N432 Postpartum Care Plan

Lakeview College of Nursing

Happy Kalavadia

Demographics (3 points)

Date & Time of Admission	Patient Initials	Age	Gender
9/12/2021 21:00	KS	30	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Works at Walmart	Not married	None
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full Code	162.6 cm	119.3 kg	Yes (Boyfriend)

Medical History (5 Points)

Prenatal History:

G1POOOO.

Class 3 Maternal obesity

Tobacco smoking during pregnancy

History of Chlamydia infection during pregnancy.

Rubella nonimmune

Spontaneous rupture of membranous(SPOM)

GBS positive

Past Medical History: Dermatoid cyst rupture

Past Surgical History: None

Family History: Mother- Diabetes. Father- CHF, COPD, Leukemia and Lymphoma

Social History (tobacco/alcohol/drugs):

Smokes 5 to 8 cigarettes a day, 62 packs a year.

Alcohol- Patient drinks socially and she did not the number of drinks.

Drug abuse- She smokes marijuana and cannabinoid.

Living Situation: Patient lives with her boyfriend

Education Level: High school graduate

Admission Assessment

Chief Complaint (2 points): Cramping abdominal pain

Presentation to Labor & Delivery (10 points):

Patient presented to Obstetrics department after slight vaginal bleeding and abdominal cramping pain after dinner at her home. She was 39 weeks pregnant at that time during the onset of pain. The location of pain is in her lower abdominal area . The duration of the pain is intermittent but very sharp and unbearable. The characteristic symptoms of the pain described by the patient was that the pain intensity increased when she was in supine position. Patient mentioned that the associated manifestations of the pain were nausea and dizziness. She mentioned that her pain her did not relieved by any means and she did not do any home treatment for it.

Diagnosis

Primary Diagnosis on Admission (2 points): Spontaneous Abdominal pain

Secondary Diagnosis (if applicable): None

Postpartum Course (18 points)

Labor is typically divided into four stages (Susan et al., 2017). The first stage consists of latent or early phase, active phase and transition phase. The latent phase consists approximately of 6 hours and the dilation of cervix is from 1 to 3 cm in primigravida

females (Susan et al., 2017). Then comes the active phase of labor which lasts about 2 hours and the dilation of cervix is from 4 to 7 cm (Susan et al., 2017). The transition is the third part of the first phase of labor and usually lasts from 20 to 40 minutes with full cervical dilation (Susan et al., 2017). The second stage is pushing the fetus and lasts from 30 minutes to 2 hours in primigravida females (Susan et al., 2017). The cervix contracts every 1 to 2 minutes during this phase. The third phase consists of delivery of the neonate and initiation of expulsion of the placenta. It lasts from about 5 minutes to 30 minutes (Susan et al., 2017). The fourth stage consists of completion of expulsion of placenta and initiation of physiologic adjustment and stabilization of vital sings in the mother (Susan et al., 2017). The patient is in fourth stage of labor in their post-partum course because she has completed her placental eruption completely and is regaining her physiologic functions slowly. The main clinical evidence that the patient is in fourth stage of labor is the firmness of fundus as it was found to be the at the level of symphysis pubis (Susan et al., 2017). Another clinical evidence is the presence of lochia which was experienced by the patient. Lochia is a red whitish discharge that come from vagina after post-partum (Susan et al., 2017). This information was noted from the electronic medical records and from the patient while performing comprehensive head to toe assessment . Breast milk discharge called colostrum is also another clinical evidence that the patient is in fourth stage of labor. Patient had second degree cervical tear and had episiotomy which is another clinical evidence that she is in last or fourth stage of labor. The risk factors for post-partum are mainly post-partum hemorrhage , serious infection like sepsis from the remained placental pieces as well as postpartum depression. The most important task for a nurse in this stage is to monitor the mother closely to prevent hemorrhage, bladder distension and venous

thrombosis (Susan et al., 2017). The clinical data that proves that patient is in postpartum course is live baby girl, placenta and decrease in the hormone progesterone after delivery of the baby (Susan et al., 2017). It is also equally important to assess for mental wellbeing of the mother by asking her open-ended questions if she is comfortable with it (Mayo Foundation for education and research , 2020). The patient is very eager to talk, and she is alerted to person, place and time. She is very excited to start a new life and she mentioned during her head to toe assessment that her mood is good, but she feels little weak after giving birth which is normal physiologic response. Fatigue is a normal physiologic response and the patient is advised to have adequate rest (Susan et al., 2017). The patient is very adaptable, and she is eager to learn about breastfeeding as she is having difficulty latching the newborn. Patient should be properly educated about postpartum depression and measures to avoid SIDS in newborn. Blood pressure and other vital signs should be monitored every 4 hours (Susan et al., 2017). In addition, vaginal bleeding should be monitored by nurse to avoid postpartum depression. Labor in women's life is a major remarkable event and pain is a universal experience. Hence it is important for a nurse to ease the pain and make patient comfortable so that patient has memorable birthing experience.

