

N432 Labor & Delivery Care Plan

Lakeview College of Nursing

Ana Punsalan

**Demographics (3 points)**

<b>Date &amp; Time of Admission</b> 7/8/2020 1700	<b>Patient Initials</b> B.B.	<b>Age</b> 24	<b>Gender</b> Female
<b>Race/Ethnicity</b> Caucasian	<b>Occupation</b> No occupation	<b>Marital Status</b> Single	<b>Allergies</b> Raspberry
<b>Code Status</b> Full Code	<b>Height</b> 5'13"	<b>Weight</b> 215 lbs.	<b>Father of Baby Involved</b> Yes

**Medical History (5 Points)**

**Prenatal History:** G1P0 at 39w0d

**Past Medical History:** Anemia

**Past Surgical History:** No past surgical history.

**Family History:** Breast cancer – maternal grandmother; Diabetes – paternal grandfather

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

**Living Situation:** Lives with her boyfriend.

**Education Level:** College

**Admission Assessment**

**Chief Complaint (2 points):** Induction of labor

**Presentation to Labor & Delivery (10 points):** B.B. arrived at OSF hospital for the induction of labor for high-risk pregnancy. She is a 24-year-old G1P0 at 39w0d. B.B.'s last menstrual period was approximately 10/15/2019. Her estimated delivery day is 7/15/2020. She appears to be in a lot of pain and wants to deliver the baby already. Her vital signs are: Pulse = 93; BP = 118/74; Resp Rate = 16; Temp = 98.2°F; and Oxygen at 99%. She rated her pain an 8/10 on a numeric scale and received butorphanol for the pain.

### **Diagnosis**

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

**Secondary Diagnosis (if applicable):** Term pregnancy.

### **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**

B.B. is in her first stage and latent phase of labor, starts with regular contractions and ends when rapid cervical dilation begins (Mayo Clinic, 2020). Cervical effacement happens at this phase, and the cervix dilates from 0-3 cm (Ricci et al., 2017). B.B.'s cervical dilation is at 3cm and an 80% effacement, which is also indications of the latent phase. B.B is at 39 weeks gestation, classifying this labor as normal labor since it is equivalent to 9 months (Ricci et al., 2017). Contractions occur every 5-10 minutes and 30-45 seconds (Ricci et al., 2017). During the early phase of labor, there are mild irregular contractions (Mayo Clinic, 2020). B.B. states she has Braxton Hicks contractions due to the irregularity.

B.B.'s vital signs during my care includes Pulse 104, BP 113/76, Resp Rate 18, Temp 97.3°F, and oxygen 98%. Her vital signs are within the standard ranges during the first stage of labor (Ricci et al., 2017). B.B.'s WBC (13.70), neutrophils (76.1), and lymphocytes (16.4) are elevated and are a normal finding during the first stage of labor (Pagana et al., 2019).

Interventions include assessing the B.B.'s psychological readiness, measuring the duration of the latent phase, conducting health teachings, educating B.B. on different relaxation techniques, and ensuring that her partner is present throughout labor (Ricci et al., 2017).

Cervical dilation of 4-7cm indicates that B.B. progresses to another phase (Ricci et al., 2017).

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

Mayo Clinic. (2020). *Labor and delivery, postpartum care*. <https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/stages-of-labor/art-20046545>

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Moby's diagnostic and laboratory test reference* (14<sup>th</sup> ed.). Elsevier.

Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing* (3<sup>rd</sup> 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	3.50-5.20	N/A	4.37	N/A	
Hgb	11-16	N/A	13.1	N/A	
Hct	34-47	N/A	37.6	N/A	
Platelets	140-400	N/A	285	N/A	
WBC	4-11	N/A	13.70	N/A	Elevated levels due to the stress imposing on the body through pregnancy (Pagana et al., 2019).
Neutrophils	1.5-8	N/A	76.1	N/A	Elevated due to adequate bone marrow response to an increased drive for erythropoiesis occurring during pregnancy (Pagana et al., 2019).
Lymphocytes	1-4.9	N/A	16.4	N/A	Elevated due to adequate bone marrow response to an increased drive for erythropoiesis occurring during pregnancy (Pagana et al., 2019).
Monocytes	2-8	N/A	5.7	N/A	
Eosinophils	0-0.5	N/A	1.3	N/A	

<b>Bands</b>	0-0.2	N/A	0.3	N/A	
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**Other Tests** **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

