



# INTRODUCTION





# HOW TO USE THIS BOOK

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According to the American Nurses Association (ANA, 2013), *nursing* is “the protection, promotion, and optimization of health and abilities, prevention of illness and injury, [and] alleviation of suffering through the diagnosis and treatment of human response.” A care plan is a guide for delivering care.

## Nursing and Collaborative Care Plans

Most nurses work in systems in which collaborative (interdisciplinary) practice has become the norm. Furthermore, most patient care is given according to preplanned, computerized, or preprinted standards of care or collaborative pathways—documents that outline the common, shared needs of all patients with a particular condition. For example, all women with gestational hypertension must have their blood pressure assessed, and all women receiving magnesium sulfate for preeclampsia with severe features require assessment of their reflexes and  $\text{MgSO}_4$  levels. For this reason, the care plans in this book are organized according to clinical conditions, e.g., medical diagnoses or treatments such as normal labor, cesarean birth, and amniocentesis. You will need to refer to the table of contents in the front of the book for a list of care plans included in this text.

Many of the needs of childbearing women can be met with a common set of nursing activities; thus, preplanned nursing care plans are an efficient approach. However, nurses must not overlook individual needs—those that are not easily predicted on the basis of the medical diagnosis and that may be unique to a particular woman. Nurses should, therefore, individualize preprinted plans and address individual needs for care.

## Creating a Care Plan

The following are steps to take when using this book to plan care for a patient:

1. Identify the appropriate clinical condition or medical diagnosis, such as antepartum bleeding, normal labor, or mastitis.
2. Locate the medical diagnosis/condition in the table of contents and turn to the page indicated for that diagnosis/condition.
3. Read the introductory material as needed to become familiar with the medical diagnosis/condition. This information is brief and is not intended to replace your primary maternity or obstetrics textbook.
4. To individualize care for a particular woman, refer to the initial subsection under each medical diagnosis entitled “Individualized Nursing Care Plans.” This subsection includes nursing care plans for common problems that are often, but not always, seen with the condition. Your nursing assessment will provide the information you need to choose the appropriate nursing care plans from this subsection. These nursing care plans (NCPs) may also refer you to one or more of the generic care plans in Chapter 2 or collaborative care plans in Chapter 3.
5. Next, refer to the subsection titled “Collaborative Care for All Women With” the medical diagnosis or condition you identified for a description of the care that is needed for women with that condition. These collaborative care plans address potential problems that may or may not occur, such as “Potential Complication of Pregnancy: Hypertensive Disorders.” These care plans are collaborative because nurses cannot address complications of medical diagnoses or conditions independently. The focus of these care plans is on

prevention and assessment. Collaborative care plans in this subsection may also refer you to one or more generic care plans included in Chapter 2 or the collaborative care plans in Chapter 3.

6. The generic care plans in Chapter 2 and collaborative care plans in Chapter 3 represent common nursing care needs and collaborative problems that tend to occur frequently in the care of childbearing women, regardless of their medical diagnosis. For example, the nursing diagnosis, Activity Intolerance<sup>1</sup>, is often seen in women with anemia, cardiac disease, and antepartum hemorrhage. Therefore, information that is appropriate for all women with Activity Intolerance<sup>1</sup>, regardless of their medical diagnosis or of the cause of their intolerance to activity, was placed in this generic care plan in Chapter 2. As another example, “Potential Complication: Preterm Labor,” in Chapter 3, is a potential complication of gestational hypertension, antepartum infections, and premature rupture of membranes; it includes certain nursing activities necessary for assessing and preventing hypertension in all pregnant women, regardless of the medical diagnosis that placed them at risk for hypertension. It can, therefore, be used with the topics “Pregnant Adolescent,” “Gestational Diabetes,” and so forth. The individualized nursing care plans (see step 4) and collaborative care plans (see step 5) will refer you to the generic care plans when it is appropriate to use them. This eliminates the need to repeat generic information countless times in various topics.

## Components of Care Plans in This Book

### Clinical Condition or Topic

Each care plan (or topic) begins with a discussion of the topic, problem, medical diagnosis, or clinical condition (e.g., gestational diabetes, postpartum infection). This section includes a brief overview of the pathophysiology of the condition and enough other information to provide an understanding of the associated nursing and collaborative care needs.

### Key Nursing Activities

This section provides an overview, a sort of road map for the care of a woman with the topic condition. These specific activities are, in very general terms, the most important aspects of nursing activity related to the topic of the care plan.

### Etiologies and Risk (or Related) Factors

This section provides an overview of the etiology (cause) of the condition, if known. Risk factors refer to those conditions that place the woman at increased risk for the condition or medical diagnosis; for example, previous placenta previa, age greater

than 35 years, and multiparity are risk factors for antepartum hemorrhage.

### Signs and Symptoms

The subjective and objective signs and symptoms (clinical manifestations) commonly associated with the clinical condition (topic) are listed in this section. The only chapter that does not contain a signs and symptoms section is Chapter 2, the generic NCP chapter.