Postpartum Course References (2) (APA):

Mayo Foundation for Medical Education and Research. (2020, February 6). ***Stages of labor and birth: Baby, it's time!*** **Mayo Clinic. Retrieved September 15, 2021, from https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/stages-of-labor/art-20046545.**

Ricci, S. S., Kyle, T., & Carman, S. (2021). ***Maternity and pediatric nursing*** **(4th ed.).**

Wolters Kluwer.

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	4.0-4.9 10^6/ uL		4.27	4.08	Within normal range.
Hgb	12.0-16.0 g/dL		13.0	14.0	Within normal range.
Hct	37.0-48.0%		37.8	35.7	Within normal range.
Platelets	150-400 10^3/uL		230	175	There is hemodilution in blood during pregnancy resulting in low platelet count in blood due to dilution of blood (Susan et al., 2017).
WBC	4.1-10.9 10^3/uL		11.2	13.4	Patient has GBS positive bacterial infection and hence there is increased WBC to fight the infection (Susan et al., 2017).
Neutrophils	1.50-7.70 10^3/uL		8.0	8.2	Patient has bacterial infection and hence neutrophils are increased because the body is fighting the infection (Susan et al., 2017).
Lymphocytes	1.00-4.90 10^3/uL		5.3	6.4	Lymphocyte count is elevated in patient who has active bacterial infection (Susan et al., 2017).
Monocytes	0.00-0.80 10^3/uL		1.40	0.50	Monocytes count is increased in GBS infection

					(Susan et al., 2017).
Eosinophils	**0.00-0.50 10^3/uL**		**0.04**	**0.03**	**Within normal range.**
Bands	**Less than 0.01 percent**		**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	**O, AB + /-, B+/- and A+/-**	**O +**	**O+**	**O+**	**Within normal range.**
Rh Factor	**+ /-**	**+**	**+**	**+**	**Within normal range.**
Serology (RPR/VDRL)	**Reactive/ nonreactive**	**Reactive**	**Nonreactive**	**Nonreactive**	**RPR is reactive in patient with syphilis (Susan et al., 2017).**
Rubella Titer	**Immune/ Nonimmune**	**Nonimmune**	**Nonimmune**	**Nonimmune**	**Patient did not receive titer and hence is considered nonimmune (Susan et al., 2017).**
HIV	**Positive/Negative**	**Not detected**	**Not detected**	**Not detected**	**Within normal range.**
HbSAG	**Positive/Negative**	**Not detected**	**Not detected**	**Not detected**	**Within normal range.**
Group Beta Strep Swab	**Detected/ Non detected**	**Detected**	**Detected**	**Detected**	**Patient has Group beta streptococcus infection and hence is positive (Susan et**

					al., 2017).
Glucose at 28 Weeks	**Less than 140**	**89**	**89**	**89**	**Within Normal range.**
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
Covid SARS-COV-2	**Positive / Negative**	**N/A**	**Negative**	**Negative**	**Within normal range.**
INR	**Less than 1.1**	**N/A**	**N/A**	**0.9**	**Within normal range.**
PTT	**25 -35**	**N/A**	**N/A**	**28**	**Within normal range.**
Urine cannabinoid	**Detected/Not detected**	**Detected**	**detected**	**detected**	**Patient did abuse Cannabinoid and hence detected in urine (Susan et al., 2017).**
RH	+/-	+	+	+	**Patient is Rhesus factor positive (Susan et al., 2017).**

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	**500 to 2000 mg/ day**	**N/A**	**N/A**	**N/A**	**N/A**

applicable)					

Lab Reference (1) (APA):

Ricci, S. S., Kyle, T., & Carman, S. (2021). ***Maternity and pediatric nursing*** **(4th ed.). Wolters Kluwer.**

