N432 Labor & Delivery Care Plan

Lakeview College of Nursing

Patricia East

Demographics (3 points)

Date & Time of Admission 4/1/2020	**Patient Initials** LS	**Age** 28 years old	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Waitress	**Marital Status** Single	**Allergies** Diltiazem Penicillin
Code Status Full	**Height** 68”	**Weight** 286 lbs.	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: Prenatal care begun at 10-week gestation. At 28 weeks gestation, the patient was diagnosed with gestational diabetes. Blood sugar was more than 190 mg/dL after the 3-hour glucose tolerance test.

Past Medical History: Obesity

Past Surgical History: NA

Family History: The patient is currently living with her boyfriend. He is the father of the baby. The partner works full time, and the patient works part time in a restaurant as a waitress. They are each other's support system. The patient’s family lives an hour away.

Social History (tobacco/alcohol/drugs): the patient has no history of tobacco, alcohol, and drug use.

Living Situation: LS is currently living at home with her boyfriend, BG. They have family support, but they live about an hour away and may not have access to them

Education Level: Highschool level education. LS seems to be active in her healthcare. She wants to learn and participate. There are no barriers to education currently.

Admission Assessment

Chief Complaint (2 points): Patient states that she has started to feel contractions for the past couple of hours.

Presentation to Labor & Delivery (10 points): The patient is a 28-year-old Caucasian female G1P0 who is 34 weeks gestation. Patient states that she has started to feel contractions on 4/1/2020, but believes they are Braxton hicks. The contractions have been occurring for the past few hours. They are inconsistent, occurring Q5-30 minutes, 30-45 seconds in duration (ATI, 2019). She has been admitted to labor and delivery for preterm labor. Preterm labor is birth before 37 weeks gestation (ATI, 2019). Upon examination, the patient is 2 cm dilated, 80% effaced, and -2 station with intact BOW. Patient's vital signs are within normal range, temp is 98.7, pulse is 88 bpm, respirations are 18, and blood pressure is 130/70. 20 gauge IV in left hand. LR is being infused at 100 mL/hr. Patient is on continuous fetal monitoring and best rest with privileges to the bathroom. Blood sugar checks are fasting & ACHS. Vitals will be monitored every 4 hours. US for culture and sensitivity, GBS culture, type and screen, CBC with differential, CMP were drawn. Administering Nifedipine and Betamethasone. Diet is 2200 calories ADA diet.

Diagnosis

Primary Diagnosis on Admission (2 points): Preterm 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:

The patient is G1P0. The patient is 34 weeks gestation and EDC is 5/13/2020. The patient arrived in labor and delivery on 4/1/2020 with contractions that she believed to be Braxton hicks. Currently, the patient appears to be in the latent phase of the first stage of labor, the contractions are inconsistent (ATI, 2019). The contractions are coming and going between 5 to 30 minutes (ATI, 2019). The contractions are lasting 30-35 seconds in duration. Continuous fetal monitoring was placed on the patient. During vaginal exam, the provider found the patient to be 2 cm dilated, 80% effaced, and -2 station. Patient was transferred to antepartum on 4/1/2020. The patient denies any pain, no pain medications currently. After 24 hours of continuous monitoring, the patient was transferred to the antepartum. The patient has denied any pain, no pain medication at this time. At 0510 on 4/2/2020, The patient gets up to use the restroom. The patient reports a sudden gush of fluid that is accompanied with contraction at 0510 on 4/2/2020. ROM was confirmed with a positive Nitrozene and Amnisure. Upon admission back to labor and delivery, the patient was having contractions every 3 to minutes and 80-100 seconds duration. Vital signs were Temp: 99, HR: 98 Respiration: 18, BP: 134/88, O2: 100% Room air. The active stage of labor has begun, the vaginal exam was performed, and the cervix is 5 cm dilated, 100% effaced, and 0 station (ATI, 2019). The patient is becoming anxious and having difficulty relaxing because of pain. She requested an epidural to be started. A 1000 mL bolus of IV fluids was initiated. The patient's contractions increased to every 1 to 2

minutes, 50 to 80 seconds duration. The fetal heart rate had a deceleration. The patient is continuing to have a hard time relaxing; she is turned onto her left side and oxygen was initiated at 3L per mask. Before administration of epidural anesthesia, the patient feels pressure in her bottom and the fetal heart rate has multiple decelerations that last 10 to 40 seconds. A vaginal delivery was prepped and set up and neonatology was notified. The second stage of labor began at 0820, the patient pushed four times and the baby was delivered at 0828 (ATI, 2019). The placenta was delivered at 0835 which is the third stage of labor (ATI, 2019). Estimated blood loss was 350 mL.

