Clinical Management of The Growing Family Case Study

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NURS333: Clinical Management of The Growing Family

Ms. Elizabeth Marshall

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The purpose of this paper is to conduct an in-depth assessment of a childbearing woman and her family in order to plan nursing care specific to that client, based on nursing research and AWHONN Standards of Care. The assessment will include the appropriate physiological, psychological, social, cultural, and environmental influences pertaining to the client and her family as it relates to preconception, conception, antepartum, intrapartum, postpartum, and neonatal care.

M.C. is a 38-year-old Hispanic female. She is Roman Catholic and states that she tries to attend church every Sunday. The patient is partnered with the father of the baby and reports good support systems. The patient has had over five pregnancies which classifies as Grand Multigravida with G14 T4 P3 A6 L7. She has a history of preterm delivery, four of her previous pregnancies were complicated by a shortened cervix and three of the pregnancies resulted in preterm delivery despite the interventions. A cervical cerclage was placed on December 21st, 2021, to prevent premature birth during her most recent pregnancy. Additionally, in 2004 her pregnancy resulted in Intrauterine Fetal Demise (IUFD) at 39.1 weeks gestation due to a nuchal cord accident. M.C. was diagnosed with Hypothyroidism secondary to Hashimoto's disease in 2014 and in her current pregnancy she was diagnosed with Gestational Diabetes due to a hemoglobin A1c of 7.0 in October of 2021. Lastly, she has a history of a Pulmonary Embolism in 2017 that was developed two weeks postpartum.

The patient presented to Labor and Delivery triage on May 25th, 2022, complaining of increased contractions since her last obstetrics (OB) visit. She denied spontaneous rupture of membrane (SROM), leakage of fluid, vaginal bleeding, headache, vision changes, chest pains,

right upper quadrant pain, or shortness of breath (SOB). The patient reported good fetal movement.

Intrapartal Procedures

During the patient's initial assessment, a sterile vaginal exam (SVE) was conducted. The patient was six centimeters dilated, sixty percent effaced, and the fetus was at a negative two station. Intravenous access was started with a 20 gage on the left antecubital fossa and a continuous Lactated Ringers (LR) infusion was set at 125 mL/hr. On May 26th, 2022, at 0015 spontaneous rupture of membranes occurred.

The patient denied an epidural and stated that she wanted to have a natural birth. She also requested delayed cord clamping, skin to skin, and would like the father to cut the umbilical cord. A foley catheter was placed to prevent urinary retention so it would not interfere with fetal descent. While working alongside the registered nurse, I educated the patient on the use of the peanut ball and how it can assist in the labor process. We repositioned the patient every thirty minutes and made sure that the patient was comfortable. Additionally, we educated the patient on the medications and vaccines the infant can receive after birth which included Erythromycin ointment, a Vitamin K shot, and a Hepatitis B vaccine. Erythromycin ophthalmic ointment is prophylaxis to prevent Ophthalmia Neonatorum in newborns, the Vitamin K injection is prophylaxis to prevent Vitamin K deficiency bleeding of the newborn, and the Hepatitis B vaccine is for immunizing the newborn against infection caused by all known subtypes of the Hepatitis B virus (Lowdermilk et al., 2020).

Initially, the patient's contractions were four to five minutes apart and the duration was about sixty to ninety seconds. The intensity of the contractions was about fifty millimeters of mercury (mmHg). Oxytocin was administered to the patient at two milliunits a minute. Oxytocin

is a hormone produced in the posterior pituitary gland that stimulates uterine contractions and aids in milk ejection, it is primarily used for labor induction, augmentation, and to control postpartum bleeding (Lowdermilk et al., 2020). A fetal strip review was conducted every fifteen minutes to observe for variability, accelerations, and decelerations. The baseline fetal heart rate (FHR) was about 140 beats per minute with moderate variability ranging from six to twenty-five beats per minute. Only accelerations were present in the beginning, however, a few hours after receiving Oxytocin the registered nurse and I noticed that late decelerations were present. The nurse and I immediately reduced the amount of Oxytocin the patient was receiving, turned the patient on her left side, and administered 200 mL of IV bolus. This ended up stopping the late decelerations, however, we constantly monitored the fetal strip for any new changes.

