

N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission	Patient Initials SR	Age 37 years old	Gender female
Race/Ethnicity white/caucasian	Occupation Teacher	Marital Status Single	Allergies NKA
Code Status FULL	Height 5'7(1.702cm)	Weight 329lbs (149.2kg)	Father of Baby Involved Not involved

Medical History (5 Points)

Prenatal History: SR is a 37 year old patient female with 1UP at 38 weeks 2 days with expected delivery 07/28/2020 admitted for induction of labor for chronic hypertension, insulin resistance, AMA and morbid obesity. Reports normal fetal movement. dentens vaginal bleeding, LOF or contradictions. Patient is G 1 P 0 T 0 P 0 A 0 L 0.

Past Medical History: She has a past medical history of cat scratch disease (CSD), high cholesterol, hypertension, migraines, polycystic ovarian syndrome and premenstrual dysphoric disorder.

Past Surgical History: Tonsillectomy and adenoidectomy.

Family History: Family history includes diabetes in her maternal grandmother, heart disease in her maternal grandmother, high cholesterol in her mother and hypertension in her father.

Social History (tobacco/alcohol/drugs): She reports that she quit smoking about six years ago. Her smoking usage included cigarettes, she has never used smokeless tobacco. She reports previous alcohol use but no drug usage.

Living Situation: lives at home

Education Level: college

Admission Assessment

Chief Complaint (2 points): induction of labor

Presentation to Labor & Delivery (10 points):

Diagnosis

Primary Diagnosis on Admission (2 points): chronic hypertension affecting pregnancy.

Secondary Diagnosis (if applicable):

Stage of Labor

Stage of Labor Write Up, APA format (20 points) This should include the progression of cervical effacement & dilation as well as pain management techniques:

Stage of Labor References (2) (APA):

The client presented to the hospital with chronic hypertension affecting pregnancy. The patient was admitted for induction of labor. The patient presented with 1 cm dilation with an 80% effacement, which is an indication of the latent phase (ATI, 2019). The client is 38 weeks 2, day gestation. The following are risk factors for preterm labor placenta previa, history of smoking, and gestational diabetes (Ricci et al., 2017). The nurse reported the patient to be AMA, resistant to insulin, and morbidly obese. The fetal heart rate was in the normal ranges. The patient has denied any signs of drainage or vaginal bleeding. Both physicians and nurses performed the ROM and BPP. The fetal fibronectin swab is used to determine the placenta's infection and cervical (ATI, 2019). The rupturing of the membrane began at 1408 pm. Her BPP indicated an excellent score of 9/10 . The patient is given oxytocin to increase contracts, and dilation after reassessment patient was at 5 cm meter dilation. The patient is progressing from latent to the active phase.

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	3.80-5.30	4.54	4.14	N/A	
Hgb	12.0-15.8	13.8	12.9	N/A	
Hct	36.0-47%	38.0	36.9	N/A	
Platelets	140-440	265	258	N/A	
WBC	4.00-12.0	6.04	10.30	N/A	
Neutrophils	47.0-73.0%	50	71.1	N/A	
Lymphocytes	18.0-42.0	18.5	19.4	N/A	
Monocytes	4.0-12.0	4.8	6.0	N/A	
Eosinophils	0.0-5.0%	0.3	3.2	N/A	
Bands	0-0.2	0.1	0.1	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+	n/a	
Rh Factor	(+) (-)	positive	positive	n/a	
Serology (RPR/VDRL)	+	nonreactive	Non reactive	n/a	
Rubella Titer	>1.0	negative	Negative	n/a	
HIV		Non reactive	Non reactive	n/a	
HbSAG	positive/negative	negative	negative	n/a	
Group Beta Strep Swab	positive/negative	negative	negative	n/a	
Glucose at 28 Weeks	70-100	n/a	n/a	n/a	
MSAFP (If Applicable)	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.