The patient's vitals are stable Temp:97.8 HR: 110, Respirations: 18, BP: 110/65, and O2:95% room air. Pitocin and LR were initiated. Uterine assessment and vital signs are Q15 minutes for the first hour. This is the fourth stage of labor (ATI, 2019), the fundus and lochia are assessed. Recovery was uneventful. There was minimal uterine massage and no gushes of blood noted. Fundus is firm and at the umbilicus. Pitocin is being administered to help maintain uterine tone and hemorrhage (ATI, 2019). Mother is being monitored for the next 4 hours for bleeding. Vital signs are T:97.8 HR:100, R:16, BP:122/75, and O2:98%. The patient has no pain with urination or in general. She has good output. Urine is clear and yellow with no odor. The patient is taken to the NICU unit to see the baby. The patient was then admitted to the postpartum. Her vital signs are T:99, HR:104, Respiration:16, BP: 124/75, and O2: 98%.

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 10/16/19	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.5-5.20	4.56	4.16	NA	
Hgb	12-16	14.2	12.9	NA	
Hct	42%-52%	39.9	37.9	NA	Hct decreases when there has been blood loss. The patient is postpartum and lost 350 mL of blood. This is within the normal range of blood loss with vaginal births (ATI, 2019).
Platelets	140-400	198	178	NA	
WBC	4-11	6.04	9.08	NA	
Neutrophils	55%-70%	NA	NA	NA	

Lymphocytes	20%-40%	NA	NA	NA	
Monocytes	2-8%	4.5	4.8	NA	
Eosinophils	1-4%	0.2	0.2	NA	
Bands	0.5-1%	NA	NA	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 10/16/19**	**Value on Admission 4/1/2020**	**Today's Value**	**Reason for Abnormal**
Blood Type	O	NA	NA	NA	
Rh Factor	Positive	NA	NA	NA	
Serology (RPR/VDRL)	Negative	Negative	NA	NA	
Rubella Titer	Positive	> 500	NA	NA	
HIV	Negative	Negative	NA	NA	

HbSAG	Negative	Negative	NA	NA	
Group Beta Strep Swab	Negative or positive	Positive	NA	NA	GBS is a natural occurring bacterium found in the vagina or rectum. This mom will receive an intravenous prophylactic antibiotic to prevent infection in the baby (ATI, 2019).
Glucose at 28 Weeks	<140	>190 mg/dL	Accuchecks have been within normal range. Patient controls glucose levels through diet.	NA	Gestational diabetes develops when the pancreas can not produce enough insulin to control blood sugars (ATI, 2019).
MSAFP (If Applicable)	0.5-5.0	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
Calcium	8-10	NA	8.7	NA	
Glucose	80-100	NA	97	NA	
BUN	6-20	NA	7	NA	
Creatine	0.6-1.3	NA	0.64	NA	
TP	6-8.3	NA	6.7	NA	
Mag	1.5-2.5	NA	1.8	NA	
Sodium	135-145	NA	137	NA	
Potassium	3.5-5.0	NA	3.5	NA	

Chloride	87-124	NA	105	NA	
AST	8-33	NA	15	NA	
ALB	3.4-5.4	NA	2.6	NA	Albuminuria is common in women who have diabetes during pregnancy (Ricci et al., 2017).
ALT	2-25	NA	11	NA	
MCV	80-100	90.1	91.1	NA	
MCH	26-33	30	31	NA	
MPV	9-12	11.3	11.1	NA	
RDW	12-15	13.8	13.4	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 Admissio**	**Today's Value**	**Explanation of Findings**

			n		
Urine protein/creatinine ratio (if - applicable)	**2.8-217.0 mg/dL**	**NA**	**NA**	**NA**	

Lab Reference (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.**

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	**Your Assessment**
What is the Baseline (BPM) EFH?	The fetal heart rate is between 130-150 bpm.
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?)**	Yes, there are accelerations present in strips. The accelerations are normal and healthy signs. This tells the providers that the baby has adequate oxygen supply (ATI, 2019). In the first strip, there is one acceleration that peaks to 170 bpm that lasts for about 30 seconds. In the second strip, there are no accelerations. In the third strip, there are many accelerations that last between 10 to 40 seconds long.