### Diagnostic Studies

Studies commonly used to diagnose the condition are provided in this section, along with rationales and/or specific laboratory values.

### Medical Management

Medical management (or treatment) of the condition pertains to those actions that must be performed or prescribed by a physician, midwife, or nurse practitioner, such as treatments, diagnostic tests, and medications. This section provides a brief overview of treatment/management and is not intended to replace a maternity/obstetrics textbook.

### Individualized Nursing Care Plans

The nursing problems and activities listed in these care plans are frequently, but not always, associated with the clinical condition and are not addressed by the collaborative plan of care. (For example, many, but not all, women in preterm labor experience anxiety.) Each of the individualized nursing care plans includes the following:

- *Nursing Diagnosis, e.g., Risk for Postpartum Infection, Anxiety.*<sup>1</sup> This includes the NANDA International title.
- *Related Factors.* These are factors that may be contributing to the condition such as fear of fetal compromise contributes to a woman's anxiety.
- *Goals, Outcomes, and Evaluation Criteria.* These are outcome statements that can be used as evaluation criteria. They are not in standardized language. The nurse should choose any of these that apply to the woman and individualize them based on assessment data. For example, the text may list a goal of 1–2 cm per day for uterine involution; however, for a multigravid woman or a woman with postpartum infection, this may not be achievable.
- *Nursing Activities.* These are nursing activities that are most likely to result in desired patient outcomes. They are not written in standardized language, but are quite specific. Nonetheless, the nurse should individualize them further for each woman. For example, the text may say to “encourage oral fluids,” but for a particular woman, the nurse should specify the exact quantity and type of fluids, such as “Offer sips of water hourly today,” or “Remind the mother to drink 8 oz of water each time she feeds the baby.” Nursing activities for individualized nursing

care plans focus on several aspects of care; therefore, they are subdivided into assessments, independent nursing actions, collaborative activities, and patient/family teaching. Not all categories are addressed in all nursing care plans, however. They are only addressed if they are applicable to that particular plan of care. Note: nursing activities and nursing actions are used interchangeably throughout the book.

- **Rationales.** A rationale is provided for each of the specific nursing activities. Because of space limitations, only basic information is provided. The introductory material for the clinical condition provides further rationales.

### ■ Collaborative Care for All Women [with the Problem or Clinical Condition]

Collaborative problems are *potential* problems. Nursing activities for collaborative care problems focus on preventing, assessing for, and reporting complications; therefore, they are subdivided into focus assessments and preventive nursing activities. For example, focus assessments for all women having hemorrhage will include monitoring heart rate, blood pressure, and pulse pressure; and assessing for visible bleeding. A rationale is provided for each nursing activity.

### ■ Evidence-Based Practice (EBP) Boxes

New to this edition are periodic evidence-based practice boxes, which discuss new findings that are particularly relevant for nurses caring for maternal or newborn patients (such as vaginal cleansing prior to cesarean birth to reduce postpartum infections). These EBP boxes are included to facilitate your knowledge of current research and evidence-based findings involving maternal nursing.

### ■ Quality and Safety Education for Nurses (QSEN)

Much of the content presented in this care plan book is in concert with the Institute of Medicine's (IOM) mandate to improve the quality and safety of patient outcomes. It also supports the Quality and Safety Education for Nurses (QSEN) Institute's goal of preparing nurses with the skills, knowledge, and attitudes required for the provision of quality, safe care wherever they are employed. QSEN's work is based on six competencies: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics (QSEN, 2014)

## EXERCISE ILLUSTRATING HOW TO USE THIS BOOK

A 28-year-old woman who is gravid 6, para 4 at 30 weeks' gestation reported to the emergency department with complaints of vaginal bleeding. The woman stated that her provider informed her that she was at risk for bleeding due to low placental attachment noted on an earlier sonogram. This is her first episode of bleeding. She denies pain and says she has saturated one vaginal pad within the past hour. Discharge is bright red.

On assessment the nurse notes that the woman's oral temperature is 98.2°F, heart rate 90 beats/min, blood pressure 112/64, and respirations are 24/min. Fetal heart rate (FHR) is 140 beats/min with average variability. Uterine contractions (UCs) are absent. She is obviously anxious, tears occasionally, and voices concern about the welfare of her baby.

1. **Identify the appropriate clinical condition or medical diagnosis based on cues from the woman's data.** Many times this will be the admitting diagnosis in the woman's record. In this case, the data support the presence of *placenta previa*, based on sonographic evidence of low placental attachment and painless, vaginal bleeding at 30 weeks' gestation. You can confirm this by looking up late antepartum bleeding (placenta previa and abruptio placenta) in the table of contents and reading about the etiologies and signs and symptoms of antepartum bleeding on pp. XX in Chapter 6.