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
MCV	80-100	N/A	N/A	N/A	
MCH	26-33	N/A	N/A	N/A	
MPV	9-12	N/A	N/A	N/A	
RDW	12-15	N/A	N/A	N/A	
Ca+	8-10	N/A	N/A	N/A	
BUN	6-20	N/A	N/A	N/A	
Creatinine	0.6-1.3	N/A	N/A	N/A	
Total Protein	6-8.3	N/A	N/A	N/A	
ALB	3.4-5.4	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)	N/A	Neg	N/A	N/A	

Lab Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosbys diagnostic and laboratory test reference*. Elsevier.

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	Fetal heart rate is between 120-150 145bpm
<p>Are there accelerations?</p> <ul style="list-style-type: none"> If so, describe them and explain what these mean (for example: how high do they go and how long do they last?) <p>What is the variability?</p>	<p>Yes, accelerations were greater than 10 x 15.</p> <p>Latent Phase at 14:18</p> <ul style="list-style-type: none"> Frequency 1 -3 minutes Duration 70 seconds Variability mild to moderate <p>Active phase at 17:09</p> <ul style="list-style-type: none"> Frequency 2-3 minutes Duration 70-80 seconds

	<ul style="list-style-type: none"> • Variability moderate
<p>Are there decelerations? If so, describe them and explain the following: What do these mean?</p> <ul style="list-style-type: none"> • Did the nurse perform any interventions with these? • Did these interventions benefit the patient or fetus? 	<p>No decelerations noted.</p>
<p>Describe the contractions: Frequency: Length: Strength: Patient's Response:</p>	<p>moderate, hardly noticeable 2- 3 minutes 60-90 seconds Moderate Tolerating well, the fetus remains stable. Mother is very comfortable and will verbally state when she feels contractions.</p>

EFM reference (APA format):

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.

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

Home Medications (2 required)

Brand/Generic	Prenatal Vitamin	Mucinex (guaifenesin)	n/a	n/a	
Dose	29 mg	200 mg	n/a	n/a	

Frequency	1 daily	1 tab every 4 hours	n/a	n/a	
Route	oral	oral	n/a	n/a	
Classification	Multivitamin	Glyceryl guaiacolate	n/a	n/a	
Mechanism of Action	multivitamins contain essential vitamins and minerals such as folic acid, iron, and calcium which are released to be absorbed.	Starts the removal of mucus from the upper respiratory tract.	n/a	n/a	
Reason Client Taking	Prevent vitamin deficiency during pregnancy	Sinusitis	n/a	n/a	
Contraindications (2)	Iron metabolism disorder that causes an increase in iron storage ulcerated colon	hypersensitivity fever	n/a	n/a	
Side Effects/Adverse Reactions (2)	constipation diarrhea	Dizziness rash	n/a	n/a	
Nursing Considerations (2)	Prenatal vitamins should be taken daily to ensure the woman obtains the	Monitor patient for signs or symptoms of fever, persistent headache, and rash -- Observe for	n/a	n/a	

	necessary vitamins during pregnancy –Patient should avoid taking any OTC products	evidence of hypersensitive oral complication such as a cough lasting longer than 1 week			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	A patient with vitamin B12 deficiency should see a provider before taking folic acid because it could alter certain lab tests regarding B12 but not actually treat the anemia– Past history of drug or alcohol abuse info is needed	Monitor vitals and indications of infection prior to administration of this drug	n/a	n/a	
Client Teaching needs (2)	Maintain a well balanced healthy prenatal diet and following dietary guidelines provided by the prescriber . Store at room temperature away from light and moisture	Instruct patient to take each dose with a full glass of water -- remind patient to increase fluid intake to help lessen secretions	n/a	n/a	

Hospital Medications (5 required)

