# N432 Labor & Delivery Care Plan

Lakeview College of Nursing

Savannah Woods

## Demographics (3 points)

| | | | |
|---|---|---|---|
| **Date & Time of Admission 7/15/2020 @ 1930** | **Patient Initials A.N.W.** | **Age 20** | **Gender Female** |
| **Race/Ethnicity White** | **Occupation Rush Trucking Centers** | **Marital Status Single** | **Allergies Sulfa antibiotics** |
| **Code Status Full** | **Height 5'5** | **Weight 200 lbs.** | **Father of Baby Involved Yes** |

## Medical History (5 Points)

**Prenatal History: PT attended all prenatal visits, was up to date on immunizations and took her prenatal vitamins**

**Past Medical History: ADHD**

**Past Surgical History: Gallbladder surgery**

**Family History: Mother- diabetes, hypertension, alcohol abuse**

**MGM- Heart Attack MGF: Heart Attack**

**Social History (tobacco/alcohol/drugs): occasional smoker**

**Living Situation: lives with boyfriend**

**Education Level: high school**

## Admission Assessment

**Chief Complaint (2 points): Rupture of membranes**

**Presentation to Labor & Delivery (10 points): PT came to L&D, leakage of fluid at around 1830, fetal movement palpated, ultrasound showed baby was breech**

## Diagnosis

**Primary Diagnosis on Admission (2 points): cesarean section**

**Secondary Diagnosis (if applicable): breech**

## 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):**

**Contractions are irregular, mild, occurring every 5-30 min and last 30-45 seconds during the latent phase of the first stage of labor. Client came into Labor and Delivery around 1930, after feeling a leakage of fluid around 1830 on 7-15-2020. Client was 38 weeks gestation, classifying her as term. Around 2040 client was 3cm dilated/ 50% effaced/ -3 station. In her prenatal ultrasounds her baby was breech and is still breech upon admission. Due to baby still being breech, baby was delivered by cesarean section that started at 2247, baby was delivered at 23:24, c-section officially ended at 0011. Client lost 900ml of blood during procedure, is being given fluids and monitoring for hemorrhage and dehydration due to fluid loss.**

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

Lynn, P. (2019). *Taylor's clinical nursing skills: a nursing process approach*. 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 10(6)/mcL | NA | 4.01 | NA | |
| Hgb | 12.0-15.8 g/dL | 12.4 | 12.4 | NA | |
| Hct | 36.0-47.0% | 36.6% | 36.6% | NA | |

| | | | | | |
|---|---|---|---|---|---|
| **Platelets** | **140-440 10(3)/mcL** | **NA** | **255** | **NA** | |
| **WBC** | **4.00-12.00 10(3)/mcL** | **NA** | **18.40** | **NA** | **Bacterial infection (positive group beta strep)** |
| **Neutrophils** | **47.0-73.0%** | **NA** | **78.3** | **NA** | **Infection, inflammation** |
| **Lymphocytes** | **18.0-42.0%** | **NA** | **14.0** | **NA** | **Infection** |
| **Monocytes** | **4.0-12.0%** | **NA** | **6.5** | **NA** | |
| **Eosinophils** | **0.0-5.0%** | **NA** | **0.5** | **NA** | |
| **Bands** | **NA** | **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 | Value on Admission | Today's Value | Reason for Abnormal |
|---|---|---|---|---|---|
| **Blood Type** | **O, A, B, AB** | **A** | **A** | **A** | |
| **Rh Factor** | **+/-** | **-** | **-** | **-** | |
| **Serology (RPR/VDRL)** | **Negative** | **Nonreactive** | **Nonreactive** | **nonreactive** | |
| **Rubella Titer** | **Immune** | **Immune** | **Immune** | **Immune** | |
| **HIV** | **Negative** | **Not detected** | **Not detected** | **Not detected** | |
| **HbSAG** | **Negative** | **Not detected** | **Not detected** | **Not detected** | |
| **Group Beta Strep Swab** | **Negative** | **Positive** | **NA** | **NA** | **Bacterial infection of vagina** |
| **Glucose at 28 Weeks** | **65-140mg/dL** | **82** | **NA** | **NA** | |
| **MSAFP (If Applicable)** | **Normal risk** | **NA** | **NA** | **NA** | |
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**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 |
|---|---|---|---|---|---|
| **NA** | | | | | |
| **NA** | | | | | |
| **NA** | | | | | |
| **NA** | | | | | |
| **NA** | | | | | |
| **NA** | | | | | |
| **NA** | | | | | |
| **NA** | | | | | |
| **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 Admission | Today's Value | Explanation of Findings |
|---|---|---|---|---|---|
| **Urine protein/creatinine ratio (if applicable)** | **NA** | | | | |