The first stage of labor was the longest stage. This included the latent phase, active phase, and transition phase. The patient was admitted during the first stage of labor and had already experienced the latent phase and was in the active phase. This was evident because she was six centimeters dilated and her contractions were about four to five minutes apart. Her pain was about a five out of ten due to the increased intensity of the contractions she was experiencing. After being in the active stage of labor for a few hours she moved into the transitional phase once she was fully dilated to ten centimeters. During this time the patient appeared very exhausted and uncomfortable. Her contractions were about two to three minutes apart with strong contractions lasting about sixty to ninety seconds. In the second stage of labor, she had a strong urge to push and was able to push with contractions for about ten minutes until the baby was delivered. After the newborn was delivered the mother entered the third stage of labor and was able to do skin-to-skin contact for a few minutes. This is when the physicians started to massage the uterus until delivery of the placenta took place. Once the delivery of the placenta took place, the patient

moved into the fourth stage of labor and started the recovery process while also being observed for any complications such as abnormal bleeding.

Postpartal Procedures

After the newborn and placenta were delivered, a few of the physicians informed me that they were doing an ultrasound to make sure no pieces of the placenta were left inside the uterus. They explained that if any pieces were left over the mother would most likely not stop bleeding and potentially experience a postpartum hemorrhage. Additionally, I was informed that cord blood had to be collected because the mother's blood type was O positive. Cord blood testing is required for all newborns born to group O and Rh-negative blood types because the mother's body may create antibodies against the fetal blood cells if the infant is Rh-positive. The patient's foley catheter was removed and the patient was instructed to try and use the bathroom once every two hours even if she did not have to go. She was also instructed to change her pad every two to three hours when she used the bathroom and report any large blood clots. An episiotomy did not take place and no lacerations occurred.

The patient stated that she planned on breastfeeding the newborn because she had successfully done so with her previous children. Promotion of breastfeeding occurred within the first hour of birth due to there being a higher chance of successful breastfeeding at this time. It also aids in contracting the uterus and preventing maternal hemorrhage (Lowdermilk et al., 2020). Although this was the patient's seventh living child, the nurse and I was still able to educate the patient on how to properly swaddle, change, feed, and put the baby to sleep. This encouraged the mother to actively participate and promoted newborn and maternal bonding. I informed the patient to try to feed the baby every two to three hours, how to care for the umbilical cord and to not bathe the infant for about ten to fourteen days until the umbilical falls

off naturally, and to place the baby on its back while sleeping and avoiding putting any objects or toys in the crib. Throughout the day I assisted the nurse with additional education that included breast and bottle feeding, car seat safety, shaken baby syndrome, and complications to report such as infection, excessive bleeding, and postpartum depression. We used the teach-back method to determine understanding of the education received.

During the postpartum assessment, the patient's breasts appeared full, smooth, and evenly pigmented. They were warm to the touch with no edema or erythema present. The nipples were erect with stimulation and no fissures or cracks were present. The patient stated that her breasts were slightly tender. A fundal massage was then performed with one hand supporting the bottom of the uterus. This aids the uterus to continue to contract and prevent postpartum hemorrhage. There was no evidence of a boggy fundus, the fundus was firm at the umbilicus. The patient denied difficulty with bowel or bladder function, no abdominal distension was present. Moderate amounts of lochia rubra were present with no large clots observed. The patient was then instructed to report any large amounts of blood or clots. A small amount of edema and bruising was present in the intact perineum. Small hemorrhoids were present, however, the patient stated they were nontender and did not bother her. Lastly, the patient appeared fatigued but elated with the experience and assumed maternal responsibility very quickly. She was often holding or changing the baby when checking in on the patient to see if she needed anything. The patient stated she was experiencing occasional mood swings, and she was not very eager to learn because she was well educated on the teaching points from previous pregnancies.

