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# Preterm labor Comfort & daily function

Midwifery & O.G. Nursing | Comfort & daily function

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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

26-year-old pregnant woman with contractions before term. Care stage: During supported recovery and essential daily activity.

Medical history: Fictional obstetric history: G1P0 at 30 weeks. Regular tightening and pressure prompted assessment for preterm labor. 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 patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

## Clinical assessment

Subjective: Regular tightening, pelvic pressure and concern about early birth.

Objective findings and required checks: Gestation, contractions, cervical/membrane status and maternal/fetal condition need assessment.

Physical examination and investigations: Review gestation, infection signs, membrane assessment and ordered fetal/cervical evaluation.

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

## Clinical focus and pathophysiology

Preterm labor: Early activation of labor pathways can lead to birth before fetal maturation is complete.

## Medical / surgical management

Escalate to maternity care, monitor mother and fetus and prepare indicated transfer or prescribed gestation-specific treatment.



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## Illustrative drug and treatment study

| Medicine / treatment | Purpose | Nursing checks |
|---|---|---|
| Prescribed antenatal corticosteroid when indicated | Support fetal maturation | Verify gestation, timing and glucose monitoring |
| prescribed tocolytic or magnesium where appropriate | Use only for a specific specialist indication | Monitor drug-specific safety. |

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

## Nursing process - ADPIE

### Assessment

Regular tightening, pelvic pressure and concern about early birth. Gestation, contractions, cervical/membrane status and maternal/fetal condition need assessment. The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

### Nursing diagnosis

Prioritize pain interfering with rest or activity; emotional distress affecting participation in care; vulnerability to infection or worsening infection; 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

During the next agreed care or activity session: 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

Escalate to maternity care, monitor mother and fetus and prepare indicated transfer or prescribed gestation-specific treatment. Identify the safest achievable activity or comfort goal without overlooking the underlying illness. 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: Identify the safest achievable activity or comfort goal without overlooking the underlying illness.

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: During the next agreed care or activity session: 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. Escalate to maternity care, monitor mother and fetus and prepare indicated transfer or prescribed gestation-specific treatment. Rationale: Early activation of labor pathways can lead to birth before fetal maturation is complete. 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: During the next agreed care or activity session: 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 exposure, wound symptoms and recent invasive devices. Assess: Inspect relevant sites and monitor systemic findings and investigation trends. | Vulnerability to infection or worsening infection. Possible factors: disrupted barriers, exposure or reduced host defence. Validate against the patient's assessment. | Short-term: During the next agreed care or activity session: Aseptic care is maintained and any new signs of infection are escalated promptly. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates relevant hygiene and explains the infection-prevention plan. | 1. Use hand hygiene and risk-based standard or transmission precautions. Rationale: Interrupting transmission protects the patient, staff and other patients. 2. Review invasive device need with the team and maintain indicated aseptic care. Rationale: Unnecessary devices and barrier breaks increase infection exposure. 3. Monitor for systemic deterioration and administer prescribed antimicrobials on schedule. Rationale: Early escalation and timely indicated treatment reduce avoidable harm. | 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 understand. Assess: | Learning needs about the condition and care plan. Possible factors: new | Short-term: During the next agreed care or activity session: Explains the most | 1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few | Record the baseline and reassessed finding, the time |



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| Assessment: subjective / objective | Nursing diagnosis: original problem wording | Short- and longer-term goals | Nursing interventions with rationale | Evaluation |
|---|---|---|---|---|
| Use teach-back or demonstration to identify specific gaps. | information, complex treatment or limited prior teaching. Validate against the patient's assessment. | 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. | 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 the individualized plan, symptoms to report and neonatal-care preparation. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care. | 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 the individualized plan, symptoms to report and neonatal-care preparation.

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

**Bleeding, fever, fluid leakage with concerns, severe pain or fetal compromise 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

- Early activation of labor pathways can lead to birth before fetal maturation is complete.

- Priority concerns: Pain interfering with rest or activity; Emotional distress affecting participation in care; Vulnerability to infection or worsening infection; Learning needs about the condition and care plan.

- Bleeding, fever, fluid leakage with concerns, severe pain or fetal compromise needs urgent review.

- Explain the individualized plan, symptoms to report and neonatal-care preparation.

**Exam / viva: How can care preserve independence while staying within the patient's assessed limits?**

## References

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