N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission	Patient Initials	Age	Gender
3/4/21 14:34pm	HD	20 Years old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Caucasian	Works with special education.	Single (dating the father of her child).	NKA
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full code	5'4"	143 lbs.	Yes. Father is at the bedside.

Medical History (5 Points)

Prenatal History: Genital herpes and anemia. GTPAL: Gravida: 1 Term: 1 Abortions: 0 Living: 1

Past Medical History: Depression, anxiety, adjustment disorder, and genital herpes.

Past Surgical History: Tonsil / adenoid removal.

Family History: Mother: psoriatic arthritis, hypertension, depression (mother has attempted suicide three times). Father/paternal grandfather: hypertension. Maternal grandmother: bipolar disorder.

Social History (tobacco/alcohol/drugs): The patient does not smoke, drink, or use tobacco.

Living Situation: The patient lives with her mother and sister in Sullivan Illinois. The father of the baby is in college and lives there.

Education Level: High school diploma.

Admission Assessment

Chief Complaint (2 points): Induction.

Presentation to Labor & Delivery (10 points): The patient is a 20 year old female who was admitted to Labor & Delivery on 3/4/21 at 41 weeks 6 days gestation to be induced. The

father of the baby (who is her significant other) is present. The patient was experiencing back pain and a headache but minimal cramping. She was given pain medication which reduced her pain level. She is a G1P0. The patient was in labor for about 7 hours (406 minutes). There was a failed vacuum so the patient was sent for a cesarean section. Her baby boy was born on 3-6-21 at 02:46am weighing 7lbs 9oz.

Diagnosis

Primary Diagnosis on Admission (2 points): Induction of labor.

Secondary Diagnosis (if applicable): Postdate pregnancy (41 weeks and 6 days gestation).

Postpartum Course (18 points)

On 3-4-21, the patient was admitted to Carle foundation hospital for an induction. The patient was brought in for an induction because she was 41 weeks and six days gestation. The patient was originally going to have a vaginal delivery and was in the first and second labor stage for approximately seven hours. During the first stage of labor (three phases), the patient will go from 0-10 cm in dilation and become 100% effaced. In the beginning, the patient will experience contractions every 5-10 minutes that last about 30-45 seconds (Ricci et al., 2020). Towards the end of the first stage (active phase), the patient will have a contraction every 2-5 minutes, and they last about 45-60 seconds (Ricci et al., 2020). The patient did not have a vaginal delivery, so she was transported for a cesarean section. In the third stage of labor, the baby is born, and the placenta is due to come out (Mayo Clinic, 2020). The patients are in less pain and feel excitement and joy (Mayo Clinic, 2020).

During the fourth stage of labor, the placenta comes out of the body (typically 1-4 hours after birth), and this stage initiates the postpartum period (Ricci et al., 2020). Since the patient had a cesarean section, her placenta was removed. The fundus during the postpartum period is supposed to be round and firm and should be midline (Ricci et al., 2020). The patient's fundus is firm and midline. During the postpartum period, the woman may experience "after pains." This is a normal finding and is a result of the uterus contracting, which constricts blood flow and prevents hemorrhage (Ricci et al., 2020). Also, during the postpartum period, the woman may have trouble urinating. This can be caused by the epidural or lacerations to the perineum (Ricci et al., 2020). A complication of pregnancy/postpartum is called urinary atony (urinary retention) (Ricci et al., 2020). The patient did urinate shortly after her cesarean section and had a small bowel movement. The patient's vitals were also within the normal range. In the postpartum period, the mother and the baby also form an "attachment" or "bond" (Ricci et al., 2020). The patient did skin-to-skin holding once all the measurements were completed. Risk factors for postpartum mood disorder include a history of other mental illness disorders (bipolar, depression, etc.), your baby has health problems or special needs, have difficulty breastfeeding, have twins or triplets, have a weak support system, or have financial troubles (Mayo Clinic, 2018). During the postpartum period, signs of infection include fever, redness, swelling, pain, and discharge (Ricci et al., 2020). Risk factors for infection during postpartum include diabetes, obesity, cesarean delivery, anemia, and premature rupture of membranes (Ricci et al., 2020). Risk factors for hemorrhaging include an assisted delivery (with a vacuum or forceps), a large baby, a history of postpartum

hemorrhage, multiple births, prolonged delivery of the placenta, and excess amniotic fluid (Health line, 2016).