Case Analysis

The first AWHONN standard I utilized was Standard I, which is assessment (AWHONN Standards for the Nursing Care of Women and Newborns, n.d.). This standard was used

throughout my care and while I conducted intrapartum, postpartum, and newborn assessments. The intrapartum assessment included monitoring the length, duration, and intensity of the contractions. Additionally, the fetal heart rate was assessed every fifteen minutes by monitoring the baseline heart rate, variability, accelerations, and decelerations. The nurse and I also regularly assessed the IV pump to make sure that it was set at the correct rate of infusion and to see if the patient's Lactated Ringers needed to be replaced. Soon after the patient gave birth, a newborn assessment was conducted. While performing skin-to-skin contact, I assisted with assessing to make sure the newborn was breathing and had a patent airway. The newborn was assessed using the Apgar test and had an Apgar score of eight at one minute, eight at five minutes, and ten at ten minutes. Lastly, a postpartum Bubble-He assessment was conducted on the patient. This provided an overview of how the mother is healing both physically and emotionally. The patient was regularly assessed by checking and monitoring vital signs and blood sugars every four hours, documenting the intake and output levels, asking about pain levels, and observing for educational needs.

An additional AWHONN standard of care I used was Standard VIIII, this standard is communication (AWHONN Standards for the Nursing Care of Women and Newborns, n.d.). Communication played a major role in care due to the length of my involvement with the patient. I was with the patient during the intrapartum and postpartum process. During that time, I was able to create a therapeutic relationship with the patient through effective communication which fostered trust between us. At the start of our interaction, I noticed that the patient spoke Spanish with her family and asked if they would feel more comfortable with an interpreter present. The nurse and I then helped to create a plan of care with the patient for the process to which the patient expressed interest in having a natural birth, delayed cord clamping, having the father cut

the cord, and skin-to-skin contact immediately after birth. I made sure to ask for permission and explain why certain procedures and assessments were being performed before they took place. Additionally, I provided education to the patient and her family to inform them on car seat safety, and how to properly change, swaddle, feed, and care for her newborn. I utilized the teach-back method for the patient to ensure complete understanding and answered any questions that the family had. During the whole process, I worked closely with the nurses and physicians to help provide quality care and to help monitor both the fetus's and the patient's health. During our encounter, I ensured that the patient was provided with the best possible treatment that I could provide. Overall, this met the current standards of care and fulfilled the patient's needs and desires to ensure the safest and most comfortable stay while having informed interactions with the staff.

The first nursing diagnosis applicable to this patient was risk for unstable blood glucose. The patient was diagnosed with Gestational Diabetes in October 2021 based on a hemoglobin A1c of 7.0. The patient stated that she had been adhering to the medication regimen ordered by her provider which included 17 units of Lantus subcutaneously every night at bedtime. However, she mentioned that she was trying to eat healthier but had days where she did not follow proper dietary recommendations. I performed blood glucose checks every four hours and her fasting blood glucose levels were 104 mg/dL at 0700 and 98 mg/dL at 1100. I educated the patient on long-term implications and how to minimize risks with lifestyle modifications that included healthy eating and being active as well as medication compliance. Additionally, I encouraged breastfeeding due to added diabetes-related benefits. Early breastfeeding can help stabilize newborn blood sugars, aid in maternal weight loss, and decrease the risk of developing Type 2 Diabetes Meletus (Killion, 2018).

The second nursing diagnosis that was very important is impaired fetal gas exchange. The patient was experiencing tachysystole which is described as having more than five contractions within ten minutes averaged over thirty minutes. Because of this, the fetus started experiencing late decelerations. Late decelerations are caused by a fetal response to transient hypoxemia during a uterine contraction that reduces the delivery of oxygenated blood to the intervillous space of the placenta (Lowdermilk et al., 2020). Integrating an Oxytocin checklist can help improve outcomes and decrease complications of labor. The Oxytocin checklist used in the article "Implementation of Oxytocin Checklist to Improve Clinical Outcomes" included no more than one late deceleration, no more than five contractions in ten minutes, uterus palpates soft between contractions, and along with a few others. If the checklist criteria could not be met due to fetal heart rate abnormalities and abnormal contraction patterns, the oxytocin would be decreased or stopped (Sundin et al., 2018). Although the nurse that I was working with was not using this specific checklist she followed the same rules regarding the fetal heart rate and uterine contraction assessment. When tachysystole was present and the fetus started experiencing late decelerations the nurse and I immediately started interventions and decreased her Oxytocin. We continued to carefully monitor the fetal heart rate along with contractions every fifteen minutes and slowly increased the patient's Oxytocin when it was appropriate. It may be helpful to provide these checklists to Labor and Delivery nurses throughout the country as the checklist resulted in a 14.5% decrease in cesarean births for fetal heart rate abnormalities requiring intrauterine resuscitation as well as a reduction of tachysystole incidences by 63% (Sundin et al., 2018).

