N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 09/20/21 0622	**Patient Initials** M.K	**Age** 33 yrs. old (04/23/1988)	**Gender** Female
Race/Ethnicity Indian	**Occupation** Not employed	**Marital Status** Married	**Allergies** N/A
Code Status Full	**Height** 5'2" (157.5 cm)	**Weight** 76.7 kg (169 lb)	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: Patient has a pregnancy outcome of G2T1P0A1L1, Patient had one ectopic pregnancy in 2019. Patient has prenatal history of chorioamnionitis, mild preeclampsia**.**

Past Medical History: Patient states no past medical history.

Past Surgical History: Patient states no past surgical history.

Family History: Father- Diabetes, Thyroid Disease

Father/Mother- High cholesterol, Hypertension

Social History (tobacco/alcohol/drugs): Patient denies any use of tobacco, alcohol, or drugs.

Living Situation: Patient lives at home with her husband.

Education Level: Patient has a master's degree in biotechnology.

Admission Assessment

Chief Complaint (2 points): Decreased Fetal Movement

Presentation to Labor & Delivery (10 points):

A 33-year-old female was admitted to the labor and delivery unit on 09/20/2021. Patient is 39 weeks and 6 days, and this is her second pregnancy. Patient states that she felt decreased fetal movement and was concerned so she came to the hospital. Patient went into labor around 1017,

became dilated at 1953, started pushing at 2000, but failed to progress so went into an emergent cesarean section at 2155. Patient's membranes ruptured at 1557, it was a small bloody show.

Diagnosis

Primary Diagnosis on Admission (2 points): Labor

Secondary Diagnosis (if applicable): Mild Preeclampsia

Postpartum Course (18 points)

The patient is in stage four of labor, the postpartum stage. During this time, it is a transitional time for the mother to recovery and spend time with her newborn and family. The body will begin to return to its pre-pregnant state which is usually resolved by the 6th week after giving birth. Childbirth is a very happy period in a women's life, but some mothers may experience mood changes as well during this time. Many mothers may feel fatigued, irritable, worried, and sometimes those feelings become serve enough to require medical attention (Ricci et al., 2020). As these are all minor risk factors of postpartum, there are major risk factors of postpartum including uterine infection, lacerations, and retained blood clots. Patients will also commonly experience vaginal discharge, sore breasts, and irritability for a few days, and this is caused by an imbalance of hormone levels and is a normal part of the postpartum stage.

The patient is in the acute phase of postpartum. This period is 24 hours after childbirth. This is a time of rapid change with the potential for immediate crisis such as hemorrhage, uterine inversion, amniotic fluid embolism, and eclampsia (Lyon, 2019). These first few hours are spent with intense nursing supervision. Normal findings the patient may experience are elevation in temperature, sweating, and decreased respiration rate. My patient experienced an elevated

temperature during labor of 100.4 which eventually resolved during her postpartum stage, and her skin felt very clammy.

The patient is in the taking-in phase following delivery. During this phase the client needs sleep and depends on others to meet her needs (Ricci et al., 2020). The first 24 to 48 hours after giving birth, mothers meet their own basic needs for food, fluids, and rest with allowing the nurse to decision make for them on activities and care (Ricci et al., 2020). The new mothers will spend time with their newborn claiming and touching them.

Risk factors for postpartum complications are important to monitor following the delivery and the first 24 hours after when assessing the new mother. Risk factors for postpartum include hemorrhage, uterine inversion, amniotic fluid embolism, eclampsia, prolonged birth, and infection. Risk factors for postpartum infection include history of caesarean delivery, premature rupture of membranes, frequent cervical examination, preexisting pelvic infection, diabetes, nutritional status, and obesity (Ricci et al., 2020). Risk factors for postpartum mood disorders include previous diagnosis of bipolar disorder, depression, anxiety, single marital status, unplanned or unwanted pregnancy, and lower socioeconomic status (Ricci et al., 2020). My patient does not suffer from any of these risk factors and is not at a high risk of postpartum depression or complications.