Postpartum Course References (2) (APA):

Healthline. (2016, April 5). *Pregnancy Complications: Common Causes of Hemorrhage.* https://www.healthline.com/health/pregnancy/complications-uterine-hemorrhage

Mayo Clinic. (2018, September 1). *Postpartum depression*. https://www.mayoclinic.org/diseases-conditions/postpartum-depression/symptoms-causes/syc-20376617.

Mayo Clinic. (2020, February 6). *Stages of labor and birth: Baby, it's time!* https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/stages-of-labor/art-20046545.

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and Pediatric Nursing* (4th ed.). LWW.

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format. *Normal ranges per epic system at Carle*

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.50-5.20	3.95	3.59	2.56	RBC's are low because the patient lost blood during the cesarean section (Capriotti and Frizzell, 2016).
Hgb	11-16	11.9	10.3	7.4	The patient has anemia and lost blood during the cesarean section so her hemoglobin is low (Capriotti and Frizzell, 2016).

Hct	**34-47%**	**33.7**	**30.9**	**23.2**	**The patient has anemia and lost blood during the cesarean section so her hematocrit is low (Capriotti and Frizzell, 2016).**
Platelets	**140-400**	**204**	**222**	**159**	
WBC	**4-11.0**	**8.76**	**9.36**	**10.22**	
Neutrophils	**1.60-7.70**	**5.37**	**6.06**	**7.40**	
Lymphocytes	**1.00-4.90**	**2.34**	**2.43**	**1.82**	
Monocytes	**0-1.10**	**6.4**	**0.67**	**0.45**	
Eosinophils	**0-0.50**	**0.8**	**0.12**	**0.36**	
Bands	**NA**	**NA**	**NA**	**NA**	

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format. *Normal ranges per epic system at Carle*

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	**A, B, O, AB**	**A**	**NA**	**NA**	
Rh Factor	**Negative or positive**	**Negative**	**NA**	**NA**	
Serology (RPR/VDRL)	**Non-reactive**	**Non-reactive**	**NA**	**NA**	
Rubella Titer	**10.00 or above**	**102**	**NA**	**NA**	**The patient is immune to rubella.**
HIV	**Non-reactive**	**Non-reactive**	**NA**	**NA**	
HbSAG	**Non-reactive**	**Non-reactive**	**NA**	**NA**	
Group Beta Strep Swab	**Negative**	**Negative**	**NA**	**NA**	
Glucose at 28 Weeks	**<140**	**88**	**NA**	**NA**	
MSAFP (If Applicable)	**NA**	**NA**	**NA**	**NA**	

Additional Admission Labs Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Covid-19 test	**Non-reactive/ negative**	**Negative**			

Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Explanation of Findings
Urine Creatinine (if applicable)	***Lab not drawn***				

Lab Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2016). ***Pathophysiology: introductory concepts and clinical perspectives*****. Philadelphia: F.A. Davis Company.**

Stage of Labor Write Up, APA format (15 points):

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	**The patient had an estimated delivery date of 2-28-21. She was in postdate pregnancy so she was brought in at 41 weeks and 6 days gestation for an induction. The patient was induced because she was postdate (41 weeks and 6 days) which increases the risks to the mother and baby. A postdate pregnancy also increases the chance of a cesarean delivery (Caughey, 2020). The patient was in labor for 406 minutes (about 7 hours). The patient was in the first stage of labor for 3 hours and 52 minutes, the second stage for 2 hours and 53 minutes, and because there were non-reassuring fetal heart tones and a failed vacuum, the patient was sent for a cesarean section because the risk factors of complications were increased** (Ricci et al., 2020). **After a long labor, the baby was born at 02:46am.**
Current stage of labor	**The patient is currently in the postpartum stage of labor. The fourth stage.**