The third nursing diagnosis is risk for deep vein thrombosis (DVT). During the patient's pregnancy in 2017, she developed deep vein thrombosis two weeks postpartum which led to a

pulmonary embolism. A pulmonary embolism is a complication of deep vein thrombosis occurring when part of a blood clot dislodges and is carried to the pulmonary artery, where it occludes the vessel and obstructs blood flow to the lungs (Lowdermilk et al., 2020). Because of the patient's history and current pregnancy, she is at an increased risk of developing this complication again. Venous thromboembolism (VTE) can occur in any trimester of pregnancy and in the postpartum period with the highest incidence of postpartum venous thromboembolism being during the first three weeks after birth (Lowdermilk et al., 2020). The interventions I utilized included providing education on deep vein thrombosis and how to reduce the risks such as encouraging leg exercises, early ambulation, frequent position changes, and increased fluid intake. The patient was very cooperative and willing to work with the nurse and I to help reduce her risk for venous thromboembolism. Lastly, I frequently assessed for possible signs and symptoms of deep vein thrombosis which include pain and tenderness in the lower extremities, warmth, and enlarged or hardened veins (Gulanick & Myers, 2021).

Risk Factor

The patient was diagnosed with Hypothyroidism secondary to Hashimoto's disease in 2014. She is currently followed by endocrinology, her most recent lab levels from January 2022 are 7.2 mU/L for thyroid-stimulating hormone (TSH) and 1.3 ng/dL for thyroxine (T4). Although her thyroxine is within normal limits, the patient's thyroid-stimulating hormone is above the normal range. Laboratory values in pregnancy include elevated levels of thyroid-stimulating hormone, with or without low levels of thyroxine. The fetus depends on maternal thyroid hormones until about eighteen weeks gestation. Additionally, normal maternal thyroxine levels in early pregnancy are important for fetal brain development. Hypothyroidism is significant to the patient's health because it is not often seen during pregnancy and when left untreated the

patient is at increased risk for miscarriage, preeclampsia, placental abruption, low birth weight, cognitive impairment of the fetus, preterm birth, and stillbirth (Lowdermilk et al., 2020).

Pathophysiology

The thyroid gland is the largest endocrine gland, it is butterfly-shaped and located in the lower neck. It produced three hormones which include thyroxine (T4), triiodothyronine (T3), and calcitonin. The thyroid undergoes physiologic changes during pregnancy, including an increase in size and a 50% increase in production levels of thyroxine and triiodothyronine while human chorionic gonadotropin (HCG) stimulates thyroid-stimulating hormone receptors resulting in a decrease in thyroid-stimulating hormone reference ranges. These changes can be different for each stage of pregnancy which makes the interpretation of laboratory results for dysfunction difficult (Lowdermilk et al., 2020). Thyroxine and triiodothyronine are needed by all body cells for metabolism, this is important because it is necessary for normal growth and development (Hinkle et al., 2018). Metabolic needs are greatly increased during pregnancy. The most common cause of hypothyroidism in adults is autoimmune thyroiditis, also known as Hashimoto's disease. Normally, your immune system will protect your body by attacking foreign substances such as bacteria and viruses that should not be present. However, with Hashimoto's disease, your thyroid becomes inflamed, and the body makes antibodies that attack the cells in your thyroid and damages the gland. This results in low thyroid hormone levels from the thyroid no longer being able to produce enough. It is more common in women, and the patient is at a higher risk if they have an additional autoimmune disease (John Hopkins Medicine, 2021).