Postpartum Course References (2) (APA):

Lyon, D. S. (2019). Postpartum Care. *The Global Library of Women's Medicine*. Published. https://doi.org/10.3843/glowm.10143

Ricci, S., Kyle, T., & Carman, S. (2020). *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	3.50-5.20	4.16	4.61	3.87	
Hgb	11.0-16.0	11.1	11.6	9.8	The patient had low hemoglobin from losing blood during birth and cesarean section (Ricci et al., 2020).
Hct	34-47	33.9	36.3	30.7	The patient had low hematocrit from losing blood during birth and cesarean section (Ricci et al., 2020).
Platelets	140-400	155	159	130	The patient had low platelets from losing blood during birth and cesarean section (Ricci et al., 2020).
WBC	4.00-11.00	11.43	10.40	16.90	The patient had a high WBC count because she had an infection in the chorion and amniotic fluid (Ricci et al., 2020).
Neutrophils	1.60-7.70 47.0-73.0%	8.84	73.5	88.4	The patient had high neutrophils count because she had an infection in the chorion and amniotic fluid (Ricci et al., 2020).
Lymphocytes	18.00-42.00%	15.4	19.1	5.3	The patient had low lymphocyte count because she had an infection in the chorion and amniotic fluid (Ricci et al., 2020).
Monocytes	4.00-12.00%	5.9	6.3	6.0	
Eosinophils	0.00-0.50	0.7	0.7	0.0	
Bands	0.00-0.33	NA	NA	NA	

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

Lab Test	Normal	Prenatal	Value on	Today's	Reason for

	Range	Value	Admission	Value	Abnormal
Blood Type	A, B, AB, O	O	O	O	
Rh Factor	Positive/ negative	Positive	Positive	Positive	
Serology (RPR/VDRL)	Positive/ negative	Negative	Negative	Negative	
Rubella Titer	Immune/ Nonimmune	Nonimmune	Nonimmune	Nonimmune	The patient was nonimmune to Rubella because her body does not produce enough antibodies to fight it off (Ricci et al., 2020).
HIV	Positive/ negative	Negative	Negative	Negative	
HbSAG	Positive/ negative	Negative	Negative	Negative	
Group Beta Strep Swab	Positive/ negative	Positive	Positive	Positive	The patient tested positive for group beta strep because her body produces excess amounts of group beta strep (Ricci et al., 2020).
Glucose at 28 Weeks	70-99	N/A	N/A	N/A	
MSAFP (If Applicable)	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
SARs-COV-2 by molecular	Positive/ Negative	N/A	Negative	N/A	

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)	Less than 0.25	N/A	N/A	N/A	

Lab Reference (1) (APA):

OSF Lab Reference per Epic Charting

Ricci, S., Kyle, T., & Carman, S. (2020). *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**	The patient's labor was a total of 12 hours and 53 minutes. The first stage of labor lasted 9 hours and 36 minutes. The second

Time in each stage	stage of labor lasted 3 hours and 16 minutes. The third stage of labor lasted only 1 minute in length. The length of labor can vary from hours to days depending on if it is a first-time birth or subsequent delivery (*Stages of Labor and Birth: Baby, It's Time!*, 2020). The labor was initially spontaneous but then turned into induced because of the patient's failure to progress. The placenta was delivered immediately following the baby during the cesarean section.
Current stage of labor	The patient is currently in the fourth stage of labor. The patient is with her baby in the postpartum stage to recovery and spend time with her newborn. This stage lasts about 6 weeks and during these weeks the women's body begins to return to its prepregnant state. As seen not all women recover the same way, so the postpartum stage can last as long 9-12 months. The mother's body adjusts psychologically to the new life changes and takes on the role of a mother (Ricci et al., 2020).