Stage of Labor References (2) (APA):

Caughey, A. B. (2020, August 27). ***Postterm Pregnancy: Overview, Timing of Delivery, Prevention of Postterm Pregnancy*****. https://emedicine.medscape.com/article/261369-overview.**

Ricci, S., Kyle, T., & Carman, S. (2020). ***Maternity and Pediatric Nursing*** **(4th ed.). LWW.**

Current Medications (7 points, 1 point per completed med)
7 <u>different</u> medications must be completed

Home Medications (2 required)

Brand/Generic	**Valtrex / Valcyclovir**	**Tylenol / Acetaminophen**			
Dose	**1 gram tablet**	**500mg**			
Frequency	**1X daily**	**PRN for pain.**			
Route	**orally**	**orally**			
Classification	**Antiviral**	**antipyretic, nonopioid analgesic**			

Mechanism of Action	**After conversion to acyclovir, several actions combine to inhibit herpes virus replication.**	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system**			
Reason Client Taking	**The patient is taking because she has genital herpes.**	**The patient is taking for pain.**			
Contraindications (2)	**Hypersensitivity to acyclovir or its salt or components.**	**Severe hepatic impairment, Hypersensitivity to acetaminophen or its components.**			
Side Effects/Adverse Reactions (2)	**Coma, hepatitis.**	**Hypokalemia, Hepatoxicity.**			
Nursing Considerations (2)	**Maintain adequate hydration because this medication can affect the kidneys, monitor patient closely for central nervous system adverse reactions.**	**Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease, ensure that the daily dose of acetaminophen from all sources does not exceed maximum daily limits.**			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Assess renal function and labs (creatinine, BUN).**	**Monitor liver function tests (AST, ALT, bilirubin, and creatinine). These must be monitored to ensure liver hepatoxicity has not occurred. Monitoring renal function is also important.**			
Client Teaching needs (2)	**Instruct patient to begin therapy at the**	**Tell patient that tablets may be**			

	earliest symptom of a cold sore or recurrent genital herpes, such as burning, itching, or tingling in the area. Inform the patient that valacyclovir is not a cure for herpes.	**crushed or swallowed whole, teach patient to recognize signs of hepatoxicity such as bleeding, easy bruising, and malaise.**			

Brand/Generic	**Benadryl / Diphenhydramine**	**Vantrela ER / Hydrocodone**	**Advil / Ibuprofen**	**Arymo ER/ Morphine**	**Zofran / Ondansetr**
Dose	**50mg**	**10 ml**	**600 mg**	**2 mg**	**4 mg**
Frequency	**Every 4 hours PRN**	**Every 4 hours PRN**	**Every 6 hours PRN**	**1X**	**PRN**
Route	**Orally**	**Orally**	**Orally**	**Injection (IV)**	**IV**
Classification	**Antihistamine, antivertigo, antiemetic.**	**Opioid analgesic**	**NSAID, antipyretic.**	**Opioid analgesic**	**Antiemetic**
Mechanism of Action	**Binds to central and peripheral H1 receptors, competing with histamine for these sites and preventing it from reaching its site of action.**	**Bind to and activates opioid receptors at sites in the periaqueductal and periventricular gray matter, the ventromedial medulla, and the spinal cord to produce pain relief.**	**Blocks activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain, swelling, and vasodilation.**	**Binds with and activates opioid receptors in brain and spinal cord to produce analgesia and euphoria.**	**Blocks serotonin receptors centrally in chemorecep trigger zon and peripherall vagal nerve terminals i the intestin**
Reason Client Taking	**The patient is taking to treat her itchiness. After medication earlier, she had slight itching.**	**The patient is taking to treat pain.**	**The patient is taking to treat pain / inflammation.**	**The patient got an injection one time for severe pain during labor.**	**The patient taking for nausea.**
Contraindications	**Breastfeeding,**	**Acute or**	**Angioedema,**	**Acute or**	**Concomita**

