N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 06/15/2021 1524	**Patient Initials** C.K.	**Age** 26 years old	**Gender** Female
Race/Ethnicity White/ Caucasian	**Occupation** Preschool Teacher	**Marital Status** Married	**Allergies** No known drug allergies
Code Status Full Code	**Height** 5'3''	**Weight** 216 lbs.	**Father of Baby Involved** Yes, Father is at the bedside

Medical History (5 Points)

Prenatal History: GTPAL: Gravida 2, Term 1, Preterm 0, Abortion 0, Living 1. She has one living child who was a term at birth and almost two years old now. She had oligohydramnios for the first pregnancy. During this pregnancy, she also has oligohydramnios, marginal insertion of the umbilical cord, and concern of ventricular septal defect on the baby.

Past Medical History: No past medical history

Past Surgical History: The patient had refractive surgery (2017), tonsillectomy and adenoidectomy (2005).

Family History: The patient's father has hypertension and possible Lyme disease. The patient's mother has thyroid disease and GI problems.

Social History (tobacco/alcohol/drugs): The patient denies any past or current tobacco and smokeless tobacco use. The patient denies current alcohol consumption. However, the patient used to drink one glass of wine per week before pregnancy. The patient denies any use recreational drug or substance use.

Living Situation: The patient lives with her husband and son in Rantoul, Illinois.

Education Level: Patient has a bachelor's degree.

Admission Assessment

Chief Complaint (2 points): Induction of labor

Presentation to Labor & Delivery (10 points):

The patient is a 26-year-old female admitted to Carle Labor and Delivery on June 15, 2021, at 1524 at 39 weeks five days gestation due to the concern of ventricular septal defect of the fetus and induces labor. They gave her a dinoprostone vaginal insert and IV Pitocin to induce labor. They gave her an epidural on the morning of June 17, 2020, to increase unbearable discomfort and artificially ruptured the membrane at 0936. She was fully dilated around 1440 and delivered the baby vaginally. Her baby boy was born on 06/17/21 at 03:20 pm, weighing 9 lbs. 8oz.

Diagnosis

Primary Diagnosis on Admission (2 points): Labor induction

Secondary Diagnosis (if applicable): Marginal insertion of umbilical cord affecting management of mother and concern of ventricular septal defect of baby.

Stage of Labor

Stage of Labor Write Up, APA format (20 points) This should include the progression of cervical effacement & dilation as well as pain management techniques:

True labor is distinguished by changes in cervical dilation, effacement, frequent and regular contraction (Swearingen & Wright, 2020). According to the chart, the patient was 0 cm dilated and 40% effaced on June 15, 2021. The cervix was intact, and the fetal station was +3. In the latent phase of the first stage of labor, the patient should experience contraction frequency every 5-10 minutes with a duration of 30-45 seconds, cervical dilation between 0-6 cm, and effacement from 0% to 40% (Ricci et al., 202). During this stage, the woman can stay at their

home and contact their provider about the onset of the labor (Ricci et al., 2020). However, the patient was admitted for labor induction.

During the active phase of the first stage, the patient should experience contraction frequency every 2-5 minutes with a duration of 45-60 seconds, cervical dilation between 0-6 cm, and effacement from 40% to 70% (Ricci et al., 202). The patient may feel intense discomfort due to contraction becoming more frequent and increasing duration (Ricci et al., 202). The nursing interventions for this stage are turning the patient to the side to provide comfort and implementing non-pharmacological pain measures such as breathing techniques and a quiet environment for resting. Monitor the mother's vital signs and fetal heart rate per doctor order or hospital policy.