**Lab Reference (APA):** *Tests Index*. Lab Tests Online. https://labtestsonline.org/tests-index.

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

| Component of EFHM Tracing | Your Assessment |
|---|---|
| **What is the Baseline (BPM) EFH?** | **140bpm** |
| **Are there accelerations?**<br>• **If so, describe them and explain what these mean (for example: how high do they go and how long do they last?)**<br><br>**What is the variability?** | **On strip one there is a moderate to 160, lasting 40 seconds. On the second strip there is one acceleration to 165, that last 30 seconds. Accelerations are good, they reassure fetal health.**<br><br>**Moderate** |
| **Are there decelerations? If so, describe them and explain the following: What do these mean?**<br>o **Did the nurse perform any interventions with these?**<br>o **Did these interventions benefit the patient or fetus?** | **There were no decelerations** |
| **Describe the contractions:**<br>**Frequency:**<br>**Length:**<br>**Strength:**<br>**Patient's Response:** | **Strip1:**<br><br>**Frequency: every 3-4 minutes**<br><br>**Length: 30 seconds**<br><br>**Strength: mild-moderate**<br><br>**Patients response: NA**<br><br>**Strip2:**<br><br>**Frequency: every 3 minutes** |

| | |
|---|---|
| | **Length: 20 seconds**<br><br>**Strength: mild-moderate**<br><br>**Patients response: NA** |

**EFM reference (APA format):** Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing*. 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** | **Cholecalciferol (vitamin D3)** | **Aspirin** | | | |
|---|---|---|---|---|---|
| **Dose** | **25 mcg** | **81 mg** | | | |
| **Frequency** | **Daily** | **PRN** | | | |
| **Route** | **Oral** | **Oral** | | | |
| **Classification** | **Supplement** | **Anti-inflammatory** | | | |
| **Mechanism of Action** | **Increased calcium absorption** | **Blocks the activity of cyclooxygenase** | | | |
| **Reason Client Taking** | **Kept D3 level** | **Pain, swelling** | | | |
| **Contraindications (2)** | **Allergy to D3, history of high calcium** | **Asthma, bleeding problems** | | | |
| **Side Effects/Adverse Reactions (2)** | **Possible rash or itching (rare)** | **Diarrhea, GI bleeding** | | | |
| **Nursing Considerations (2)** | **Caution in diabetic** | **Don't crush time released** | | | |

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|---|---|---|---|---|---|
| | **patients, caution in liver disease patients** | **tablets, ask about tinnitus** | | | |
| **Key Nursing Assessment(s)/Lab(s) Prior to Administration** | **Monitor D3 levels, may interact with phosphate binders** | **Monitor platelets, assess for excessive bruising** | | | |
| **Client Teaching needs (2)** | **Do not use medications containing calcitriol, may interfere with your cholesterol tests** | **Take with food, stop taking if bloody or tarry stool occurs** | | | |