(2)	**hypersensitivity to diphenhydramine.**	**severe bronchial asthma or hypercarbia, significant respiratory depression.**	**asthma.**	**severe bronchial asthma, respiratory depression.**	**use of apomorphi congenital QT syndro**
Side Effects/Adverse Reactions (2)	**Arrhythmias, thrombocytopenia .**	**Hypotension, CNS depression.**	**MI, GI bleeding.**	**Seizures, adrenal insuffiency.**	**Hypotensio intestinal obstruction**
Nursing Considerations (2)	**Keep elixir container slightly closed, expect to give parenteral form of diphenhydramine only when oral ingestion isn't possible.**	**Be aware that hydrocodone increases the risk of abuse, addiction, and misuse. Know that hydrocodone should not be given to a patient with impaired consciousness.**	**Use cautiously in patients with hypertension, and monitor blood pressure throughout therapy. Keep in mind that GI bleeding, perforation, and ulceration can occur.**	**Be aware that morphine can lead to abuse, addiction, and misuse. Use morphine with extreme caution in patients who may be at risk for carbon dioxide retention.**	**Know that hypokalem or hypo magnesia is present, it needs to be corrected before administra Use calibra container o oral syring measure do of oral solution.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Assess the patients CNS and monitor for allergic reactions.**	**Assess the patients level of consciousness, assess for respiratory depression.**	**Assess the patients' blood pressure and for risks of an MI.**	**Assess patient's drug use and OTC drugs before therapy, Assess respiratory status.**	**Assess pati for hypersensit y to ondansetro**
Client Teaching needs (2)	**Advise patient to take drug with food to avoid GI distress. Caution patient to avoid hazardous activities until drugs CNS effects are known.**	**Instruct patient to take drug exactly as ordered and not to adjust dosage without speaking to the provider first. Caution**	**Instruct patient to take tablets with a full glass of water, and caution not to lie down for 15-30 minutes to prevent esophageal**	**Instruct patient to notify prescriber about worsening or breakthroug h pain. Tell patient to change**	**Advise pati to immedia report sign hypersensit y like rash. Advise pati to notify provider of persistent, severe,**

		patients to avoid ingesting alcohol.	**irritation. Advise patients to take drug with food to avoid GI distress.**	**positions slowly to minimize orthostatic hypotension.**	**unusual, or worsening symptoms.**

Hospital Medications (5 required)

Medications Reference (1) (APA):

Jones & Bartless Learning. (2020). 2020 Nurse's drug handbook (19th ed.). Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:**	**The patient is alert and oriented X4.** **The patient is not in distress.**

Orientation: **Distress:** **Overall appearance:**	**The patient's overall appearance is well. Her hair is combed, she has earrings in, and looks good.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**The patient's skin is dry, warm, and intact. ** **The patient's skin is white and looks normal for her skin tone.** **Normal turgor: 2+** **The patient does not have any rashes or bruises.** **Braden score: 21** **The patient has an incision on her suprapubic region—it looks to be healing well.** **No drains present.**
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**The patients head is symmetrical (midline with no deviations).** **The patient has dark brown hair with no balding or patches.** **The patient's ears are clear and pink with no drainage.** **The tympanic membrane is visible and is pearly grey.** **PEERLA is present.** **The patient does not have nasal deviation.** **The oral mucosa is pink and moist.** **The patient's teeth are clean and in good condition.** .
CARDIOVASCULAR (1 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	. **The patient was in normal sinus rhythm.** **S1 and S2 present.** **The patient's radial and pedal pulses are palpable.** **There is no peripheral edema.** **Normal capillary refill: less than 3 seconds.** **The patient has no neck vein distension.**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**The patient's breath sounds are normoactive bilaterally. The breath sounds are clear and normal.**
GASTROINTESTINAL (5 points): **Diet at Home:** **Current Diet:**	**The patient is on a regular diet at home and here at the hospital.** **Height: 5'4"**