Presenting Symptoms

The presenting symptoms of the patient included thin brittle hair, brittle nails, muscle aches, menstrual irregularities, and fatigue. Additional signs and symptoms of hypothyroidism

include increased weight gain, cold intolerance, deepening of the voice, bradycardia, irritability, and constipation. Advanced hypothyroidism may produce cognitive changes, sleep apnea, pleural effusion, pericardial effusion, elevated serum cholesterol levels, coronary artery disease, and poor left ventricular function. However, myxedema is the most advanced and life-threatening form of hypothyroidism. Myxedema coma is when the individual becomes hypothermic and unconscious, it is often caused by not taking thyroid replacement medicine, infection, systemic diseases, sedatives, or opioid analgesic agents. The mortality rate remains at forty percent which is why proper diagnosis and treatment are essential (Hinkle et al., 2018).

Treatments

Pharmacologic therapy can assist an individual diagnosed with hypothyroidism. The goal of treatment is to restore a normal metabolic state by replacing the missing thyroid hormone, this also includes the prevention of disease progression and potential complications of hypothyroidism. The aim of drug therapy is to maintain the thyroid-stimulating hormone level at the lower end of the normal range for pregnant women. As pregnancy progresses, increased doses of thyroid hormone are usually required (Lowdermilk et al., 2020). Synthetic Levothyroxine is the drug of choice for the treatment of hypothyroidism. The range of prescribed Levothyroxine ranges from about 75mcg to 150mcg per day. Typically, treatment is started at a lower dose and titrated slowly until desired levels of serum thyroid-stimulating hormone concentration are achieved (Hinkle et al., 2018) The patient I was caring for was taking 137mcg of Levothyroxine by mouth once a day at 1800. It is important to perform medication reconciliation for the patients taking Levothyroxine. It may interact with many other medications such as Insulin, Warfarin, and Estrogen.

One of the most important nursing interventions is educating both the patient and family about hypothyroidism. We should first explain what hypothyroidism is and explain the treatment options available to them. Levothyroxine is considered safe while breastfeeding so it would be important to provide that information to the patient (Lowdermilk et al., 2020). As nurses, we must emphasize the importance of medication compliance and inform the patient that it is a lifelong therapy, and that thyroid medication needs to be taken every day. Additionally, is it important that we educate on the signs and symptoms because it is possible that individuals may have continued clinical manifestations despite regulated thyroid-stimulating hormone levels (Hinkle et al., 2018). Although symptoms may improve after treatment the medication should continue to be taken. Discomfort associated with cold intolerance can be minimized by appropriate clothing and regulation of environmental temperatures, as a nurse, we can assist the patient by providing blankets or additional clothing if needed. Lastly, it may be helpful to provide nutritional counseling. It will help teach the patient how to eat well-balanced meals to ensure an adequate intake of nutritional foods to meet both the maternal and fetal needs (Lowdermilk et al., 2020).

Overall, Hypothyroidism can be dangerous and potentially put both the mother and the fetus at risk for complications. However, it is a treatable disease, and it is extremely important to start treatment once the patient is diagnosed to help the body return to a normal metabolic state. Important points to discuss with the patient and her family include the disorder and the potential effect on her, her family, and her fetus (Lowdermilk et al., 2020). The importance of medication adherence should be highly emphasized to improve the outcomes of the mother and her fetus.