<b>Lab Test</b>	<b>Normal Range</b>	<b>Prenatal Value</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>Blood Type</b>	N/A	A+	A+	A+	
<b>Rh Factor</b>	+	+	+	+	
<b>Serology (RPR/VDRL)</b>	-	-	-	-	
<b>Rubella Titer</b>	>1.0	immune	immune	immune	
<b>HIV</b>	Negative	Negative	Negative	Negative	
<b>HbSAG</b>	Negative	Negative	Negative	Negative	
<b>Group Beta Strep Swab</b>	Negative	Negative	Negative	Negative	
<b>Glucose at 28 Weeks</b>	70-100	86	89	88	
<b>MSAFP (If Applicable)</b>	0.5-5.0	N/A	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.

<b>Lab Test</b>	<b>Normal Range</b>	<b>Prenatal Value</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
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)	>3 mg/dL	N/A	N/A	N/A	

**Lab Reference (APA):**

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Moby's diagnostic and laboratory test reference* (14<sup>th</sup> ed.). Elsevier.

**Electronic Fetal Heart Monitoring (16 points)**

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	125 bpm.
Are there accelerations? • If so, describe them and explain	Yes, accelerations were at least 15 x 15. Last one noted to rise to

<p><b>what these mean (for example: how high do they go and how long do they last?)</b></p> <p><b>What is the variability?</b></p>	<p>140 and lasted 20 seconds.</p> <p>20 bpm</p>
<p><b>Are there decelerations? If so, describe them and explain the following: What do these mean?</b></p> <ul style="list-style-type: none"> <li>o <b>Did the nurse perform any interventions with these?</b></li> <li>o <b>Did these interventions benefit the patient or fetus?</b></li> </ul>	<p>There were no decelerations noted.</p>
<p><b>Describe the contractions:</b></p> <p><b>Frequency:</b></p> <p><b>Length:</b></p> <p><b>Strength:</b></p> <p><b>Patient’s Response:</b></p>	<p>Mild, hardly noticeable</p> <p>1x during 10-minute period</p> <p>More than 90 seconds</p> <p>Very mild</p> <p>Tolerating well, fetus remains stable.</p>

**EFM reference (APA format):**

ATI Nursing Education (2019). *RN maternal newborn nursing* (11<sup>th</sup> ed.). Assessment

Technologies Institute, LLC.

**Current Medications (7 points, 1 point per completed med)  
\*7 different medications must be completed\***

**Home Medications (2 required)**

<b>Brand/Generic</b>	Ferrous sulfate (Feosol)	Docusate sodium (Colace)			
<b>Dose</b>	325 mg	100 mg			
<b>Frequency</b>	2x Daily	2x Daily			
<b>Route</b>	Oral	Oral			
<b>Classification</b>	Anti-anemic	Laxative			
<b>Mechanism of Action</b>	Acts to normalize RBC production by binding with hemoglobin	Acts as a local irritant on the colon stimulating peristalsis.			
<b>Reason Client Taking</b>	To prevent iron deficiency anemia.	Softening and passage of stool.			
<b>Contraindications (2)</b>	Hemochromatosis .  Hemosiderosis.	Hypersensitivity .  Abdominal pain.			
<b>Side Effects/Adverse Reactions (2)</b>	-Dizziness.  -Nausea.	-Electrolyte imbalances.  -Urine discoloration.			
<b>Nursing Considerations (2)</b>	-Give iron tablets and capsule with a full glass of water or juice.  -Do not crush enteric coated tablets or open capsules.	-Administer with a full glass of water or juice preferably in the evening.  -Do not administer within 2 hrs. of other laxatives, especially			

		mineral oil. Mat cause increased absorption.			
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	Monitor hemoglobin, hematocrit, and reticulocyte values.	Fluid, electrolytes, vitamin, and minerals.			
<b>Client Teaching needs (2)</b>	-Stool should become dark green or black during therapy.  -Not to chew any solid form of iron except for chewable tablets	-Advise pts. that laxatives should be only used for short-term therapy.  -Advise patient not to use laxatives when abdominal pain, nausea, vomiting, or fever is present.			