#### Cues (Data)

- ▶ History of low placental attachment: predisposes the woman to bleeding
- ▶ Bright red vaginal bleeding: objective indication of placenta previa
- ▶ Absence of pain: subjective indication of placenta previa
- ▶ Absence of UCs: UCs are absent in 80% of women with vaginal bleeding
- ▶ Normal FHR: indicates maternal blood loss rather than fetal compromise
- ▶ 30 weeks' gestation: time during which upper and lower uterine segments begin to differentiate and cervix begins to dilate
- ▶ Tearing: subjective indication of fear/anxiety
- ▶ Expression of concern regarding welfare of fetus: subjective indication of fear

2. **Look at the "Individualized Nursing Care Plans" section beginning on p. 5.** You will select the care plan or plans that best suit the woman's individual needs and add them to her plan of care.

**Nursing Care Plan for the Woman Experiencing: Nursing Diagnoses.** Identify the nursing diagnoses that are appropriate for this particular woman. This section lists several care plans for women experiencing

various nursing diagnoses that are commonly seen with acute antepartum bleeding: placenta previa. This woman *does not* have data to support the nursing care plan for the woman experiencing Interrupted Family Processes,<sup>1</sup> or Acute Pain;<sup>1</sup> therefore, there is no need to include either of these nursing diagnoses in this patient's plan of care. Based on the cues (data) in this case, you should include the care plan for the woman experiencing Anxiety/Fear<sup>1</sup> related to fear of fetal compromise.

**Goals, Outcomes, and Evaluation Criteria.** For each nursing care plan, choose the goals, outcomes, and evaluation criteria that best fit the woman's data and individualize them as needed. For this woman,<sup>1</sup> you might use:

- ▶ Displays no physical symptoms of anxiety (e.g., trembling, pallor, or facial tension)
- ▶ Concentrates and participates in decision making regarding own care and treatment
- ▶ Identifies and uses support persons (e.g., partner, caregivers)

**Nursing Activities.** For each nursing care plan (for this woman, only Anxiety/Fear<sup>1</sup>), choose the nursing activities most likely to achieve the outcomes you have selected. The rationale provided should help you to decide which activities are appropriate. Individualize them as necessary. For this woman's nursing care plan of Anxiety/Fear,<sup>1</sup> nursing orders on a care plan might include:

- ▶ Teach use of relaxation techniques such as slow, purposeful deep breathing; guided imagery; and progressive muscle relaxation.
- ▶ Explain all tests and procedures, including sensations likely to be experienced.

Note that the nursing care plan for Anxiety/Fear<sup>1</sup> also refers you to the generic NCP for Anxiety /Fear<sup>1</sup> on pp. 10–11 in Chapter 2. Therefore, you should include appropriate goals and nursing activities from that generic NCP in your plan of care for this woman, too.

**Other Nursing Care Planning.** At the end of the content about some clinical conditions, although not included in the care plan on acute antepartum bleeding (placenta previa and abruptio placentae), you may find a list of additional nursing care plans that may accompany the clinical condition but are not commonly seen. Review this list to determine whether you should add any of these to the care plan. Not all clinical conditions include a list of other nursing diagnoses.

3. **Now look at the “Collaborative Care” section, beginning on p. XX, for a description of the care that is needed for all women with late antepartum bleeding as a result of placenta previa.** The collaborative problem, Potential Complication of Placenta Previa: Hemorrhage, Hypovolemic Shock, DIC, applies to this woman, as it would to any woman with antepartum vaginal bleeding. Add the focus assessments and preventive nursing activities in this section to the woman's care plan. Individualize them as necessary; for example, for “Promote nutritional food intake,” you would add this particular woman's food preferences.

Follow the same procedure for the rest of the collaborative care plans (potential complications) for late antepartum bleeding (placenta previa and abruptio placentae), because in any woman with antepartum bleeding, including the woman in this exercise, the complications of preterm labor (premature rupture of membranes, fetal hypoxia, anemia, and intrauterine infection) may develop. Therefore, focus assessments and preventive nursing activities from those complications should be added to her care plan. Examples of focus assessments for the woman with placenta previa include:

- ▶ Assess for abdominal tenderness, pain, and rigidity
- ▶ Assess for visible vaginal bleeding: count or weigh vaginal pads. One gram of pad weight = 1 ml of blood loss
- ▶ Assess for UCs
- ▶ Assess FHR

Preventive nursing activities include:

- ▶ Institute bed rest, usually with bathroom privileges
- ▶ Avoid vaginal and rectal exams

Content in this book addresses four of these competencies: patient-centered care (assessment, nursing diagnoses, independent nursing actions, evaluation); teamwork and collaboration (collaborative actions and collaborative care plans); evidence-based practice (EBP boxes); and safety (nursing actions often pertain to safety measures in rationales throughout the book).

## ENDNOTE

<sup>1</sup>NANDA International Nursing Diagnoses: Definitions and Classifications 2012–2014; Herdman T. H. (ED); copyright © 2012,

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## REFERENCES

- American Nurses Association (ANA). (2013). *What is nursing?* Retrieved from <http://www.nursingworld.org/EspeciallyForYou/What-is-Nursing>
- Quality & Safety Education for Nurses (QSEN). (2014). *Competencies.* Retrieved from <http://www.qsen.org/competencies>