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

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	**The total length of labor was 25 hours.** **The labor was spontaneous.** **Not mentioned in the chart but below mentioned are duration of each stage.** **First stage- Latent- 6 hours, Active -2 hours, Transtion-20 to 40 minutes (Susan et al., 2017)** **Second stage- 20 minutes to 2 hours (Susan et al., 2017)** **Third -5 to 30 minutes (Susan et al., 2017)** **Fourth stage is 1 to 2 hours. (Susan et al., 2017)**
Current stage of labor	**Patient presented to OB department with spontaneous**

	rupture of membranes shortly after having dinner. **The patient is currently in fourth stage of labor (Hutchison, 2021).The patient's fundus is firm and is at the level of umbilicus (Susan et.al, 2017). Patient does have mild vaginal bleeding. Patient also had lochia which is red blood mixed with mucus. This information was derived from the patient during head to toe assessment.**

Stage of Labor References (2) (APA):

Hutchison, J. (2021, February 25). *Stages of labor*. StatPearls [Internet]. Retrieved September 14, 2021, from https://www.ncbi.nlm.nih.gov/books/NBK544290/#_article-29431_s9_.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

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

Home Medications (2 required)

Patient had only one home medication. The other one medication was obtained from textbook.

Brand/Generic	**Prenatal**	**Zofran/**			

	Multivitamin 27/ Prenatal multivitamin	**Odensetron (Susan et.al, 2017).**			
Dose	**0.8 mg**	**4 mg**			
Frequency	**1**	**1 PRN (8 hourly)**			
Route	**Oral**	**Oral**			
Classification	**Multivitamin**	**Antiemetics**			
Mechanism of Action	**It increases all major vitamins and minerals for normal growth and development of fetus.**	**It is a 5HT3 receptor antagonist which prevents nausea (Susan et.al, 2017).**			
Reason Client Taking	**Patient is pregnant.**	**Patient can take if she feels nauseated.**			
Contraindications (2)	**Allergy Severe constipation**	**Allergy Rash**			
Side Effects/Adverse Reactions (2)	**Rash from allergy Nausea**	**Diarrhea Heartburn**			
Nursing Considerations (2)	**Take the tablet at the same time to prevent maximal absorption.** **Take after meals to prevent GI upset.**	**Do not lie down for 30 minutes after taking tablet for prevent heartburn.** **Take after meals to prevent heartburn.**			
Key Nursing	**None**	**None**			

Assessment(s)/Lab(s) Prior to Administration					
Client Teaching needs (2)	**Take the tablet without crushing or chewing .** **Do not consume tablet if it expired.**	**Take the tablet without crushing or chewing .** **Do not consume tablet if it expired.**			

Hospital Medications (5 required)

Brand/Generic	**Colace/ Docusate sodium**	**Motrin/ Ibuprofen**	**Bicillin C-R / Penicillin G**	**Tucks/ Witch hazel pad**	**Benzocaine menthol/ dermoplast**
Dose	**100 mg**	**800 mg**	**5 million units**	**1 pad**	**Spray two puffs**
Frequency	**Daily**	**Every 8 hours PRN**	**Once IV**	**Every hour PRN**	**4 times PRN**
Route	**Oral**	**Oral**	**IV**	**On skin**	**Puffs**
Classification	**Stool softener**	**Analgesic**	**Antibacterial**	**Analgesic**	**Analgesic**
Mechanism of Action	**It allows the water to enter stool to make it soft and easier to pass. (Susan**	**It is reversible inhibitor of cyclooxygenase enzymes Cox1 and 2 which relieves pain (Susan et.al,**	**The bactericidal activity inhibits the cell wall synthesis inhibiting gram positive**	**It has powerful antioxidant property relieving itching and burning pain.**	**It inhibits pain receptors decreasing the pain fibers and relieving pain.**

	et.al, 2017).	**2017).**	**and negative bacteria (Jones & Bartlett, 2021)**		
Reason Client Taking	**Constipation**	**For pain**	**Patient is GBS positive**	**Vaginal pain**	**Vaginal pain**
Contraindications (2)	**Allergy Rash**	**Allergy Rash**	**Allergy Rash**	**Allergy Rash**	**Allergy Rash**
Side Effects/Adverse Reactions (2)	**Electrolyte imbalance Diarrhea**	**Gi upset Acidity**	**Diarrhea Nausea**	**Hypothermia Skin erythema**	**Skin rash Itching**
Nursing Considerations (2)	**Drink plenty of fluid to prevent dehydration. Take at the same time for maximal absorption.**	**Take with milk to prevent acidity. Take at the same time for maximal absorption.**	**Take at the same time for maximal absorption. Take with food to prevent nausea.**	**Apply pad on small skin surface to check if there is skin erythema . Apply the patch gently to prevent skin eruption.**	**Apply two puffs on a small area of skin to test for any allergy. Hold the spray away from the eyes to avoid eye injury.**
Key Nursing Assessment(s)/Lab (s) Prior to Administration	**None**	**Assessment of the patient's pain on numeric scale.**	**None**	**Assessment of the patient's pain on numeric scale.**	**Assessment of the patient's pain on numeric scale.**
Client Teaching needs (2)	**Take the tablet without crushing or chewing . Do not consume**	**Take the tablet without crushing or chewing . Do not consume**	**Do not bend hand at the iv site to avoid iv disruption. Do not rub**	**Apply the pad on skin evenly and press gently Do not rub the area after**	**Apply two spray and do not overspray . Do not**