**Hospital Medications (5 required)**

<b>Brand/Generic</b>	Ondansetron (Zofran)	Methylergonovine (Methergine)	Misoprostol (Cytotec)	Lactated Ringers	Dinoprostone (Cervidil Vaginal Insert)
<b>Dose</b>	4 mg	200 mcg	25 mcg	125 mL/hr.	10 mg
<b>Frequency</b>	Q12H PRN	Q2H PRN	Q4H	continuous	ONCE
<b>Route</b>	Oral	IM	Cervical	IV	Vaginal
<b>Classification</b>	Antiemetic	Oxytocic	Prostaglandin	IV fluid/electrolytes replacement	Prostaglandin
<b>Mechanism of Action</b>	Blocks serotonin receptors.	Directly stimulates uterine & vascular smooth muscle.	Decreases gastric acid secretion and increasing the production of protective mucus.	Replaces lost fluids and electrolytes during labor	Produces contractions similar to those occurring during labor at term.
<b>Reason Client Taking</b>	To prevent nausea and vomiting.	For uterine contraction.	For cervical ripening and labor induction.	Labor	Initiation of labor.
<b>Contraindications (2)</b>	Hypersensitivity.  Congenital	Hypersensitivity.  Should not be	Hypersensitivity.  Potential for	Renal failure.  CHF.	Fetal distress.  Traumatic delivery or

	long QT syndrome.	used to induce labor.	fetal harm/death.		difficult labor.
<b>Side Effects/Adverse Reactions (2)</b>	Arrhythmias. Bronchospasms	Tinnitus. Hypertension.	Headache. Miscarriage.	Hyperkalemia. Hypercalcemia *Rare	Chills. Vomiting.
<b>Nursing Considerations (2)</b>	-First dose is administered prior to emetogenic event.  -Immediately place tablet on tongue; tablet will dissolve in seconds, the swallow with saliva. Administration of liquid is not necessary.	-Assess for signs of ergotism.  -Notify health care provider promptly if uterine relaxation becomes prolonged or if character of vaginal bleeding changes.	-Misoprostol therapy should be started at the onset of treatment with NSAIDs.  -Assess uterine cramping and bleeding during therapy.	-Administer prior to delivery.  -Monitor IV site for infiltration	-Auscultate breath sounds. Wheezing & sensation of chest tightness may indicate hypersensitivity reaction. -Monitor uterine activity, fetal status, and dilation and effacement of cervix continuously.
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	Assess pt. for nausea, vomiting, abdominal distention, and bowel sounds. Monitor ECG.	Monitor BP, HR, and uterine response. Assess calcium levels. Decrease serum prolactin levels.	Assess for abdominal pain and for frank or occult blood in the stool, emesis, or gastric aspirate.	Electrolytes. VS.	Vital signs
<b>Client Teaching needs (2)</b>	-Instruct patient to take ondansetron as directed.  -Advise pt. to notify health care provider immediately if symptoms of irregular heartbeat or involuntary movement of eyes, face, or limbs occur.	-Advise patient that medication may cause menstrual-like cramps.  -Caution patient to avoid smoking because nicotine constricts blood vessels.	-Inform pt. that misoprostol will cause spontaneous abortion.  -Inform pt. that diarrhea may occur. Healthcare provider should be notified if diarrhea persists for more than 1 week.	-Let client know why they need LR.  -Let them know that this is a medication that will only be administered while in hospital	-Explain purpose of medication and vaginal exams.  -Advise pt. to notify healthcare provider if contractions become prolonged.

**Medications Reference (APA):**

2019 Nurse's Drug Handbook (18<sup>th</sup> ed.). Jones & Bartlett Learning.

**Assessment**

**Physical Exam (18 points)**

<p><b>GENERAL (0.5 point):</b>  <b>Alertness:</b>  <b>Orientation:</b>  <b>Distress:</b>  <b>Overall appearance:</b></p>	<p>A&amp;O x4.                  Has some distress.                  Pt shows signs of proper hygiene.</p>
<p><b>INTEGUMENTARY (2 points):</b>  <b>Skin color:</b>  <b>Character:</b>  <b>Temperature:</b>  <b>Turgor:</b>  <b>Rashes:</b>  <b>Bruises:</b>  <b>Wounds/Incision: .</b>  <b>Braden Score:</b>  <b>Drains present: Y</b> <input type="checkbox"/> <b>N</b> <input checked="" type="checkbox"/>  <b>Type:</b></p>	<p>Warm, and dry. Color is normal per ethnicity.                  Rapid recoil                  No rash, bruises wounds, drains, or incisions present.                  Body temp 98.1  <b>Braden score: 22</b></p>
<p><b>HEENT (0.5 point):</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b></p>	<p>normocephalic                  neck midline- no vein distension                  PERRLA                  Pink conjunctiva.                  No drainage/redness/bleeding from ears or nose.                  Clean, white teeth.</p>
<p><b>CARDIOVASCULAR (1 point):</b>  <b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>  <b>Capillary refill:</b>  <b>Neck Vein Distention: Y</b> <input type="checkbox"/> <b>N</b> <input checked="" type="checkbox"/>  <b>Edema Y</b> <input type="checkbox"/> <b>N</b> <input checked="" type="checkbox"/>  <b>Location of Edema:</b></p>	<p>Clear S1 and S2.                  No murmurs or gallops                  Normal rhythm                  2+ pulses throughout                  &lt;3 sec cap refill                  No edema</p>
<p><b>RESPIRATORY (1 points):</b>  <b>Accessory muscle use: Y</b> <input type="checkbox"/> <b>N</b> <input checked="" type="checkbox"/>  <b>Breath Sounds: Location, character</b></p>	<p>Clear breath sounds. No crackles, rhonchi, or wheezes. No signs of distress. RR WNL.</p>