Stage of Labor References (2) (APA):

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

Stages of labor and birth: Baby, it's time! (2020, February 6). Mayo Clinic. https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/stages-of-labor/art-20046545?reDate=24092021

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

Home Medications (2 required)

Brand/Generic	Prenatal Multivit-Min-Fe-FA (Tricare Prenatal DHA)	Guaifenesin (Mucinex)
Dose	0.8 mg	400 mg
Frequency	Once Daily	Every 4 hours as needed
Route	Oral	Oral
Classification	Vitamin	Expectorant
Mechanism of Action	This medication replaces vitamins not consumed enough in the diet.	Increases fluid and mucus removal from the upper respiratory tract by increasing volume of secretions and reducing their adhesiveness and surface tension
Reason Client Taking	Insufficient amount of vitamins and nutrients in the diet to support both the baby and mom	To relive cough and congestion
Contraindications (2)	Allergic to ingredients, B12 deficiency	Hypersensitivity, high blood pressure
Side Effects/Adverse Reactions (2)	Upset stomach, unusual taste in mouth	Dizziness, headache
Nursing Considerations (2)	Seek emergency help if an overdose occurs, avoid taking with milk or other dairy products	Do not exceed the maximum daily amount, watch for evidence of more serious condition
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor intake of vitamin dose, monitor ALT/AST for liver damage	Monitor blood pressure, monitor for signs of anaphylaxis
Client Teaching	Never take more than the	Take with a full glass of water, tell

needs (2)	recommended dose, take the prenatal vitamin with a full glass of water	patient to increase fluid intake to help thin secretions

Hospital Medications (5 required)

Brand/Generic	Acetaminophen (Tylenol)	Aluminum/ Magnesium Hydroxide simethicone (Mylanta)	Ampicillin (Omni pen)	Ketorolac (Toradol)	Lactated Ringers in 5% dextrose
Dose	975 mg	20 mg/5mL	2g in normal saline	30mg	125 mL/hr
Frequency	Q6H	Q6H PRN	Q6H	Q6H	Continuous
Route	Oral	Oral	IV push	IV push	IV
Classification	Antipyretic, nonopioid analgesic	Antacid, phosphate binder	Antibiotic	Analgesic	Alkalinizing agent
Mechanism of Action	Blocks prostaglandin production and interfering with pain impulse generation; acts directly on temperature-regulating center in the hypothalamus	Neutralizes or reduces gastric acidity, increasing stomach and duodenal alkalinity	Inhibits bacterial cell wall synthesis	Blocks cyclooxygenase, an enzyme needed to synthesize prostaglandins	Restores fluid and electrolyte balances, produced diuresis, and reduced acidity
Reason Client Taking	Reduce fever	Treat heartburn	To treat chorioamnionitis	Reduce pain	Maintain fluid and electrolyte balance
Contraindications (2)	Hypersensitivity, severe hepatic impairment	Hypersensitivity, hypersensitivity to aluminum	Hypersensitivity to ampicillin, infection caused by	Hypersensitivity, concurrent use of other NSAIDS	Allergy to corn, allergy to corn products

			penicillinase organism		
Side Effects/Adverse Reactions (2)	Hypotension, pulmonary edema	Electrolyte imbalances, encephalopathy	Throat tightness, erythema multiforme	GI bleeding, respiratory depression	Lightheadedness, swelling of face, arms, hands, lower legs, feet
Nursing Considerations (2)	Do not exceed daily maximum dose, monitor renal function	Do not give within 1-2 hours of other oral drugs, monitor patient's electrolyte levels	Dilute with normal saline for infusion, administer 24-48 hours after becoming asymptomatic	Know risks of heart failure increases, give IV injection over 15 seconds	Monitor for hypovolemia, increased intercranial pressure may cause cerebral edema
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess blood pressure, auscultate lung fields	Complete CMP panel, monitor for aluminum intoxication	Monitor platelet count, monitor RBC count	Assess/ monitor respiration status, complete CMP panel	CMP panel, monitor fluid balance
Client Teaching needs (2)	Tablets may be crushed or swallowed whole, teach client to recognize S/S of hepatotoxicity	Instruct patient to chew tablets completely before swallowing, teach patient to increase fiber and fluid intake to prevent constipation	Take full course of medication, review signs of allergic reaction	Take with antacid or food, advise clients to avoid other NSAIDS	Teach patient to recognize S/S of hypercalcemia, check with doctor before breastfeeding