**Hospital Medications (5 required)**

| **Brand/Generic** | **Docusate sodium** | **Ketorolac (Toradol)** | **Metoclopramide (Reglan)** | **Ondansetron (Zofran)** | **Acetaminophen** |
|---|---|---|---|---|---|
| **Dose** | **100mg** | **30mg** | **10mg** | **8mg** | **650mg** |
| **Frequency** | **Daily** | **Every 6 hrs.** | **PRN 6 hrs.** | **PRN 12 hrs.** | **PRN 4 hrs.** |
| **Route** | **Oral** | **Intravenous** | **Intravenous** | **Intravenous** | **Oral** |
| **Classification** | **stool softener** | **Analgesic** | **Upper GI stimulant** | **Antiemetic** | **Nonopioid analgesic** |
| **Mechanism of Action** | **Increases water absorption** | **Blocks cyclooxygenase** | **Antagonizes the inhibitory effect of dopamine on the GI smooth** | **Reduces nausea and vomiting** | **Pain management** |

| | | | | | |
|---|---|---|---|---|---|
| | | | **muscle** | | |
| **Reason Client Taking** | **constipation** | **pain** | **Heartburn** | **Prevent postoperative nausea** | **Pain** |
| **Contraindications (2)** | **Hypersensitivity to docusate salts, nausea** | **Renal impairment, peptic ulcer disease** | **Hypersensitivity to metoclopramide, seizure disorders** | **Use of apomorphine, congenital long QT syndrome** | **Hepatic impairment, liver disease** |
| **Side Effects/Adverse Reactions (2)** | **Stomach cramps, diarrhea** | **Edema, hyperglycemia** | **Anxiety, confusion** | **Agitation, anxiety** | **Constipation, fatigue** |
| **Nursing Considerations (2)** | **Expect long term use to cause dependence, expect possible electrolyte imbalances** | **Avoid in patients with recent MI, give IV over at least 15 seconds** | **Should not be used in patients with depression, use cautiously in pt.'s with hypertension** | **Dilute in 50 ml D5W or normal saline if indicated, know if hypokalemia or hypomagnesemia is present** | **Use cautiously in patients with hepatic impairment, don't confuse a dose in milligrams with a dose in milliliters** |
| **Key Nursing Assessment(s)/ Lab(s) Prior to Administration** | **Assess for laxative abuse** | **Monitor for GI bleed, use cautiously in patients with hypertension** | **Asses for intestinal obstruction, don't need to dilute 10 mg or less** | **Monitor for signs of hypersensitivity, monitor patient's electrocardiogram** | **Monitor renal function in patients on long term therapy, monitor the end of a parenteral infusion for air embolism** |
| **Client Teaching needs (2)** | **Encourage fiber intake, notify provider if experience rectal bleeding** | **Report any blood in urine, report blood in stool** | **Avoid alcohol, watch for involuntary movements of face** | **Report rash, report if worsening of nausea symptoms** | **Tablets can be crushed or swallowed, do not exceed recommender dosage** |

**Medications Reference (APA):** Jones & Bartlett Learning. (2019). *2019 Nurse's drug handbook.*

## Assessment

**Physical Exam (18 points)**

| | |
|---|---|
| **GENERAL (0.5 point):**<br>**Alertness:**<br>**Orientation:**<br>**Distress:**<br>**Overall appearance:** | **Appears alert and oriented x3, well groomed, no acute distress** |
| **INTEGUMENTARY (2 points):**<br>**Skin color:**<br>**Character:**<br>**Temperature:**<br>**Turgor:**<br>**Rashes:**<br>**Bruises:**<br>**Wounds/Incision:** .<br>**Braden Score:**<br>**Drains present: Y☐ N ☒**<br>**Type:** | **Pt skin color good for race, warm and dry, turgor <3, no rashes, bruises, or wounds noted, except for client cesarian incision which has no issues noted**<br><br>**Client did have a drain in her cesarian incision, has since been removed** |
| **HEENT (0.5 point):**<br>**Head/Neck:**<br>**Ears:**<br>**Eyes:**<br>**Nose:**<br>**Teeth:** | **Head and neck are symmetrical, trachea is midline without deviation, thyroid is not palpable, no noted nodules, septum is midline, sinuses nontender, sclera is white, cornea clear, conjunctiva is pink, no visible drainage, lids are moist and pink without lesions or discharge noted, teeth are clean and well kept**<br><br>. |