<p><b>GASTROINTESTINAL (5 points):</b>  <b>Diet at Home:</b>  <b>Current Diet:</b>  <b>Height:</b>  <b>Weight:</b>  <b>Auscultation Bowel sounds:</b>  <b>Last BM:</b>  <b>Palpation: Pain, Mass etc.:</b>  <b>Inspection:</b>              <b>Distention:</b>              <b>Incisions:</b>              <b>Scars:</b>              <b>Drains:</b>              <b>Wounds:</b></p>	<p>Regular (normal) diet followed at home.          NPO during admission but can have ice chips.          Height: 5'13"          Weight: 215 lbs.          Last BM: one day ago          No abdominal distention, incisions, scars, drains, or wounds</p>
<p><b>GENITOURINARY (5 Points):</b>  <b>Bleeding:</b>  <b>Color:</b>  <b>Character:</b>  <b>Quantity of urine:</b>  <b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Inspection of genitals:</b>  <b>Catheter:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>              <b>Type:</b>              <b>Size:</b>  <b>Rupture of Membranes:</b>  <b>Time:</b>  <b>Color:</b>  <b>Amount:</b>  <b>Odor:</b>  <b>Episiotomy/Lacerations:</b></p>	<p>No blood in urine.          Color, character, and quantity within expected ranges. No clotting or foul odor.          100mL – Foley; x4 before Foley          Genitals pink and slightly tender. No hematoma presents.          No irregularities or discharge. Lower pelvic area slightly distended.          Foley          15          1902          Clear with come blood          Exact amount not documented          No odor          No episiotomy/lacerations</p>
<p><b>MUSCULOSKELETAL (2 points):</b>  <b>ADL Assistance:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Fall Risk:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Fall Score:</b>  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib)</b> <input checked="" type="checkbox"/>  <b>Needs assistance with equipment</b> <input type="checkbox"/>  <b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p>Able to perform ADLs.          Mobility status: Independent  <b>Fall Score: 0</b></p>
<p><b>NEUROLOGICAL (1 points):</b>  <b>MAEW:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -  <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b>  <b>Mental Status:</b></p>	<p>A&amp;O x4          Educated          No deficits noted.          DTR present</p>

<b>Speech:</b> <b>Sensory:</b> <b>LOC:</b> <b>Deep Tendon Reflexes:</b>	
<b>PSYCHOSOCIAL/CULTURAL (1 points):</b> <b>Coping method(s):</b> <b>Developmental level:</b> <b>Religion &amp; what it means to pt.:</b> <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b>	Pt is slightly tired. Appears to be coping. In a positive mood after administration of epidural. Pt. lives with her boyfriend who is at her bedside and is involved.
<b>DELIVERY INFO: (1 point)</b> <b>Delivery Date:</b> <b>Time:</b> <b>Type (vaginal/cesarean):</b> <b>Quantitative Blood Loss:</b> <b>Male or Female</b> <b>Apgars:</b> <b>Weight:</b> <b>Feeding Method:</b>	Patient did not deliver today, but her water broke.

**Vital Signs, 3 sets (5 points)**

<b>Time</b>	<b>Pulse</b>	<b>B/P</b>	<b>Resp Rate</b>	<b>Temp</b>	<b>Oxygen</b>
<b>Prenatal</b>	95	119/83	18	97.6°F	98%
<b>Admission to Labor/Delivery</b>	93	118/74	16	98.2°F	99%
<b>During your care</b>	104	113/76	18	97.3°F	98%

**Vital Sign Trends:**

Vital signs remained in expected ranges.