The patient stayed in the hospital for three days before reaching the second stage. The second stage consists of complete cervical dilation and the end of birth of the baby ((Swearingen & Wright, 2020). When I took care of her, the patient was already 10 cm dilated and 100% effaced. Her contraction was every 2-3 minutes with a duration of 60-70 seconds which supports the finding for the second stage of labor of contraction frequency 2-3 minutes with a duration of 60-90 (Ricci et al., 2020). She started pushing at 1540. She was educated about breathing techniques and given a cool, damp washcloth for the forehead. Nurses should take the mother's vital signs every 5-30 minutes during the second stage (Ricci et al., 2002). All of her vital signs and fetal status are within normal limits. The baby was born at 1620, which start the third stage of labor. The third stage of labor consists of the birth of the baby and placenta expulsion (Swearingen & Wright, 2020). During the third stage, the mother was providing skin-to-skin contact with the baby. The placenta was delivered at 1635, which signal the fourth stage of labor. The fourth stage of labor happens when the placenta is delivered, and the mother is stable. The

mother's vital signs should be monitored by the nurse every 15 minutes. Her vitals were heart rate of 85 bpm, blood pressure of 120/72, respiration of 18, the temperature of 98.7 F, and oxygen saturation of 100%. The patient was ready to be transferred to the postpartum unit around 1730.

Stage of Labor References (2) (APA):

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier.

Laboratory Data (15 points)

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

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**3.50 – 5.20**	4.10	4.30	4.49	N/A
Hgb	**11.0 – 16.0**	11.1	11.1	11.8	N/A
Hct	**34.0 – 47.0%**	35.5	36.0	37.3	N/A
Platelets	**140 – 400**	212	204	203	N/A
WBC	**4.0 – 11.0**	8.36	8.08	8.60	N/A
Neutrophils	**1.60 - 7.70**	N/A	6.29	N/A	N/A
Lymphocytes	**1.00 – 4.9**	N/A	1.24	N/A	N/A
Monocytes	**0.00 – 1.10**	N/A	0.41	N/A	N/A
Eosinophils	**0.00 - 0.50**	N/A	0.08	N/A	N/A
Bands	**0.01 - 0.20**	N/A	N/A	N/A	N/A

Other Tests 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
Blood Type	**A, B, O, AB**	A	A	A	N/A
Rh Factor	**Negative or positive**	Positive	Positive	Positive	N/A
Serology (RPR/VDRL)	**Non-reactive**	Non-reactive	Non-reactive	Non-reactive	N/A
Rubella Titer	**10.00 or above**	12.20	N/A	N/A	N/A
HIV	**Non-reactive**	Nonreactive	Non-reactive	Non-reactive	N/A
HbSAG	**Non-reactive**	Nonreactive	Non-reactive	Non-reactive	N/A
Group Beta Strep Swab	**Negative**	negative	negative	Negative	N/A
Glucose at 28 Weeks	**<140**	145	N/A	N/A	Higher than 140 glucose level may indicate gestational diabetes (Pagana et al., 2020). The patient had another glucose test which came back normal.
MSAFP (If Applicable)	**N/A**	N/A	N/A	N/A	N/A

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
Glucose tolerance test (two hours)	**<140**	**135**	**N/A**	**N/A**	**N/A**
Covid-19	**Negative**	N/A	Negative	N/A	N/A

test					

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 protein/creatinine ratio (if applicable)	**0-254**	N/A	N/A	N/A	N/A

Lab Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's diagnostic and laboratory test reference* (15th ed.). Elsevier.

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	135 beats per minutes
Are there accelerations? • **If so, describe them and explain what these mean (for example: how high do they go and how long do they last?)** **What is the variability?**	Yes. There are accelerations that are 15 beats by 15 seconds. Acceleration is elevation of fetal heart rate more than 15bpm lasting more than 15 seconds. The accelerations are measured from their start to their peak (Ricci et al., 2020). Moderate Variability
Are there decelerations? If so, describe them and explain the following: What do these mean? o **Did the nurse perform any interventions with these?** o **Did these interventions benefit the patient or fetus?**	There are early and variable deceleration. Early deceleration is gradual decrease in fetal heart, the lowest point concurs with the peak of contraction which typically caused by compression of the baby's head in the birth canal (Ricci et al., 2020). Variable deceleration can happen anytime, before, during or after contraction which also indicate the umbilical cord is temporarily compressed (Ricci et al., 2020). The patient was turned onto her side when variable deceleration happens to benefit the fetus. The deceleration improved when this intervention was performed. No intervention needed for early deceleration. Continue to monitor the patient and the labor progress.
Describe the contractions:	The contraction occurred about every 2-3 minutes. The contraction

Frequency: **Length:** **Strength:** **Patient's Response:**	lasted about 60-70 seconds. The strength of contraction was moderate at first and got stronger as the baby delivery was near. The patient was comfortable.