	tablet if it expired.	**tablet if it expired.**	**the iv site if it itches.**	**placing pad.**	**wipe after applying spray.**

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2021 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient is alerted to person, place and time. Patient is pleasant to talk to and not in distress.**
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score: 19** **Drains present: Y☐ N ☒** **Type:**	**Skin is pink and moist without any rashes or lesions. There are not bruises present on the skin. Skin turgor and integrity is normal with no cyanosis or clubbing present.**
HEENT (1 point): **Head/Neck:** **Ears:**	**The head is atraumatic without any tenderness or lesions. Head and neck are**

Eyes: **Nose:** **Teeth:**	**symmetrical, and trachea is midline with no deviation. PERRLA and EOM is intact. Ears are pink and moist with no tenderness present. Teeth are intact with no evidence of gum bleeding present.**
CARDIOVASCULAR (2 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:**	**.Clear S1 and S2 heard without gallops or rubs. Pt in normal sinus rhythm with PVC'S, Peripheral pulses palpable. Capillary refill less then 3sec. No murmur heard.**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**The chest wall is symmetric and without deformity. No signs of respiratory distress are noted. No rales, rhonchi and crackles present .**
GASTROINTESTINAL (2 points): **Diet at Home: Regular diet** **Current Diet: regular** **Height: 5 feet 4 inch** **Weight: 263 lb** **Auscultation Bowel sounds:** **Last BM: 9/12/21** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention: No** **Incisions:No** **Scars: No** **Drains: No** **Wounds: no**	**Bowel sounds are present and normoactive in all four quadrants. Abdomen is soft, symmetric with no pain or tenderness. Aorta is midline with bruit or visible pulsation. No hepatomegaly or splenomegaly noted. Mild pain on palpation of abdomen due to rigidity of uterus during fundus height assessment.**
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Patient have normal urine output and is 1500 ml per day. This information was obtained from the patient's nurse. She did not have pain with urination but have vaginal pain due to her birthing event.**
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 30** **Activity/Mobility Status:** **Independent (up ad lib) ☒**	**Patient is completely stable to walk. She can use restroom by herself and does not have any pain or burning upon urination.**

Needs assistance with equipment ☐ **Needs support to stand and walk☐**	
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☒ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **DTRs:**	**Motor function is normal with muscle strength 5/5 bilaterally . Sensation is intact bilaterally. Reflexes 2+ bilaterally. No gait abnormality noted.**
PSYCHOSOCIAL/CULTURAL (2 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):**	**Patient coping method includes color painting, talking with her mom and likes to be by herself. Patient is developmental level is age appropriate. She is Christian by religion and her support person is her boyfriend.**
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	**Patient's fundal height is within the line of umbilicus. Spontaneous rupture of membranes. Lochia color is light red, and she has second degree cervical tear.**
DELIVERY INFO: (1 point) **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Delivery Date: 9/12/2021** **Time: 21:00** **Type (vaginal/cesarean): Vaginal** **Quantitative Blood Loss: 300 ml** **Male or Female - Female** **Apgars: 8** **Weight:8.3 lb** **Feeding Method: breast feeding as well as formula**	**Spontaneous rupture of membranous . The color of the fluid is clear, and the amount is unknown. The fluid is odorless.**

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**97**	**121/85**	**16**	**98.3**	**98**
Labor/Delivery	**65**	**102/57**	**16**	**97.6**	**99**
Postpartum	**71**	**126/87**	**18**	**97.9**	**98**

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
10 am	**Numeric scale 0-10**	**Abdomen**	**2**	**Cramping**	**Clustered care**
15:00	**Numeric scale 0-10**	**Abdomen**	**4**	**Cramping**	**Ibuprofen**

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:**	Patient did not have IV line during student's care.