**Pain Assessment, 2 sets (2 points)**

Time	Scale	Location	Severity	Characteristics	Interventions
1515	Numeric	Abdomen	8	Pressure; Cramping	Butorphanol IV
1830	Numeric	Abdomen	6	Pressure; Cramping	Butorphanol IV

**IV Assessment (2 Points)**

IV Assessment	Fluid Type/Rate or Saline Lock
<b>Size of IV:</b> <b>Location of IV:</b> <b>Date on IV:</b> <b>Patency of IV:</b> <b>Signs of erythema, drainage, etc.:</b> <b>IV dressing assessment:</b>	20 g L. metacarpal vein 7/8/2020 Infusing No erythema or drainage Clean, dry, and intact

**Intake and Output (2 points)**

Intake (in mL)	Output (in mL)
IV: 125 mL	X4 before Foley
Ice chips x3: 360 mL	Foley: 100 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.
Epidural Administration	Once	Epidural administered due to the patient being in a lot of pain.
External contraction monitoring (N)	Continuously	Monitor contraction frequency and fetal response to contractions.

Turn on left side (N)	Once	Patient was turned on the left side because of hypotension due to epidural administration.
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**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.”**

<b>Nursing Diagnosis (2 pt each)</b> Identify problems that are specific to this patient. Include full nursing diagnosis with “related to” and “as evidenced by” components	<b>Rational (1 pt each)</b> Explain why the nursing diagnosis was chosen	<b>Intervention/Rational (2 per dx) (1 pt each)</b> 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.	<b>Evaluation (1 pt each)</b> <ul style="list-style-type: none"> <li>How did the patient/family respond to the nurse’s actions?</li> <li>Client response, status of goals and outcomes, modifications to plan.</li> </ul>
1. Anxiety related to situational crisis as evidenced by increased tension.	The patient has a lot of anxiety due to painful contractions.	1. Encourage appropriate coping or relaxation techniques. <b>Rationale:</b> Enhances sense of control; optimizes participation in the birth process (Ricci et al., 2017). 2. Provide a quiet environment and privacy within parameters of the situation. Position client for optimal comfort. <b>Rationale:</b> Reduces distractions and discomfort, allowing the client to focus (Ricci et al., 2017).	Patient uses breathing and relaxation techniques effectively.
2. Acute pain related to contractions as evidenced by facial mask of pain and giving a rating of 8/10 on a numeric pain scale.	The patient was moaning and crying and rated her pain intensity an 8/10.	1. Acknowledge reports of pain immediately. <b>Rationale:</b> An immediate response to reports of pain may decrease anxiety in the patient (Ricci et al., 2017).	Patient displays improved well-being such as relaxed muscle tone and body posture.

		<p>2. Get rid of additional stressors or sources of discomfort whenever possible.</p> <p><b>Rationale:</b> Patients may experience an exaggeration in pain or a decreased ability to tolerate painful stimuli if environmental, intrapersonal, or intrapsychic factors are further stressing them (Ricci et al., 2017).</p>	
<p>3. Risk of impaired urinary elimination related to gravid uterus as evidenced by urinary frequency.</p>	<p>Patient voided frequently.</p>	<p>1. Teach patient to perform pelvic floor strengthening exercises.</p> <p><b>Rationale:</b> Have client contract pelvic muscles while voiding and stop midstream, hold for 6 seconds, then release. Practicing this once a day help improve muscle tone (Ricci et al., 2017).</p> <p>2. Perform Kegel exercises 1-2x throughout day.</p> <p><b>Rationale:</b> Contract pelvic muscles while in the sitting position (Ricci et al., 2017).</p>	<p>Patient demonstrates proper techniques to prevent urinary frequency.</p>
<p>4. Fatigue related to pregnancy as evidenced by pain.</p>	<p>Patient is restless due to painful contractions.</p>	<p>1. Administer epidural for pain management.</p> <p><b>Rationale:</b> Anesthetic that stops pain signals traveling from the spine to the brain (Ricci et al., 2017).</p> <p>2. Provide patient with nonpharmacological methods, such as deep breathing, imagery, and distraction techniques.</p> <p><b>Rationale:</b> These techniques assists an individual decrease pain experience.</p>	<p>Patient displays improvement in mood, coping, and can get proper sleep.</p>

**Other References (APA):**

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

Swearing, P., & Wright, J. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health* (5<sup>th</sup> ed). Elsevier.