| | |
|---|---|
| **CARDIOVASCULAR (1 point):**<br>**Heart sounds:**<br>**S1, S2, S3, S4, murmur etc.**<br>**Cardiac rhythm (if applicable):**<br>**Peripheral Pulses:2+ throughout**<br>**Capillary refill:<3**<br>**Neck Vein Distention: Y ☐ N ☒**<br>**Edema Y ☐ N ☒**<br>**Location of Edema:** | **Clear S1 and S2 without murmurs gallops or rubs, PMI at 5th intercostal space** |
| **RESPIRATORY (1 points):**<br>**Accessory muscle use: Y☐ N ☒**<br>**Breath Sounds: Location, character** | .<br>**Respirations are regular and nonlabored, symmetrical, lungs sound clear throughout bilaterally, no wheezes or crackles noted** |
| **GASTROINTESTINAL (5 points):**<br>**Diet at Home: Normal**<br>**Current Diet: Normal**<br>**Height: 5'5**<br>**Weight:200 lbs.**<br>**Auscultation Bowel sounds:**<br>**Last BM: this morning**<br>**Palpation: Pain, Mass etc.:**<br>**Inspection:**<br>**Distention:**<br>**Incisions:**<br>**Scars:**<br>**Drains:**<br>**Wounds:** | **Bowel sounds are normoactive in all four quadrants, no current pain, no organomegaly or masses, no distension, incisions, scar from gallbladder surgery, drain has been removed, client has cesarian incision that has no issues noted** |
| **GENITOURINARY (5 Points):**<br>**Bleeding:**<br>**Color:**<br>**Character:**<br>**Quantity of urine: 300ml**<br>**Pain with urination: Y ☐ N ☒**<br>**Inspection of genitals:**<br>**Catheter: Y ☒ N ☐**<br>**Type: indwelling single lumen**<br>**Size:10**<br>**Rupture of Membranes:**<br>**Time: 1930**<br>**Color: meconium thin**<br>**Amount: 900ml**<br>**Odor: none**<br>**Episiotomy/Lacerations: C-section** | **No blood in urine, urine is dark yellow orange suspected from dehydration due to fluid loss, genitals are clear of any lesions or wounds** |
| **MUSCULOSKELETAL (2 points):**<br>**ADL Assistance: Y☐ N ☒** | **Pt has obtained use of lower extremities following epidural, no DVT tenderness** |

| | |
|---|---|
| **Fall Risk: Y ☐ N☒**<br>**Fall Score:**<br>**Activity/Mobility Status:**<br>**Independent (up ad lib) ☐**<br>**Needs assistance with equipment ☐**<br>**Needs support to stand and walk☐** | |
| **NEUROLOGICAL (1 points):**<br>**MAEW: Y ☒ N☐**<br>**PERLA: Y ☒ N☐**<br>**Strength Equal: Y ☒ N ☐ if no -**<br>**Legs ☐ Arms ☐ Both ☐**<br>**Orientation:**<br>**Mental Status:**<br>**Speech:**<br>**Sensory:**<br>**LOC:**<br>**Deep Tendon Reflexes:** | **Pt is alerted and oriented x3, speaks well, and understands when communication with her** |
| **PSYCHOSOCIAL/CULTURAL (1 points):**<br>**Coping method(s):**<br>**Developmental level: appropriate for age**<br>**Religion & what it means to pt.:**<br>**Personal/Family Data (Think about home environment, family structure, and available family support):** | **Smokes on occasion** |
| **DELIVERY INFO: (1 point)**<br>**Delivery Date: 7/5/2020**<br>**Time: 23:24**<br>**Type (vaginal/cesarean): cesarean**<br>**Quantitative Blood Loss: 900ml**<br>**Male or Female: female**<br>**Apgar's: 8 @ 1, 9 @ 5**<br>**Weight:7 lbs. 3.7 oz**<br>**Feeding Method: breastfeeding** | |