Intake and Output (2 points)

Intake	Output (in mL)
Eating normal regular diet	**Normal urine output (1500 ml a day)**

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.
Teaching patient on how to use dermoplast spray (N). Open legs and gently spray two puffs holding the spray at least 2 inches away from the vagina.	**once**	**This is important so that patient can ease her vaginal pain due to second degree tear of her birthing event.**
Measure blood pressure four hourly (M).	**Every 4 hour**	**Blood pressure is an important vital sign to monitor for patient due to her history of high blood pressure.**
Initiate using icepacks to minimize her vaginal pain (N)	**Every 6 hours PRN**	**This is important because patient had burning vaginal pain and ice packs will decrease her pain.**
To apply Lanozolin cram for sore nipples (M)	**Every 4 hours**	**Patient has sore nipples and she felt quite relief with the application of cream in her nipples.**

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? Post-partum stage four of labor

What evidence supports this? The patient had lochia which is definitive sign of delivery the baby and she had mild abdominal pain and vaginal bleeding which further shows evidence of stage four labor. In addition, her fundus of uterus is in line with umbilicus which marks that she is postpartum and in stage four.

Discharge Planning (2 points)

Discharge location: Danville, IL

Equipment needs (if applicable): None

Follow up plan (include plan for mother AND newborn): Six weeks follow up appointment

Education needs: Breast feeding and taking care of newborn.

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 (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. Acute pain related to post-partum delivery of female infant evidenced by facial mask of pain and verbalization of the pain.	**Patient mentioned that she has pain of 4 on a scale of 10 and is abdominal as well as vaginal pain. The pain is cramping type and is intermittent.**	**1.** Reviewing available pain medications such as Ibuprofen every 6 hourly PRN as pain did not subside without medication (Mary & Kabembo, 2019). **2.** Offering more ice packs to relieve the pain but patient refused for it (Mary & Kabembo, 2019).	**Patient pain was 2 in the morning and it increased to 4. Patient was offered more ice packs and Ibuprofen. Patient verbalized that her pain is better than before, and she wants to rest for now. Outcome- 1)Patient's pain is well controlled.** **2)Patient has decrease in her pain episodes.**
2. Knowledge deficit about breastfeeding	**Patient verbalized that she is not**	**1. Patient's nurse did one on one session about how**	**Patient is feeling more comfortable after learning the right**

a newborn related to patient's anxious nature and as evidenced by no milk when baby starts to suck. (The information was obtained from chart)	**getting enough milk out from her breasts and she wants to learn new positions for latching from the nurse.**	**to breast feed and asked patient to demonstrate the teaching to the nurse (Mary & Kabembo, 2019).** **2.** Patient was given some private time to learn the technique taught and lactation services were consulted upon patient request (Mary & Kabembo, 2019).	**technique from the nurse.** **Outcome- Patient is feeling confident about breast feeding.** **Patient is excited to consult lactation services for breast feeding.** **Outcome- Patient feels better after having some private time to learn breastfeeding.**
3. Knowledge deficit of SIDS related to birth of newborn female as evidenced by patient not putting baby back to sleep. (This information was obtained from the patient's nurse).	**One of the caregivers saw patient not safely putting baby back into her crib .**	**1. Patient was instructed properly on safe methods like putting baby back to sleep and removing all stuffed toys from the crib** (Mary & Kabembo, 2019). **2. Patient was taught not sleep in the same bed with the baby to prevent SIDS. She was taught to sleep in the same room if she wishes** (Mary & Kabembo, 2019).	**Outcome- Patient agreed the instructions and demonstrated it by properly putting baby back to sleep.** **Outcome- Patient agreed with the instructions and assured the nurse that she will never sleep with the baby in the same bed.**
4. Risk for blood clots related to patients high BMI as evidenced by patient's sitting in her bed for long periods post-partum.	**Patient is at high risk for developing a blood clot because she feels numb in her legs due to epidural and hence less mobile.**	**1. Patient was given a pair of SCD which are calf muscle boots which allows for more pumping of the blood and prevent blood clots** (Mary & Kabembo, 2019). **2. Patient was advised to ambulate more often and use restroom by herself** (Mary & Kabembo, 2019).	**Outcome- SCD would help prevent the blood clot and patient is compatible with it.** **3. Outcome- Patient agreed to it and started ambulating more often as evidenced by**

			this student nurse as she uses restroom by herself.

Other References (APA)

Mary, & Kabembo. (2019, May 31). *36 labor Stages, induced and Augmented Labor nursing care plans*. Nurseslabs. Retrieved September 15, 2021, from https://nurseslabs.com/labor-stages-labor-induced-nursing-care-plan/6/#f1.