EFM reference (1) (APA format):

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

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

Home Medications (2 required)

Brand/Generic	Prenatal Vitamin/Ferrous fumarate-folic acid	Tums regular/calcium carbonate
Dose	29 mg/1 capsule	500 mg
Frequency	Once daily	PRN
Route	PO	PO
Classification	Vitamin	Antacid
Mechanism of Action	Replenish and prevent loss of vitamin and mineral essential to fetal growth and development	This medication neutralizes or buffer stomach acid to relieve discomfort caused by hyperacidity.
Reason Client Taking	Prophylaxis for potential vitamin deficiencies	Heartburn
Contraindications (2)	Iron overload Peptic Ulcer	Hypersensitivity to calcium salt Hypophosphatemia
Side Effects/Adverse Reactions (2)	Constipation GI upset	Hypotension Hypercalcemia

Nursing Considerations (2)	Monitor liver enzyme due to risk of elevation Deferoxamine should be prepared in case of iron toxicity	Give to patient 1 to 2 hours after meals. Do not freeze and protect from moisture and direct light.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess patient RBC, Hgb and Hct. Monitor iron level	Assess serum calcium level of patient
Client Teaching needs (2)	Take medication with 8 oz of water. Take medication regularly to get full benefit.	Instruct to avoid talking calcium within 2 hours of another oral drug due to risk of interaction. Take medication with a glass of water.

Hospital Medications (5 required)

Brand/Generic	Pitocin/ oxytocin	Toradol/ ketorolac	Cervidil/ dinoprostone	Lactated Ringer's Infusion	Corphedra/ Ephedrine Sulfate
Dose	30 units	15mg	10mg	125ml/hr	5mg
Frequency	Continuous	PRN Q 6hrs.	One time	Continuous	PRN every 1 minute
Route	IV	IV push	Vaginal insert	IV	IV push
Classification	Oxytocic/ stimulates contraction	NSAID/ analgesic	Prostaglandin Analog	Fluid replacement	Alpha/Beta Adrenergic Agonists
Mechanism of Action	This medication causes the uterus to contract and induce labor	This medication blocks cyclooxygenase that is need for the synthesize of prostaglandin which blocks inflammatory response	This medication mechanism gave off prostaglandin which initiate cervical ripening .	Restores fluids and electrolytes and reduces acidity	This medication acts as an agonist at alpha- and beta-adrenergic receptors and indirectly causes the release of

		and pain			norepinephrine from sympathetic neurons.
Reason Client Taking	Labor induction	For pain	Cervical Dilation	To prevent dehydration and maintain electrolyte balance.	To treat hypotension caused by anesthesia
Contraindications (2)	Hypersensitivity to Pitocin Fetal distress	Hypersensitivity to ketorolac Concurrent use with other NSAID	Hypersensitivity to prostaglandin Unexplained vaginal bleeding	Severe metabolic acidosis/ alkalosis High potassium level	Hypersensitivity to Ephedrine Cardiac arrhythmias
Side Effects/Adverse Reactions (2)	Nausea Vomiting	Cerebral hemorrhage Respiratory depression	Flushing skin dizziness	Hypervolemia Venous phlebitis	Dizziness Headache
Nursing Considerations (2)	Check for any discoloration and cloudiness in the solution. Monitor uterine activity and the fetal heart rate continuously throughout infusion of Pitocin.	Monitor patient closely for thrombotic event such as MI or stroke due to increased risk. Assess patient skin routinely for rash or other signs of allergic reaction because it can cause serious skin reaction even in patient with no history of drug allergy.	Monitor for allergic reaction Monitor for increase bleeding, sudden abdominal pain or change in fetal heart rate	Assess vitals before administration. Monitor patient for fluid volume overload	Protect solution from light. Monitor cardiovascular status of patient
Key Nursing	Assess fetus	Assess	Assess blood	Assess	Assess blood