Brand/Generic	Acetaminophen (Tylenol)	Calcium carbonate (TUMS)	Carboprost (Hemabate)	Oxytocin (pitocin)	Fentanyl (sublimaze)
Dose	975 mg	1,000mg	250mg	10 units	50 mcg
Frequency	Q4H PRN	Q8H PRN	Q15 PRN	once	Q2H PRN
Route	oral	oral	IM	IM	Subcutaneous
Classification	Chemical: nonsalicylate	Antacid	Prostaglandin	Stimulates contraction of the uterus.	Narcotic-analgesic
Mechanism of Action	Inhibits the enzyme cyclooxygenase	Increases level of intracellular and extracellular calcium maintain homeostasis	causing the induction of labour	Prevent hemorrhage	Bind opioid receptors to sites in the CNS, altering perception of and emotional response.
Reason Client Taking	For mild pain	Prevent hypocalcemia	To stimulate contractions	Fetal distress, placenta previa.	The relieve chronic pain
Contraindications (2)	severe hepatic impairment, severe active liver disease	Hypersensitivity to calcium salts Renal calculi	Hypersensitivity to Hemabate Acute pelvic inflammation	Arrhythmias, jaundice	Hypersensitivity or intolerance Mild to moderate pain response
Side Effects/Adverse Reactions (2)	CNS- anxiety, fatigue CV- hypotension	Diaphoresis Flushing	Nausea Vomiting	Monitor vital signs and stop infusion of toxicity occurs.	Diaphoresis agitation
Nursing Considerations (2)	Use cautiously with patients with chronic	Store at room temperature Warm solution at room temperature before parenteral administration.	Monitor uterine contractions Take as ordered	Monitor electrolytes and fluid balance.	Do not give while breastfeeding May decrease respiratory drive.

	malnutrition and severe renal impairment				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess health status And alcohol use before usage	Assess chvosteks and Trousseau's	Access for bleeding Check vital signs	Can cause water intoxication.	Assess vital signs Assess respiratory rate
Client Teaching needs (2)	Take as directed Don't take more than directed	Urge patients to chew chewable tablets before swallowing. Advice to keep at room temperature.	Should be kept refrigerated Rotate sites of injection	Stimulates contraction of the uterus.	Advise patient to take as recommended Avoid alcoholic beverages.

Medications Reference (APA):

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

**Assessment
Physical Exam (18 points)**

GENERAL (0.5 point): Alertness: Orientation: Distress: Overall appearance:	A&O x4. No signs of distress. Complaints of pain with contractions. Patient shows adequate hygiene. Well-groomed and vibrant.
INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Pink, warm, and dry. Rapid recoil 97.8 No rash, bruises wounds, drains, or incisions present. 22
HEENT (0.5 point): Head/Neck: Ears: Eyes:	normocephalic neck midline- no vein distension PERRLA

<p>Nose: Teeth:</p>	<p>Pink conjunctiva. No drainage/redness/bleeding from ears or nose. Clean, white teeth.</p>
<p>CARDIOVASCULAR (1 point): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>Clear S1 and S2. S3,S4 No murmurs or gallops Normal rhythm 2+ pulses palpable <3 sec cap refill</p>
<p>RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>.</p>
<p>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:</p>	<p>Regular diet . Regular diet . 5'7" 329 lbs Last BM within expected ranges. No signs of distention No signs scars No signs drains No signs wounds</p>
<p>GENITOURINARY (5 Points): Bleeding: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size: Rupture of Membranes: Time: Color: Amount: Odor: Episiotomy/Lacerations:</p>	<p>No blood in urine Color, character, and quantity within expected ranges. No clotting or foul odor ROM 1408 pm Clear 240 mL Artificial ROM laceration</p>
<p>MUSCULOSKELETAL (2 points):</p>	<p>.</p>

<p>ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Fall Score: 0</p> <p>Activity/Mobility Status: Independent (up ad lib) Needs assistance with equipment Needs support to stand and walk</p>	<p>.Fall score: 0 Minimal risk. Able to perform ADLs. Mobility status: independent (up ad lib)</p>
<p>NEUROLOGICAL (1 points):</p> <p>MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/></p> <p>Orientation: Mental Status: Speech: Sensory: LOC: Deep Tendon Reflexes:</p>	<p>A&O x4 Educated and cognitive No deficits noted. DTR is present</p>
<p>PSYCHOSOCIAL/CULTURAL (1 points):</p> <p>Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>Pt states she doesn't feel too much pain and is in a great mood. The patient is calm and talkative. The patient enjoys repositioning and breathing to reduce pain. The patient lives at home with the mother to assist with support. The client lives out of town in Danville, where their family will be able to support her.</p>
<p>DELIVERY INFO: (1 point)</p> <p>Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:</p>	<p>Patient did not deliver today, but she is expected to be born 07/28/2020</p> <p>Male</p> <p>Patient wants to breastfeed.</p>

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	90	136/62	18	99.4	95%
Admission to Labor/Delivery	80	117/65	18	97.5	97%

During your care	80	128/66	16	97.5	97%
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Vital Sign Trends:

Vital signs remained in expected ranges, Blood pressure was elevated upon admission and during my care. When an individual is anxious or stressed prior to the labor processes, pulse, temp, and blood pressure may increase (Ricci et al., 2017).