What is the variability?	In the fourth strip, there are no accelerations.
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, there are decelerations present. In the first strip, there are no decelerations. In the second strip, there are two late decelerations that last between 70 to 110 seconds. In the third strip, there is one variable deceleration that lasts about 20 seconds long. In the fourth strip, there are multiple decelerations that last about 10 to 40 seconds. After the deceleration in the third strip, the patient was turned onto her side and oxygen was administered to help increase the amount of oxygen supply to the fetus. The FHR did return to normal range (ATI, 2019).
Describe the contractions: **Frequency:** **Length:** **Strength:**	In strip one, contractions are mild, Q 4 to 5 minutes, and 50-90 seconds in duration. The patient believed these contractions were Braxton hicks. In strip two, contractions are moderate, Q 3 to 5 minutes and 80-100 seconds in duration. The patient is anxious and having

Patient's Response:	difficulty relaxing. Patient requested for an epidural for pain In strip three, contractions are moderate, Q 1 to 2 minutes, and 50-70 seconds in duration. The patient was turned onto her side and oxygen was administered due to the FHR decelerations In strip four, contractions are strong, Q 1 to 2 minutes, and 50-70 seconds in duration. The patient states that she feels pressure in her bottom and appears to frantic

EFM reference (APA format):

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

Current Medications (7 points, 1 point per completed med)

7 <u>different</u> medications must be completed

Home Medications (2 required)

Brand/Generic	Prenatal Vitamin /	NA	NA	NA	NA

	Brand Unknown				
Dose	1 vitamin	NA	NA	NA	NA
Frequency	Daily	NA	NA	NA	NA
Route	PO	NA	NA	NA	NA
Classification	Vitamin	NA	NA	NA	NA
Mechanism of Action	Gives the body the essential vitamins and minerals to support fetal and maternal needs.	NA	NA	NA	NA
Reason Client Taking	Prenatal pregnancy	NA	NA	NA	NA

Contraindications (2)	Diverticular disease Allergy to iron supplement	NA	NA	NA	NA
Side Effects/Adverse Reactions (2)	Nausea Vomiting Loss of appetite	NA	NA	NA	NA
Nursing Considerations (2)	Avoid giving an antacid within 2 hours of this medication Do not crush medication	NA	NA	NA	NA
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Allergy Existing disease that are contraindications	NA	NA	NA	NA
Client Teaching needs (2)	This medication	NA	NA	NA	NA

	should be taken on an empty stomach (1 before or 2 hours after a meal). Take it with a full glass of water.				

Hospital Medications (5 required)

Brand/Generic	LR	Nifedipine (Procardia)	Betamethasone/ Celestone Soluspan	Pitocin/ Oxytocin	N/A
Dose	100 mL/hr	30 mg STAT & 10 mg Q6 hours	12 mg	100ml	NA
Frequency	continuous	STAT and then Q6 hours.	STAT and then Q24 hours	500ml/hr.	NA
Route	IV	PO	IM	IV	NA

Classification	IV fluid/electrolyte replacement	Calcium channel blocker	Steroid	Uterine active agent	NA
Mechanism of Action	Restores fluid and electrolyte balance, produces diuresis, and reduces acidity	Slows the movement of calcium into the myocardial and vascular smooth muscle. This will dilate the arteries and decrease the demand for myocardial oxygen, lower blood pressure and the afterload.	Bind to specific intracellular glucocorticoid receptors an	Stimulates the uterus to contract by increasing the calcium inside the uterine muscle.	NA
Reason Client Taking	Labor	Control blood pressure	To help with fetal lung development related to preterm labor	Prevention of hemorrhage	NA
Contraindications (2)	Hypersensitivity to sodium lactate CHF	Hypersensitivity to nifedipine Sick sinus syndrome	Hypersensitivity to betamethasone	Small pelvis High blood pressure	NA
Side Effects/Adverse	Fluid overload	Dizziness	Hives	Uterine hyperstimulatio	NA