Assessment(s)/Lab(s) Prior to Administration	and mothers' contractions.	patient pain level	pressure	patient electrolyte level	pressure and respiratory status of patient.
Client Teaching needs (2)	Inform patient that Pitocin is given to stimulate contraction and speed up labor. Inform patient that there will be increase strength of contraction.	Explain that the medication may increase risk of serious adverse cardiovascular reaction and report immediately if patient experience chest pain or shortness of breath. Instruct to report any blood in urine, itching, rash or swelling.	Instruct patient to report if they experience severe or prolonged headache, chills, fever, or GI problems. Patient should remain in lateral or supine position for 30 minutes to1 hour to prevent leakage	Tell patient to keep head of bed elevated at least 35 degrees. Instruct patient to report any swelling in legs.	Inform patient to report any dizziness or sign of hypotension immediately. Inform patient to report any sign and symptoms of an allergic reaction

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2019). *2020 nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Patient is aware alert and oriented X4 person, place, time, and situation. Comfortable, no acute distress. Well-groomed, well-developed, well-nourished
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Normal for race Dry/Normal Warm Normal Turgor No noted rashes No noted bruises No noted wounds/incisions Braden score: 23 No drain present. N/A
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Head and Neck symmetrical/midline without deviation. No lesions or rashes noted. Ears are clear and pink. Tympanic membrane is visible and pearly grey. No lesion, discharge, or rashes. Sclera was white, cornea was clear, conjunctiva was pink with no lesions or discharge noted. Septum midline. Nostril patent bilaterally. No drainage or bleeding noted. Good dentition overall
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:**	 S1, S2 sounds present. No murmur, friction rubs or gallop. Normal sinus rhythm. Normal heart rate Peripheral pulses (radial and dorsalis pedis) are palpable and 2+ bilaterally. Normal capillary refill less than 3 second No neck vein distension No edema N/A
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	 No accessory muscle used. Anterior and posterior breath sounds bilaterally clear. No adventitious breath. Respirations are bilateral regular, even and nonlabored,

	symmetrical. No shortness of breath and cough. No wheeze, crackles.
GASTROINTESTINAL (5 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	 Normal diet NPO 5'3'' 216 lbs. Normal active bowel sound all four quadrants 06/17/2021 while she was pushing. No mass, pain or guarding. No skin abnormalities and mass through inspection No distention No incisions No scars No drains No wounds
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** Foley Catheter **Size:** 16 French **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Episiotomy/Lacerations:**	 Minimal bleeding Rubra Urine total with foley was 1075 ml. The color was yellow and clear. The patient genitals are clean and intact. AROM 06/17/21 at 0936 Clear moderate No odor None
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 30** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	 Moderate fall risk Patient is weak in the lower extremities due to some epidural residual, but she can move all extremities. She needs support when standing and walking.
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐**	

Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **Deep Tendon Reflexes:**	 The patient is oriented to person, time, place, and situation. Negative for altered mental status. Normal speech and appropriate for age Normal sensory and appropriate for age Alert 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 was just resting to cope with the birth. Developmental level as appropriate for age. The patient is Christians and goes to church weekly. The patient lives with her husband and son. Her husband is at the bedside. The patient has available family support.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	 6/17/21 1520 Vaginal birth 50ml of blood loss Male 1 minute= 8 5 minutes= 9 9lbs 8oz Breastfeeding

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	68 bpm	116/73	16 bpm	98.5 F orally	100% room air
Admission to Labor/Delivery	91 bpm	113/62	18 bpm	98.6 F orally	99% room air
During your care	85 bpm	120/72	18 bpm	98.9 F orally	100% room air

Vital Sign Trends: The vital signs were consistent. All the vital signs are within normal range/stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1147	Numeric	Abdomen	2/10	Pressure and discomfort	Turn patient
1700	Numeric	N/A	0/10	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:16 **Location of IV:** Right antecubital **Date on IV:** 6/15/21 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** No sign of erythema, drainage, swelling or tenderness. **IV dressing assessment:** Dry and intact	Lactated Ringers continuous infusion Rate: 125ml/hours.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
06/17/2021 1700 mL- Lactated ringers	06/17/2021 1075 ml- urine (Foley) 1 void

Nursing Interventions and Medical Treatments during Labor & Delivery (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.

