical**	**Intravenous**	**Intravenous**	**Oral**	**N/A**
Classification	**Prostaglandin Analog**	**IV fluid**	**Opioid analgesic**	**Antiemetic**	**N/A**
Mechanism of Action	**Synthetic prostaglandin that stimulates an increase in contraction and softens the cervix**	**Replace fluid lost and glucose used during labor**	**Binds to opioid receptors in CNS altering perception and response to pain**	**Blocks serotonin receptors at vagal nerve to reduce nausea.**	**N/A**
Reason Client Taking	**Induction of labor**	**Labor**	**Severe pain**	**Nausea**	**N/A**
Contraindications (2)	**Contractions are occurring too frequently.** **Fetal decelerations**	**Fluid overload** **Hyperglycemia**	**Asthma** **Opioid intolerance**	**Hypersensitivity to ondansetron** **Long QT syndrome**	**N/A**
Side Effects/Adverse Reactions (2)	**Placental abruption**	**Edema**	**Drowsiness**	**Hypotension**	**N/A**

	Hyperstimulation	Headache	Constipation	Dry mouth	
Nursing Considerations (2)	**Administer the medication vaginally and let dissolve.** **Monitor the patient's vitals every 15 minutes.**	**Monitor IV site for edema, coolness, and discomfort.** **Monitor the patient for signs of hyperglycemia.**	**Can cause neonatal opioid withdrawal symptoms when given to patients pregnant or breastfeeding.** **Only administer if other analgesic interventions are not affective.**	**Monitor patient for serotonin syndrome including confusion, chills, restlessness, fever.** **Dilute the medication in D5W if indicated by physician orders.**	**N/A**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Vitals** **Cervical Check**	**Electrolytes** **IV patency**	**Pain assessment** **Vitals**	**Serotonin levels** **Electrolytes**	**N/A**
Client Teaching needs (2)	**Remain lying on your back for at least 30 after administration to allow the medication to dissolve.** **Educate the patient on the purpose of the medication including side effects.**	**Educate the patient on the purpose of the medication.** **Notify the nurse if you have any pain, burning, or swelling at the IV site.**	**Educate patient on the risk for opioid dependence.** **Increase fluid and fiber intake in diet.**	**Report any signs of rash.** **Report signs of gastric distention or abdominal pain.**	**N/A**

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurse's drug handbook.* Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness: Alert** **Orientation: Oriented to person, place, time, and situation.** **Distress: No acute distress** **Overall appearance: Well-groomed, well-nourished**	
INTEGUMENTARY (2 points): **Skin color: Pink** **Character: Dry** **Temperature: Warm** **Turgor: Intact** **Rashes: No rashes** **Bruises: No bruises** **Wounds/Incision: No wounds** **Braden Score: 22** **Drains present: Y☐ N ☒** **Type: N/A**	
HEENT (0.5 point): **Head/Neck: Normal cephalic, atraumatic, no lesions, erythema, or edema.** **Ears: No erythema, lesions, or drainage noted.** **Eyes: Symmetrical, no lesions, edema, or erythema noted. Sclera white, conjunctive pink, PERRLA, EOE intact.** **Nose: No erythema, lesions, or drainage noted.** **Mouth: Oral mucosa pink and moist, dentition intact.**	.
CARDIOVASCULAR (1 point): **Heart sounds: S1, S2 noted. No murmurs, gallops, or rubs.** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): Normal sinus rhythm** **Peripheral Pulses: Palpable 2+** **Capillary refill: <3 seconds** **Neck Vein Distention: Y ☐ N ☒ Edema Y ☐ N ☒** **Location of Edema: No edema noted.**	.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Bilateral breath sounds clear, no wheezes or crackles noted. Equal**	.

effort and expansion.	
GASTROINTESTINAL (5 points): **Diet at Home: Regular diet with no restrictions, adequate intake.** **Current Diet: NPO, ice chips only.** **Height: 5'6"** **Weight: 176 lbs** **Auscultation Bowel sounds: Active bowel sounds in all 4 quadrants** **Last BM: 7/1/2020** **Palpation: Pain, Mass etc.: Pregnant, soft, no pain upon palpation.** **Inspection:** **Distention: Pregnant** **Incisions: No incisions.** **Scars: No scars.** **Drains: No drains.** **Wounds: No wounds.**	.
GENITOURINARY (5 Points): **Bleeding: No blood in urine.** **Color: Yellow** **Character: Clear** **Quantity of urine: Adequate** **Pain with urination: Y ☐ N ☒** **Inspection of genitals: No erythema or lesions noted.** **Catheter: Y ☐ N ☒** **Type: N/A** **Size: N/A** **Rupture of Membranes: Membranes intact.** **Time: N/A** **Color: N/A** **Amount: N/A** **Odor: N/A** **Episiotomy/Lacerations: N/A**	
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N ☒** **Fall Score: 1 – patient has a continuous IV running** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk☐**	.
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation: Oriented to person, place, time, and situation** **Mental Status: Competent**	.