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Appendix A

CASE STUDY CLIENT ASSESSMENT

Prenatal Course History	
Age:	M.C. 38 years old DOB: 5/3/1984
Ethnicity/Cultural Background	Hispanic/Latino
Single/Married/Committed Relationship/Sexual Preference	Single but in a committed relationship with boyfriend.
Educational Level	High school with some college.
Occupation	Patient states that she is self-employed.
GTPAL	G14 T4 P3 A6 L7
Past Pregnancies	See below.
Dates of Delivery Outcomes (SVD or C/S) Risk factors Current Status of children	- **1:** 2002 IAB - **2:** 2003 SAB - **3:** 2004, SVD, Fetal Demise due to nuchal cord accident (stillbirth), (Term: 39.1) - **4:** 2005 SAB - **5:** 2006 SAB - **6:** 2007 SAB - **7:** 2008 IAB - **8:** 2009, SVD, Living (Term: 39.0) - **9:** 2010, SVD, Living (Preterm: 36.1) - **10:** 2013, SVD, Living (Preterm: 36.0) - **11:** 2016, SVD, Living (Term: 37.1) - **12:** 2017, premature ROM, transverse lie of fetus, C/S, Living (Preterm: 27.0) - **13:** 12/10/2019, SVD, Living (Term: 37.3) - **14:** 5/26/2022, SVD, Living
LMP/EDC (EDD) Planned pregnancy?	LMP: 9/11/2021 EDC: 6/18/2022 The patient stated that this was a planned pregnancy.
Prenatal Care (Where, when started, number of visits) Number of ultrasounds/significant findings	The patient's prenatal care took place at Sentara Williamsburg Regional Medical Center. She stated her visits started at the end of September and had an appointment about every four weeks until she was 28 weeks, after that she had an appointment about every 2 weeks until her water broke. Three ultrasounds were taken, the patient stated that there were no significant or abnormal findings.

Other testing	Screened negative for CF.
Nutrition/Vitamins (any changes with pregnancy	The patient stated she was trying to eat healthier with more fruits, vegetables, and proteins due to her gestational diabetes. Additionally, the patient stated that she used One a Day Prenatal Vitamins and said it included folic acid, iron, omega 3, vitamin a, vitamin b, vitamin c, vitamin d, and vitamin e.
Gynecological History	Menarche at age 16 Cycles regularly every 24-32 days, however, she stated that she has occasional menstrual irregularities such as spotting. Menses last 3-6 days Last PAP smear was January 2021 and was within normal limits. She has a history of abnormal pap smears in April 2009, December 2009, and January 2014. These included findings of ASCUS and LGSIL. No history of STIs or STDs. The patient denies history of rape or abuse. The patient denies the use of birth control or other contraceptives.
Menarche (onset, duration and frequency), PAP smears, (problems or procedures?), sexual partners, history of rape or abuse. Birth control use.	
Medical or Surgical History	The patient denies history of traumas or childhood diseases. Previous surgeries include cesarean delivery in 2017 due to premature ROM and transverse lie of the fetus. The patient also states that she had her wisdom teeth removed in 2006.
Any traumas? Surgeries Normal childhood diseases?	
Psychological History	The patient denies a history of psychological illnesses and states that she has a previous history of postpartum depression. There is evidence of bonding by the patient actively holding, feeding, and changing the baby.
History of psychological illnesses? History of Postpartum Depression? Evidence of Bonding?	
Social/Cultural Factors	Insurance: Optima Health The patient stated that she owns a house. The patient stated that her religion is Catholic and goes to church on Sundays. The patient stated that she has a good support system and does not currently use community resources. The patient denies tobacco, illicit drug use, or alcohol during the pregnancy.
Health insurance Living quarters Religious or spiritual beliefs Support System Community Resources	
Intrapartal Course	See below.
Initial Assessment Vital signs SVE/SROM/Bleeding/Problems	Vital signs: - Temperature: 98.1F - Pulse: 82 bpm - Respirations: 20 - Blood Pressure 102/57

