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Normal labor supportive care Response monitoring

Midwifery & O.G. Nursing | Response monitoring

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

24-year-old woman in established term labor. Care stage: During review after prescribed initial care.

Medical history: Fictional obstetric history: G1P0 at 39 weeks, entering established labor. The pregnancy has had no reported major complication in this vignette. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The woman requests respectful explanation and involvement of her chosen support person with consent. Assess access to maternity follow-up, nutrition, transport and infant-care support.

Scenario: The team requests a clear account of changes after the prescribed care, rather than a statement that the patient is simply better.

Clinical assessment

Subjective: Painful regular contractions and a wish for continuous support.

Objective findings and required checks: Maternal/fetal observations and labor progress are assessed using the local pathway.

Physical examination and investigations: Review maternal observations, fetal monitoring, progress, hydration and preferences.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Normal labor supportive care: Coordinated uterine contractions and cervical change support birth; needs vary across labor.

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Medical / surgical management

Provide respectful support, comfort and mobility choices when safe, and prescribed analgesia with ongoing assessment.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed labor analgesia	Relieve pain according to informed preference	Monitor maternal/fetal effects and route-specific risks
oxytocin only when indicated	Manage a defined labor indication	Use the authorized infusion and fetal/uterine monitoring protocol.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Painful regular contractions and a wish for continuous support. Maternal/fetal observations and labor progress are assessed using the local pathway. The team requests a clear account of changes after the prescribed care, rather than a statement that the patient is simply better.

Nursing diagnosis

Prioritize pain interfering with rest or activity; emotional distress affecting participation in care; insufficient fluid replacement for current losses; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

At the next scheduled reassessment, with its interval chosen for acuity: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Provide respectful support, comfort and mobility choices when safe, and prescribed analgesia with ongoing assessment. Compare the current assessment with the documented baseline and identify benefit, harm or lack of response. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Compare the current assessment with the documented baseline and identify benefit, harm or lack of response.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about pain site, onset, severity, quality and the patient's acceptable pain level. Assess: Observe guarding, expression and effect on movement; use an appropriate pain scale.	Pain interfering with rest or activity. Possible factors: tissue irritation, injury or the underlying condition. Validate against the patient's assessment.	Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Pain decreases toward the patient-agreed target after reassessment. Longer-term: Before the clinically approved transition or agreed follow-up: Uses agreed comfort strategies and explains when new or worsening pain needs review.	1. Assess pain and associated red flags before and after treatment. Rationale: Changing pain may signal a complication and helps evaluate relief. 2. Provide comfortable positioning, reassurance and appropriate non-drug measures. Rationale: Comfort measures can reduce distress and complement prescribed treatment. 3. Give prescribed analgesia and monitor sedation, breathing and other adverse effects. Rationale: Relief should improve function without creating medication-related harm. 4. Provide respectful support, comfort and mobility choices when safe, and prescribed analgesia with ongoing assessment. Rationale: Coordinated uterine contractions and cervical change support birth; needs vary across labor. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask what worries the patient most and how they prefer to receive information. Assess: Observe distress, attention and ability to engage without making assumptions.	Emotional distress affecting participation in care. Possible factors: uncertainty, symptoms or unfamiliar treatment. Validate against the patient's assessment.	Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Identifies one immediate concern and participates in an agreed next step. Longer-term: Before the clinically approved transition or agreed follow-up: Describes helpful support and coping strategies before transition of care.	1. Listen without judgment and acknowledge specific concerns. Rationale: Feeling heard supports trust and therapeutic engagement. 2. Explain one step at a time and use teach-back with permission. Rationale: Manageable information reduces uncertainty and checks understanding. 3. Offer culturally appropriate support and refer when distress persists or safety concerns arise. Rationale: Additional support may be needed beyond bedside reassurance.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about thirst, intake, vomiting, stools and dizziness. Assess: Monitor weight trend, intake/output, mucosa, circulation and relevant electrolytes.	Insufficient fluid replacement for current losses. Possible factors: intake below requirements or increased fluid loss. Validate against the patient's assessment.	Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Hydration and circulation improve within the agreed reassessment interval. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver explains the individualized fluid plan and warning signs.	1. Measure intake and losses using age-appropriate methods. Rationale: Accurate trends guide replacement and help prevent overcorrection. 2. Offer oral fluids only when swallowing, consciousness and the treatment plan permit; otherwise implement prescribed replacement. Rationale: The safest route depends on aspiration risk and clinical severity. 3. Reassess perfusion, weight and laboratory trends after prescribed replacement. Rationale: Both continued dehydration and fluid overload require prompt recognition.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to	Learning needs about the condition and care plan. Possible	Short-term: At the next scheduled reassessment, with its interval chosen	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
understand. Assess: Use teach-back or demonstration to identify specific gaps.	factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	for acuity: Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Explain choices, breathing/comfort strategies, consent and the next stage of care. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Explain choices, breathing/comfort strategies, consent and the next stage of care.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Abnormal fetal findings, excessive bleeding, maternal collapse, severe atypical pain or concerning labor progress needs urgent review.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Coordinated uterine contractions and cervical change support birth; needs vary across labor.

- Priority concerns: Pain interfering with rest or activity; Emotional distress affecting participation in care; Insufficient fluid replacement for current losses; Learning needs about the condition and care plan.

- Abnormal fetal findings, excessive bleeding, maternal collapse, severe atypical pain or concerning labor progress needs urgent review.

- Explain choices, breathing/comfort strategies, consent and the next stage of care.

Exam / viva: Which observations demonstrate response, and which findings would require revising or stopping the current intervention?

References

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