Height: **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	**Weight: 143 lbs.** **Bowel sounds normoactive in all four quadrants.** **Last BM: this morning. "It was small but was something".** **Abdomen is slightly tender on palpation because of the cesarean section but is to be expected.** **No distension.** **There is a cesarean section scar that is healing well.** **No drains.**
GENITOURINARY (5 Points): **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Episiotomy/Lacerations:**	**Fundal height & position: 1cm below umbilicus, midline, firm without massage.** **Bleeding amount: scant (less than 2.5 cm on pad per hour).** **Lochia color: Rubra** **The patient is voiding regularly.** **The patient's genitals are clean and intact.** **The patient is not experiencing pain with urination.** **The patient does not have a catheter.** **ROM occurred on 3-6-21 at 00:49 am.** **Color: clear** **Amount: small** **Odor: no odor** **No laceration/episiotomy.**
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**The patient has active ROM bilaterally.** **The patient is sore, but she is ambulating to the bathroom independently.** **The patient Is not a fall risk.** **Fall score: 0** **The patient does not use assistive devices or support with walking.**
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:**	**The patients grip strength is equal bilaterally in the upper and lower extremities.** **PERLA is present.** **The patient is oriented and mental status is normal.** **The patient's speech is clear and normal (makes sense).** **No LOC.**

Sensory: **LOC:** **DTRs:**	**Deep tendon reflexes present.**
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**The patient is Christian "but does not attend church".** **The patient is fully developed.** **The patient copes with deep breathing, journaling, listening to music, and watching movies/TV shows (she has a PMH of depression/mood disorder). The patient does have a support system and lives with her mother and sister. Her mother also has a history of depression—with suicide attempts.**
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	**Delivery date: 3-6-21** **Time: 02:46 am.** **Type: cesarean** **Quantitative blood loss: 637 ml** **Male** **Apgar's: 2, 7.** **Weight: 7lbs 6.9 oz** **Feeding method: breastfeeding and bottle feeding. The mother is trying both.**

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**102**	**100/52**	**18**	**98.2 F oral**	**100% RA**
Labor/Delivery	**72**	**119/72**	**18**	**97.7 F oral**	**99% RA**
Postpartum	**125**	**100/59**	**18**	**98.4 F oral**	**97% RA**

Vital Sign Trends: The patients vital signs are consistent. The patients' blood pressure was slightly higher during labor (to be expected). The patient's pulse was elevated after labor, and elevations are common for this patient because she struggles with anxiety.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
13:00pm	**0-10**	**stomach**	**0**	**NA**	**NA**
15:00	**0-10**	**stomach**	**3**	**sore**	**Tylenol**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	18 gauge in the anterior, distal, left lower forearm. Dated: 3-5-21. The IV is patent, no sign of drainage or erythema. Lactated ringers running at 125 ml/hr.

Intake and Output (2 points)

Intake	Output (in mL)
IV fluids- 3,045 ml	**637—estimated blood loss** **925 ml urine**

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them, identify medical treatments with "T" after you list them.)	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.
Administration of Tylenol. T	**Every 4 hours PRN for pain.**	**Tylenol was provided for this patient because after her cesarean section, her abdomen was sore upon ambulation/movement.**
Encourage parent-infant	**After the baby is**	**The parents and baby need to bond**

attachment. N	**born, and during the hospital stay (frequently).**	**shortly after the baby is born. Encouraging skin to skin and family time is important.**
Assess fundus during the recovery period. N	**Every time an assessment is performed.**	**The fundus needs to be assessed during the postpartum period to ensure that it is firm so that bleeding won't be a concern.**
Assisting and encouraging the mother to eat/drink (provide nutrients). N	**Every 4 hours.**	**The mother is anemic and if she plans on breastfeeding (which she does) her Hemoglobin and hematocrit needs to go up to prevent further anemia and fatigue.**

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? The mother is in the "taking-hold phase".

What evidence supports this? The taking-hold phase is when the mother is typically 2-3 days postpartum and is described as the mother settling into her new role and becoming independent while still being slightly dependent (Ricci et al., 2020). The patient is showing independence in caring for herself and her baby, but she still needs to learn some vital caregiving needs (like giving her baby a bath the correct way) and she still needs reassurance.

Discharge Planning (2 points)

Discharge location: The mother and baby are going to live at home in Sullivan, Il with her mother and sister.

Equipment needs (if applicable): The mother does not need any equipment currently.