<table>
<tr><td></td><td>- SpO2: 98
- Pain: 5/10
Initial SVE: 6/60/-2</td></tr>
<tr><td>Fetal Monitoring
External or Internal or Both
FHR Baseline
Reactive/Nonreactive
Accels
Early/Late/Variable Decels?
Risk factors associated with this pregnancy?</td><td rowspan="2">External fetal monitoring
FHR baseline – 150 bpm
Variability: Moderate (6-25 bpm)
Reactive
Accelerations present.
Late decelerations are present. Interventions started immediately.
Fetal strip review q15 minutes.
Risk factors associated with this pregnancy included a history of preterm delivery, history of intrauterine fetal demise (IUFD) due to nuchal cord accident, positive group b strep, the mother’s blood type was O positive, and the mother had gestational diabetes. The mother is also a known carrier of Cystic Fibrosis and a silent carrier of Alpha Thalassemia. FOB was screened negative for CF.</td></tr>
<tr><td>Neonatal Course</td></tr>
<tr><td>Delivery Summary
Gestational age at delivery
SVD or C/S
Forceps or Vacuum</td><td rowspan="2">Gestational age at delivery was 36.5 weeks.
SVD
No forceps or vacuum utilized.
Female
Length – 18.5 in
Weight – 6.2 lbs.
Apgar score
– 1 min: 8
– 5 min: 10
– 10 min: 10
No resuscitation or stimulation required.</td></tr>
<tr><td>Sex, Length/Weight
Apgar score
Resuscitation
(Blow by Oxygen/stimulation/ chest compressions?)</td></tr>
<tr><td colspan="2">Risk Factors
- Hypothyroidism
- Gestational Diabetes
- The patient is 38 years old.
- The patient’s blood type was O positive.
- The patient tested positive for Group B Streptococcus.
- The patient has a history of pulmonary embolism. (DVT: 7/13/2017)
- The patient has a history of preterm delivery, four pregnancies were complicated due to a shortened cervix. Four pregnancies resulted in preterm delivery despite the interventions with included a Mekena injection and Cerclage placement.</td></tr>
</table>

Laboratory Findings	**Pregnancy**	**Postpartum**
Blood type	O positive	O Positive
Rubella titer	Rubella Immune	Rubella Immune
VDRL/RPR (Syphilis)	Non-reactive	Non-reactive
HBsAg (Hep B)	Negative	Negative
GBS (Group B Strep)	Positive	Positive
HIV	Negative	Negative
Chlamydia	Negative	Negative
GC (Gonorrhea)	Negative	Negative
Glucose Screening	93mg/dL	104mg/dL
Liver Enzymes (PIH)	Not available	Not available
Uric Acid (PIH)	Not available	Not available
WBC	7.7 k/uL	6.3 k/uL
RBC	4.24 m/uL	4.19 m/uL
Hct	41.7%	39.1%
Hgb	13.0 g/dL	12.2 g/dL
Urinalysis	Urine culture negative	Urine culture negative
Medications/Dosage/Route	**Purpose**	**Side Effects**
Loperamide (Imodium) - 2mg capsule PO after each loose bowel movement.	Inhibits peristalsis. Controls and relieves the symptoms of acute diarrhea.	Dizziness, drowsiness, fatigue, headache, syncope, cardiac arrest, constipation, abdominal pain, distention, dry mouth, flatulence, nausea, vomiting, rash, and hypersensitivity reactions.

Lactated Ringers (LR) - IV infusion at 125mL/hr continuous PRN.	Replaces water and electrolyte loss.	Discomfort at the injection site, headache, vomiting, nausea, allergic reactions, infection at the injection site.
Levothyroxine (Synthroid) – 137mcg tablet PO daily at 6pm.	Synthetic form of thyroxine that affects the growth of tissues, energy expenditure, and the turnover of all substrates.	Insomnia, tremor, headache, fever, fatigue, anxiety, emotional liability, arrhythmias, MI, diarrhea, vomiting, menstrual irregularities, weight loss, increased appetite, muscle weakness, dyspnea, hair loss, diaphoresis, heat intolerance, and impaired fertility.
Ampicillin – 2g in NS 100mL IVPB	Inhibits cell-wall synthesis during bacterial multiplication.	Seizures, diarrhea, nausea, abdominal pain, black hairy tongue, stomatitis, vomiting, thrombocytopenia, anemia, and overgrowth of nonsusceptible organisms.
Insulin Glargine (Lantus) – 17 units subcutaneously q night at bedtime.	Lowers blood glucose level by stimulating peripheral glucose uptake by binding to insulin receptors on skeletal muscle and in fat cells, and by inhibiting hepatic glucose production; also inhibits lipolysis and proteolysis and enhances protein synthesis.	Headache, pyrexia, peripheral edema, hypertension, pharyngitis, cataract, retinopathy, abdominal pain, nausea, vomiting, diarrhea, UTI, hypoglycemia, sodium retention, weight gain, back pain, URI, bronchitis, cough, injection site reactions, pruritis, rash, allergic reactions, flu-like symptoms, and infection.
Oxytocin (Pitocin) – IV 2 milliunits a minute continuous.	Causes potent and selective stimulation of uterine and mammary gland smooth muscle. It stimulates uterine contractions to aid in labor.	Low Apgar scores, death, neonatal jaundice, arrhythmias, anaphylaxis, uterine rupture, postpartum hemorrhage, abruptio placentae, nausea, vomiting, hypertension.