Reactions (2)	Hypotension	Flushing	High blood pressure	n Deceleration in FHR	
Nursing Considerations (2)	Monitor lung sounds Monitor blood pressure	Monitor vital signs (blood pressure) Do not give this medication with grapefruit or grapefruit juice	Give this medication IM injection May need potassium supplement	Monitor vital signs Monitor FHR	NA
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Monitor vital signs Electrolyte levels	Monitor blood pressure Make sure patient does not have CHF before administering	Monitor for blood glucose levels Monitor vital signs	Continuous monitoring FHR Administer the medication either IM or IV	NA
Client Teaching needs (2)	Educate the patient on why the medication is being administered Educate the patient on side effects of medication	Educate the patient that the extended-release tablet cannot be crushed, chewed, or broken. Educate the patient that blood pressure will be monitored because hypotension can occur	Educate that this medication will help premature lung function Educate that this medication is given twice before delivery	Educate the patient on how the medication increases contraction Educate the patient on why continuous fetal monitoring is important	NA

Medications Reference (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented x3. Appears to be in no distress. Patient complains of contractions and pain. Overall appearance, the patient is well groomed and appropriately dressed.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:**	Skin is pink, warm, and dry. There are no rashes or bruising noted. Skin is intact. Temperature is 98.7 F. Braden's score is 23. Skin turgor <3 seconds. No wounds or incisions. No drains present.

Braden Score: **Drains present: Y☐ N ☐** **Type:**	
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Normocephalic, trachea is midline. No swollen or tender lymph nodes noted. PERRLA. Conjunctiva pink. Membranes are pink and moist. There is no nasal deviation noted or nasal drainage. Good dentition, no missing teeth.
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:**	S1 and S2 noted. No presences of an S3, murmur, or gallops. Normal sinus rhythm. All pulses 2+ bilaterally. Capillary refill is less than 3 seconds. No neck vein distention or edema noted.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐**	Clear lung sounds bilaterally. No crackles, wheezes, or rubs. No use of

Breath Sounds: Location, character	accessory muscles. Respiratory rate is within normal limits.
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:**	Patient is on a diabetic diet with a 2200 calorie limit. Patient is checking blood glucose levels ACHS. She is 5'6" and weighs 286 lbs. Normal active bowels in all four quadrants. No organomegaly or pain with palpation. No distention, incisions, scars, drains, or wounds present. Last bowel movement was 4/1/2020.
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐**	No blood presents. Urine is yellow, clear with no odor. Patient has had 720 mL output. No pain with urination. Genitals are clean, no sores or abnormal findings. No catheter presents. Nitrogen and Amnisure test positive for ROM. Patient states that she felt a little bit of water gush on 4/2/2020 at 0510. No odor, rubra, light. No episiotomy or lacerations

Inspection of genitals: **Catheter: Y ☐N ☐** **Type:** **Size:** **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Episiotomy/Lacerations:**	
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 bed rest with bathroom privileges. Fall score is 4. She is not a fall risk. She is independent. She can move and walk with equipment without help.
NEUROLOGICAL (1 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐**	Alert and oriented X3. Awake and receive education appropriately. Speech is clear and appropriate. DTRs are present. PERLA intact,

Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **Deep Tendon Reflexes:**	MAEW – yes. No deficits noted.
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 is active in her and her babies' care. This is her first child but has good support from her boyfriend and family. The child's father was involved. She is nervous delivering her child at 34 weeks. She has not gone to college but shows that she is at an appropriate development stage to learn and adapt to her new role as a mom. Patient is going to use WIC and state health insurance through the health department in her town. Even though her family lives an hour away, they are close enough to provide support and help if needed.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:**	The baby was delivered 4/3/2020 at 0828. She delivered the baby vaginally. The total amount of blood loss is 350 mL. The infant is male. Apgar's were 6/8. Baby weighs 2013 grams and is 18 inches long. Feeding method is breast.

Male or Female **Apgars:** **Weight:** **Feeding Method:**	

Vital Signs, 3 sets (5 points)

Time	**Pulse**	**B/P**	**Resp Rate**	**Temp**	**Oxygen**
Prenatal	98	132/85	16	98.4	100% room air
Admission to Labor/Delivery	88	130/70	18	98.7	100% room air
During your care	98	134/88	18	99	100% room air

Vital Sign Trends: Vital signs are within normal range and stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0820	0/10- no scale was given.	Bottom	Strong	Pressure	Fluids were administered for epidural. Epidural was not administered.
1200	0/10- no further pain was reported	NA	NA	NA	NA

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV:** left hand **Date on IV:** 4/1/2020 **Patency of IV:** infusing **Signs of erythema, drainage, etc.:** no erythema or drainage present **IV dressing assessment:** dressing is dry and intact	40 unites of Pitocin in 1000 mL Lactated ringer infusing at 500mL/hr.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
IV - 600 mL Oral – 400 mL	Void - 740 mL Blood loss – 350 mL BM - 1

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.**
Administer Betamethasone (Medical Treatment)	12 mg IM STAT and then in 24 hours	This medication is a steroid and can provide great benefits to the premature infant. Many premature infants face prematurity of lungs. Betamethasone can help prevent lung, intestines, and brain bleeds in infants who are premature.