Follow up plan (include plan for mother AND newborn): The mother is going to follow up with her primary care provider in two weeks to check her cesarean section incision. The mother will also have the baby checked out in 1 week.

Education needs: The mother needs education on a proper diet because she is anemic (due to a poor diet). The mother also needs some education on mental health resources because she has mood disorder, depression, and anxiety.

Nursing Diagnosis (30 points)
Must be NANDA approved nursing diagnosis and listed in order of priority
Two of the Nursing Diagnoses must be education related i.e. the interventions must be education for the client."

2 points for correct priority

Nursing Diagnosis (2 pt each) Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational (1 pt each)** Explain why the nursing diagnosis was chosen	**Intervention/Rational (2 per dx) (1 pt each)** Interventions should be specific and individualized for his patient. Be sure to include a time interval such as Assess vital signs q 12 hours." List a rationale for each intervention and using APA format, cite the source for your rationale.	**Evaluation (1 pt each)** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to cesarean section delivery as evidence by verbalization of pain.	**The patient is getting up slowly and complaining of pain in her abdomen.**	**1.Administer Tylenol every 4 hours PRN. Rationale: Tylenol will help reduce mild to moderate pain. 2.Provide comfort measures like turning down the lights or listening to music. Rationale: Alternative forms of therapy can help reduce pain (Ricci et al., 2020).**	**Goal: to reduce the patient's pain. The patient was willing to take Tylenol for pain and closed the blinds and turned down the lights. She said that it helped reduce her pain and anxiety.**
2. Deficient knowledge related to adequate	**The patient is anemic due to her diet.**	**1. Give the patient accurate information on the proper diet in easy**	**Goals: Improve the patients nutrition so that she can be**

nutrition as evidence by the patient being anemic. *Education*	**She needs education on how to raise her hematocrit and hemoglobin.**	**terms so that she can understand. Rationale: The patient needs to know how she can resolve her anemia and raise her hemoglobin and hematocrit levels. 2.Offer meal ideas and encourage the patient to ask questions. Rationale: offering meal ideas that the patient enjoys that will help her get the proper nutrients she needs will encourage her to eat better. Encouraging questions will make her feel comfortable in asking if she is confused.**	**healthy to take care of herself and her baby. Outcome: the patient was willing to learn about the proper diet that would raise her hematocrit and hemoglobin levels. She wants to stay healthy so that she can take care of her baby. The correct way to take iron supplements were taught and she was willing to learn and ready to start taking them.**
3. Risk of postpartum depression related to current depression/anxiety as evidence by a history of anxiety and depression. *Education*	**The patient has a history of anxiety and depression, so she is at risk for developing postpartum depression as well.**	**1. Educate the patient on the resources that are available to her. Rationale: If the patient knows about the available resources to prevent depression and promote mental health, she could be helped, and the outcome would be greater. 2. Allow the patient to verbalize feelings and thoughts. Rationale: verbalizing feelings and thoughts can improve a patient's mental health. Talking about things is a therapeutic technique.**	**Goal: prevent postpartum depression and improve current mental illnesses. The patient is "feeling better" than she ever has, and she wants to stay feeling good. She is planning on meeting with her therapist once a week and will get back on anti-depressants if the therapist sees necessary.**
4. Risk of infection related to low hemoglobin and hematocrit as evidence by blood	**The patient is anemic, and this increases her risk of infection.**	**1. Administer fluids. Rationale: ensuring the patient is hydrated can decrease the risk of infection (Ricci et al.,**	**Goal: reduce the risk of infection. The patient was willing to drink more as well as be**

levels and anemia.		**2020).** **2. Record blood levels frequently.** **Rationale: to monitor levels and make sure they aren't going down.**	**on continuous IV fluids. She understands the risks of being anemic and wants to get stronger for herself and her baby.**

Other References (APA)

Ricci, S. S., Kyle, T., & Carman, S. (2021). ***Maternity and pediatric nursing*****. Wolters Kluwer.**

Swearingen, P. L., & Wright, J. D. (2020). ***All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*****. St. Louis, MO: Elsevier.**