"N" after you list them, identify medical treatments with "T" after you list them.)		
Electronic fetal monitoring N	Continuous	It is important to do continuous electronic fetal monitoring during labor to ensure the baby is doing well by checking their heart rate. The heart rate can be an indicator that the baby is doing well or in distress.
Intravenous fluid N	Continuous	Due to the patient being a nothing by mouth status, she needs to stay hydrated and prevent dehydration during labor and birth.
Fundal assessment (first hour after giving birth) N	Q15	It is important to assess the fundus every 15 minutes for the first one hour to ensure it is firm and bleeding will not be a concern.

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 the 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	**Rationale (1 pt each)** Explain why the nursing diagnosis was chosen	**Intervention/Rationale(2 per dx) (1 pt each)** Interventions should be specific and individualized for this 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 (2 pts each)** • How did the patient/ family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Anxiety related to labor evidence by three days labor	The patient has been staying in the hospital for	1. Encourage patient to do breathing technique. Rationale: Breathing	Goal: Decrease the anxiety of the patient about labor.

induction.	three days and anxious to give birth already.	technique can help calm the patient and make them feel in control (Ricci et al., 2020) 2. Implement comfort measure for the patient. Rationale: Provide the patient with a quite low stimuli environment, offer cool washcloth to put in the forehead or face and help them move round. Comfort measure can help the patient feel calmer (Ricci et al.,	Doing this intervention may help the patient feel calm and less stressed about being in the hospital for three days. The nurse provides comfort for the patient throughout her stay. She was very thankful for the patient.
2. Acute pain related to labor secondary to epidural wearing off evidence by the patient's statement of feeling sensation in her bottom.	The patient express feeling sensation in the bottom when the nurse is doing her third set of vitals after almost one hour after	1. Assess patient pain level Rationale: assessing the patient pain level will help the nurse think about the proper pain management intervention unique for the patient pain level (Swearingen & Wright, 2020)	Goal: Decrease the discomfort or pain of the patient as much as possible. The nurse asked the patient about the pain level. Patient state she is fine and experiencing some sensation in her

	the epidural was turned off	2. Use nonpharmacological measure to help sensation to subside Rationale: Providing measure such as low stimuli environment and ice pack may help the patient to be more comfortable	bottom but does not need intervention right now.
3. Knowledge deficit related to breastfeeding as evidenced by mother asking for help in breastfeeding.	The patient state that it is been one year since she last breastfed her first born. She wants to ensure she still doing it right for her second child.	1. Watch the patient how she breastfeeds and educate her about how to improve her technique Rationale: Assisting the mother with one-on-one instruction would help her to know how to properly breastfeed her baby (Ricci et al., 2020) 2. Allow time for the mother to ask question regarding breastfeeding. Rationale: Even though this is the second time the	Goal: Help patient to become more confident in breastfeeding the baby. The mother was able to demonstrate. breastfeeding correctly. The nurse asked all question regarding breastfeeding the baby.

		patient becomes a mother. It is still important to give her time to ask question to improve her breastfeeding technique. It is best to spend time with the mother and allow her to ask questions (Ricci et al., 2020)	
4. Risk for altered family process related to gaining a family member as evidence by birth of second child	The patient has a 2-year-old son. The family will transition from having one child to two children. It is important the newborn experience bond to the mother.	1. Once the baby is delivered, let the mother or father should hold the baby right away. Rationale: Providing skin to skin contact helps with bonding experience (Ricci et al., 2020). 2. Encourage the parents to participate in bathing, feeding. and soothing the baby Rational: By participating in these activities, the parents	Goal: welcome new infant to family and encourage bond between parents and baby. The mother was able to hold the baby as soon as it was delivered. The skin-to-skin contacts between the baby and mother helped initiate the bond between them. The nurse also encourages the father to do skin to skin contact

		can provide tactile stimulation to the infant while providing daily care Touch is an important thing to do for attachment to be established within parents and infant (Ricci et al., 2020	and soothe the baby while at the hospital.

Other References (APA): N/A