Monitor blood glucose levels (Nursing intervention)	Fasting and ACHS (before meals and hours of sleep).	This patient is diagnosed with gestational diabetes. It is important to monitor blood sugars and interfere if they are not in recommended ranges. If the blood sugars are out of normal limits, it can cause premature labor, increase blood pressure, UTIS, and preeclampsia.
Assess and monitor vital signs and fundal/lochia assessment (Nursing Intervention)	Q15 minutes for the first hour post delivery	For postpartum care, monitoring vital signs and fundus/lochia is important (ATI, 2019). Monitor for tachycardia, this can indicate postpartum hemorrhage (ATI, 2019). Palpate the uterus to check for firmness and location of uterus. If the uterus is boggy, massage the fundus. If the uterus is deviated to the side, this could indicate that there is urinary retention.

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. (PRIORITY #2) Risk for infection related to repeated vaginal examinations	This nursing diagnosis is chosen because the patient was in preterm labor. They were monitoring patient for over 24 hours and gave multiple vaginal exams which can increase the chances of infection	**1.** Use sterile technique when performing vaginal exam **Rationale: This will help prevent introducing microorganism into the vagina (Kyle et al., 2017).** **2.** Demonstrate good hand washing techniques **Rationale: This will help reduce the risk of spreading infective microorganisms to patient and from patient (Kyle et al., 2017).**	The patient understands why the interventions are in place. She wants to understand proper hand hygiene to help prevent infection to her and baby.
2. (PRIORITY #1) Risk for fetal injury related to decrease in oxygen supply as evidenced by multiple late decelerations	This nursing diagnosis is chosen because the FHR had multiple late decelerations	**1.** Educate the patient that when the FHR decelerates, she needs to turn on her side **Rationale: Turning the patient onto her side will**	The patient was understanding the importance of these intervention and that it is important to initiate these interventions to

	which indicates that the fetus is not getting adequate oxygen supply	**allow adequate blood flow to the fetus (ATI, 2019).** **2.** Educate the patient that when the FHR decelerates giving oxygen through nasal cannula will be initiated **Rationale: Administering oxygen at 3L through mask will help increase oxygen flow to the fetus (ATI, 2019).**	keep baby safe.
3. (PRIORITY #4) Risk for anxiety related to situation crisis as evidence by delivering a preterm baby at 34 weeks gestation	This nursing diagnosis is chosen because the patient was experiencing anxiety during delivery and can experience more anxiety and fears with baby being admitted to the NICU unit.	**1.** Educate the patient the importance of expressing fears and concerns **Rationale: this can help the patient talk about fears and help cope. This can help reduce anxiety levels (ATI, 2019).** **2.** Educate the patient on nursing interventions, plans of treatment, and possible outcomes. **Rationale: This can help the patient have realistic expectations of outcomes which can reduce anxiety and fears (ATI, 2019).**	The patient was showing signs of anxiety during delivery. She understands that it is important to learn coping strategies to help reduce anxiety. She was appreciative to have learned these techniques.
4. (PRIORITY #3) Risk for acute pain related to labor as evidence by verbalizing pain and pressure in “bottom”	This nursing diagnosis is chosen because the patient was feeling pain	**1.** Provide comfort measures like back rubs, repositioning, shower/hot tub. **Rationale: These**	The patient was appreciative of the relaxation techniques. She followed the steps to proper breathing techniques during labor

	and requested pain medication (epidural) to help relieve the pressure in bottom.	**techniques provide relaxation and promote comfort (ATI, 2019).** **2.** Teach proper breathing and relaxation techniques **Rationale: Proper breathing techniques can help block pain impulses and control pain (ATI, 2019).**	and repositioned when needed.

Other References (APA):

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

Swearingen, P.L., & Wright, J. D. (2019). ***All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health.*** **St.Louis, MO: Elsevier.**