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Preterm labor Initial assessment

Midwifery & O.G. Nursing | Initial assessment

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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.

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.

Illustrative drug and treatment study

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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.

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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: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

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: After the first indicated intervention, at the documented review time: 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: After the first indicated intervention, at the documented review time: 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: After the first indicated intervention, at the documented review time: 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.

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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 the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific gaps.	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: 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.	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves 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 the individualized plan, symptoms to report and neonatal-care preparation. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	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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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: Which finding changes the order of priorities, and what must be escalated immediately?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
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https://openstax.org/books/maternal-newborn-nursing/pages/preface

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https://www.indiannursingcouncil.org/gazette-notification

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