Appendix B

Honor Code:

"We, the students of Old Dominion University, aspire to be honest and forthright in our academic endeavors. Therefore, we will practice honesty and integrity and be guided by the tenets of the Monarch Creed. We will meet the challenge to be beyond reproach in our actions and our words. We will conduct ourselves in a manner that commands the dignity and respect that we also give to others."

Honor Pledge

"I pledge to support the Honor System of Old Dominion University. I will refrain from any form of academic dishonesty or deception, such as cheating or plagiarism. I am aware that as a member of the academic community, it is my responsibility to turn in all suspected violators of the Honor Code. I will report to a hearing if summoned."

SIGNATURE: Briana Leinart

Appendix C

CLINICAL CASE STUDY GRADING RUBRIC

Grading Criteria **(Use these as your headings)**	**Point Value**	**Points Given**	**Comments**
Introduction Purpose of Assignment Brief Patient Background Reason for Admission	**5**		
Intrapartal Procedures Discuss any invasive or non-invasive procedures during the intrapartum period such as: AROM/SROM/Amnioinfusion/ Significant Lab Values/IV access/Fluid Maintenance/Fluid Bolus/Epidural/Foley/Oxygen/ Position Changes/ Episiotomy/ Comfort Measures/ Teaching/ Focused assessments to include baseline FHR with periodic changes (accels/decels); contraction frequency/intensity; labor progress through first stage with phases/second stage/third stage.	**10**		
Postpartal Procedures Discuss any invasive or non-invasive procedures during the postpartum period such as: Fundal Massage/Fluid Maintenance/Foley/Episotomy or LacerationRepair/Focused Assessments/Hemorrhage control/ Promotion of Maternal and Newborn Bonding/ Teaching/ Comfort Measures/ Promotion of Breastfeeding	**10**		

Case Analysis Does the care provided conform to the current standards of care? Why or why not? Were the client's needs met? **Do not restate the AWHONN standards but identify specific examples of how the standard was met.** You must cite AWHONN Standards of Care in your Bibliography. Look up APA format for this as there is no author. **Identify and prioritize at least 3 nursing diagnoses.** Include contributing factors and evidence to support, nursing interventions and outcomes/with evaluation.	**20**		
Current Literature Select two (2) current references from nursing journals to support your nursing interventions. Both articles **must** be from **nursing journals**. One article **must** be **research**. Current articles are from within the last five years. Submit articles with case study	**10**		
Risk Factor Select one risk factor for your client and discuss the reason you choose this risk factor, i.e., significance to patient health. **Pathophysiology** See your clinical instructor if your client had no identifiable pathophysiology to determine an appropriate topic for this section.	**5**		

Pathophysiology Discuss the pathophysiological processes that occur or could occur with the risk factor you chose.	**10**		
Presenting Symptoms Identify presenting symptoms of your client. In addition, include typical signs and symptoms for this risk factor.	**5**		
Treatments: Discuss all standard medical treatments and nursing interventions, including patient education.	**5**		
Grammar/Syntax **APA format including citations and bibliography** Grading Rubric attached There is an example of a correct APA format paper on blackboard. If you have questions or would like assistance with editing or input, you may ask your clinical instructor for help or the clinical coordinator during class time (Linda Bennington, Phd,RN).	**10**		
Appendix Attach Case study client assessment Be sure it is accurate and thorough to include medications, side effects and purpose, and include significant lab values.	**10**		
Total Points:	**100**		