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

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|---|---|---|---|---|---|
| **Prenatal** | **74** | **111/57** | **18** | **98.3** | **98** |
| **Admission to**<br><br>**Labor/Deliver** | **100** | **144/58** | **18** | **98.3** | **95** |

| | | | | | |
|---|---|---|---|---|---|
| **y** | | | | | |
| **During your care** | **78** | **98/44** | **16** | **98.5** | **99** |

**Vital Sign Trends: Patients vital signs were generally normal, except for her blood pressure. Her prenatal BP and postpartum BP were both low, patient says it's normal for her BP to be low.**

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

| Time | Scale | Location | Severity | Characteristics | Interventions |
|---|---|---|---|---|---|
| **0900** | **0-10** | **At incision site** | **4** | **Sharp** | **Meds administered** |
| **1629** | **0-10** | **NA** | **0** | **NA** | **NA** |

**IV Assessment (2 Points)**

| IV Assessment | Fluid Type/Rate or Saline Lock |
|---|---|
| **Size of IV: 20 g**<br>**Location of IV: top of right hand**<br>**Date on IV: 7/15/2020**<br>**Patency of IV: patent/open**<br>**Signs of erythema, drainage, etc.: none**<br>**IV dressing assessment: clean and dry** | General fluids for hydration currently |

**Intake and Output (2 points)**

| Intake (in mL) | Output (in mL) |
|---|---|
| **NA** | **1900ml** |

**Nursing Interventions and Medical Treatments during Labor & Delivery (6 points)**

| Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them, | Frequency | Why was this intervention/ treatment provided to this patient? Please give a short rationale. |
|---|---|---|

| | | |
|---|---|---|
| **identify medical treatments with "T" after you list them.)** | | |
| Administer pain meds (T) | **PRN** | **Occasional pain at incision site** |
| Provide water (N) | **Constant** | **Patient lost 900ml of blood in c-section, need to get her hydrated** |
| **Educate on breast feeding (N)** | **When needed** | **Patients first child, needed instruction and additional information regarding breastfeeding** |

**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. **Risk for acute pain related to c-section as evidenced by occasional sharp sensation** | **Pt voiced occasional pain at incision site** | 1. Assess site **Rationale: make sure there is no redness or bleeding** 2. Administer medications **Rationale: blocks pain impulses** | **Patient is doing well after pain medications** |
| 2. **Risk for infection related to c-section as evidenced by incision wound** | **Wounds have a risk of getting infected if not cared for properly** | **1. assess for signs and symptoms of infection Rationale: discharge, redness, swelling can be an indicator of infection** 2.make sure incision is clean and dry | **Patient understands need for assessment of site** |

| | | | |
|---|---|---|---|
| | | **Rationale: helps prevent growth of bacteria** | |
| **3. Deficient fluid volume related to c-section as evidenced blood loss** | **Patient lost 900 ml of blood in procedure** | **1. monitor patients urine output<br>Rationale: color and volume can be an indicator for dehydration<br>2. monitor patients' intake<br>Rationale: continuous fluid infuses and drinking water will help with fluid deficit** | **Patient is willing to drink more water to help increase her fluid volume** |
| **4. Risk for infection related to UTI as evidenced by urinary catheter** | **Patient still has catheter in so that nurse can monitor her urine better** | **1. make sure catheter is clean<br>Rationale: helps prevent bacteria from getting in the urinary tract<br>2. empty bag often<br>Rationale: monitors the color and amount of urine as well as prevents back up** | **Patient understands the need to keep her catheter in until nurse is comfortable with her hydration level** |

**Other References (APA):** Swearingen, P. L. (2016). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, psychiatric nursing care plans*. Elsevier/Mosby.