Reference:

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

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1500	2 numeric scale of 1-10	back	dull	cramping	Deep breathing
1700	6 numeric scale of 1-10	back	Moderate	Cramping	Deep breathing refuse

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	18 gauge Dorsal right hand 07/15/2020 No signs of erythema, drainage, bruises, dry, and intact.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
145	240

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.
Internal contraction monitoring (N)	Continuously	Monitors accurate contraction frequency and fetal response to contractions.
Deep breathing (N)	Continuously	This is recommended due to the mother refusing medication for pain and wanting a non-pharmacological method of treatment.
Repositioning	hourly	Monitor vital signs and drop in blood pressure preventing fetal compression of cord and provide comfort.

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) <ul style="list-style-type: none">How did the patient/family respond to the nurse’s actions?Client response, status of goals and outcomes, modifications to plan.
1. Anxiety could be related to preterm labor as evidenced	This patient's first time as a mother. Her and mother are supporting each other. Mother is a single mother but has a	1. Allow the patient to express her emotions about anxiety. Rationale: Addressing issues of anxiety often ten to help patients redirect their feelings with nurses to identify what is the cause and how to treat it. 2. Instruct all activities,	This patient felt relieved after being educated during the latent stage. The patient knows that there are multiple sources of support, such as groups or online blogs, to help out if needed. Also, knows to ask nurses questions if she does not

<p>by the first child.</p>	<p>boyfriend she is very anxious.</p>	<p>procedures, or issues that involve a newborn. Nurses Role to educate these new moms on what to expect.</p> <p>Rationale Educating the patient will decrease anxiety levels and distress that may follow and finding coping methods to assist.</p>	<p>understand anything.</p>
<p>2. Deficient knowledge related to progression of labor as evidenced by verbal concerns stating “what happens after water breaks”.</p>	<p>Patient is questioned about having artificial rupture of the membrane.</p>	<p>1. Assist in education on pregnancy stages Rationale; Awareness of what to expect throughout the stages of pregnancy allows for improved intended outcomes. 2. Administer educational handouts Rationale: The client needs education to safely navigate through her pregnancy being first time mother and AMA (Ricci et al, 2017).</p>	<p>The client responded well to the teaching plan. She exhibits increased knowledge from her visit today. Goals have been met no modifications needed.</p>
<p>3. Acute pain related to uterine contraction evidenced by stating “my pain is by 6/10 and it hurts.</p>	<p>Patient ask if there is any other methods to relieving pain without medication</p>	<p>1. Repositioning patient to side light Rationale The patient was feeling uncomfortable with infant pressure. Turning patients allows for more blood flow for both newborn and mother. 2. Teach deep breathing exercise Rationale: This technique allows the infant to relax as each contractions come and control pain levels</p>	<p>Patient was happy to be taught these techniques and understand the importance of changing position, as well as deep breathing exercise. The patient responds well to treatment although contractions are progressing.</p>
<p>1. Risk of impaired urinary elimination related to gravid uterus as evidenced by urinary frequency</p>	<p>Increase in urinary elimination and frequency related to pregnancy term</p>	<p>1. Teach client to perform pelvic floor strengthening exercises Rationale: Have client contract pelvic muscles while urinating and stop urine midstream, hold for 3-6 seconds, then release. (Swearing & Wright, 2019). 2. Perform kegel exercises 1-2x throughout day Rationale: contract while in upright position</p>	<p>Client responded well to the teaching. She is excited to start these exercises at home once the child is delivered .</p>

Other References (APA)

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

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