Speech: Clear and intact. **Sensory: No sensory impairment.** **LOC: Alert** **Deep Tendon Reflexes: Intact**	
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s): Patient has adequate coping mechanisms.** **Developmental level: Appropriate for age** **Religion & what it means to pt.: No religion noted.** **Personal/Family Data (Think about home environment, family structure, and available family support): Patient has a supportive spouse and stable family structure.**	
DELIVERY INFO: (1 point) **Delivery Date: Labor still in progress** **Time: N/A** **Type (vaginal/cesarean): Plans to deliver vaginally.** **Quantitative Blood Loss: N/A** **Male or Female: Female** **Apgars: N/A** **Weight: N/A** **Feeding Method: Plans to breast and bottle feed.**	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**72 bpm**	**112/70**	**18**	**98.0 F** **Oral**	**100%** **Room air**
Admission to Labor/Delivery	**83 bpm**	**128/78**	**16**	**98.1 F** **Oral**	**99%** **Room air**
During your care	**73 bpm**	**114/69**	**16**	**98.3 F** **Oral**	**100%** **Room air**

Vital Sign Trends:

The patient's vital signs during prenatal care and throughout her hospital admission have remained stable and within the age-appropriate expected limits. There has been minimal variability in her vital signs.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1400	**0-10**	**Lower abdomen**	**2**	**Pressure, tightness**	**Patient repositioned and offered ice chips. Patient did not want pain medication at this time.**
2000	**0-10**	**Lower abdomen**	**5**	**Pressure, tightness**	**Patient requested IV pain medication. Physician notified.**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 g **Location of IV: Right anterior forearm** **Date on IV: 7/2/20** **Patency of IV: Patent** **Signs of erythema, drainage, etc.: No erythema, drainage, or edema noted.** **IV dressing assessment: Clean, dry, intact.**	**Dextrose 5% with lactated ringers running at 125 mL/hour**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1000 mL - IV D5W	**750 mL – urine**

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.

Cervical Checks - N	**Q 4 hours**	**Patient is receiving Cytotec, a medication to ripen the cervix. Cervical checks are necessary to assess for cervical changes.**
Fetal Heart Monitoring and TOCO monitoring - N	**Continuous**	**Fetal heart rate and TOCO monitoring are used to assess the fetus's and mother's conditions.**
Vital Signs - N	**Q 15 minutes**	**Cytotec was administered to the patient. Vitals are performed to monitor the patient's response to the medication.**

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 labor contractions as evidenced by a pain rating of 5/10.	**The patient is having moderate contractions occurring every 2-3 minutes.**	**1. Assess for physiological indicators of pain. Rationale: Labor causes significant pain which can cause increased heart rate, respirations, and blood pressure (Ricci et al., 2017).**	**Goal: The patient's vitals will remain within the expected range. She will rate her pain within her stated acceptable pain range and express satisfaction with her pain management.**

		2. Teach the patient breathing and relaxation techniques. **Rationale: Breathing and relaxation techniques can help reduce pain and serve as a distraction (Swearingen, 2016).**	**The patient was receptive of education on breathing and relaxation techniques. The patient is using techniques to manage pain.**
2. Anxiety related to unfamiliar process and procedures as evidenced by the patient's statement that she is nervous and does not know what to expect.	**The patient is in labor with her first child and is unfamiliar with the birthing process.**	**1. Assess what prenatal classes and education the patient has received up until this point.** **Rationale: By assessing current knowledge, the nurse can provide education based on the patient's needs (Swearingen, 2016).** **2. Educate the patient on the stages of labor and what to expectation during each phase.** **Rationale: Educating the patient on steps and processes will help her understand what to expect and decrease anxiety (Ricci et al., 2017).**	**Goal: The patient states that she is more familiar with the processes and feeling less anxious.** **The patient was receptive to education about the birthing process and what to expect.**
3. Risk for infection related to impaired skin integrity as evidenced by frequent cervical checks and bloody discharge following exams.	**The patient is having cervical checks performed every 4 hours resulting in tissue irritation and damage.**	**1. Wash hands and apply sterile gloves prior to performing cervical checks.** **Rationale: Hand washing and sterile gloves will reduce bacteria being introduced during cervical checks (Swearingen, 2016).** **2. Monitor for signs of infection.** **Rationale: Signs of infection may present as changes in CBC, increased temperature, and vitals (Ricci et al., 2017).**	**Goal: Patient will remain infection free and present with no signs of infection.** **The patient was receptive to monitoring for infection, including frequent vital checks and blood work.**
4. Risk for	**The patient**	**1. Cluster care when**	**Goal: The patient will**

fatigue related to labor process as evidenced by patient's statement of being tired and a long day of induction processes.	**has been in the latent phase of labor for over 9 hours and only dilated to 2.5 cm.**	**appropriate to reduce interruptions.** **Rationale: Clustering care will reduce interruptions and promote rest and relaxation (Ricci et al., 2017).** **2. Dim the lights, limit visitors, and keep a calm, quiet environment.** **Rationale: A quiet, calm environment will promote rest, conserve energy, and help the patient relax (Ricci et al., 2017).**	**display increased energy.** **The patient understands that she needs to get adequate rest and conserve energy. The patient is receptive of cluster care and enjoys fewer interruptions.**

Other References (APA)

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

Swearingen, P. L. (2016). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, psychiatric nursing care plans*, (5th ed.). Elsevier.