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2020 Nurses drug handbook*. Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Alert and oriented to time, place, person, and date X4 No distress Well groomed, nourished, and developed
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Black/Brown Dry/elastic Warm, clammy Elastic turgor 2+ No rashes No bruises Bilateral, transverse abdominal incision 20
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Head/neck symmetrical, equal range of motion TM gray/pearly, free of discharge Eyes symmetrical, EOM intact Nose symmetry, no deviation Gum's pink/moist, good dentition
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:**	. Hear sounds auscultated S1 and S2 present, no murmurs No gallops or rub in S3 and S4 Carotid, radial, ulnar, brachial, femoral, popliteal, dorsal pedis, and posterior tibial pulses +2 Capillary refill less than 3 seconds Lower Left/Right leg +1 Left/Right foot +2
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	No crackle or wheezes. Lungs clear posterior and anterior in all lobes.
GASTROINTESTINAL (2 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:**	. Regular diet at home Regular diet 5'2" (157.5 cm) 169 lb (76.7 kg) Bowel sounds active in all four quadrants. 09/20 No masses/palpations

Inspection: **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	 No distention Bilateral, transverse abdominal incision No scars No drains No wounds
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:**	 2400 mL Genitals clean and dry Indwelling single lumen 16 Fr
MUSCULOSKELETAL (1 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☐**	 5 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:**	 Patient is orientated to person, place, time, and date. Slight dizziness, no weakness or headache Articulative speech Alert No gross focal neurological deficits Present but diminished
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):**	 Husband is at bedside for support and is attentive to patient. Mature, no depression/suicidal thoughts. Patient is Hindu and follows all practices. Patient is calm, cooperative, and pleasant. Patient is involved in plan of care.
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:**	 1 cm below umbilicus Scant Light, rubra

Character: **Episiotomy/Lacerations:**	<10 cm on pad/hr, no odor N/A- cesarean section
DELIVERY INFO: (1 point) **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	 Spontaneous ROM 1557 Bloody show Small No odor 09/21/21 1557 Cesarean 929 mL Male 9 at 1 minute, 9 at 5 minutes 3565 g (7 lbs 13.8 oz) Bottle

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	99 bpm	139/69 Brachial, mechanical	18	98.4 F (36.9 C) (Orally)	98%
Labor/Delivery	104 bpm	143/73 Brachial, mechanical	18	100.4 F (38.0 C) (Orally)	98%
Postpartum	84 bpm	126/68 Brachial, mechanical	18	98.2 F (36.8 C) (Orally)	97%

Vital Sign Trends: The patient's prenatal vital signs were all within normal limits except her blood pressure which is common for women in their first and second trimesters. The patient had

increased pulse, blood pressure, and temperature during labor and delivery. This is most likely caused from patient having chorioamnionitis which is a bacterial infection causing the spike in temperature. The pulse and blood pressure were elevated because the patient was going through labor and exerting her body. All postpartum vitals remained stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numeric	N/A	N/A	Patient states she has no pain.	N/A
1130	Numeric	N/A	N/A	Patient states she has no pain.	N/A

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 Left antecubital fossa 09/20/21 IV patent No signs of erythema/drainage No phlebitis/infiltration; dressing clean, dry Lactated Ringers 125 mL/hr

Intake and Output (2 points)

Intake	Output (in mL)
4094.5 mL- IV 100 mL- IV piggyback Total: 4194.5 mL	2400 mL- urine 929 mL- blood Total: 3,329 mL

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.
Administer prescribed medications (T)	As scheduled or as needed	This treatment was provided to the patient to help reduce any pain and help with patient's nausea.
Perform peri care (N)	Every 2 hours	This intervention was provided to the patient because she was still bleeding and needed proper clean up in the area to prevent infection.
Assess patient's fundus (N)	Every 1 hour	This intervention is used to determine uterine size, firmness, and rate of descent.
Assess patient's pain (N)	Every 2 hours	This intervention is used to ensure the patient is comfortable and as pain free as possible.

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? The patient is in the taking-in phase.

What evidence supports this? This is the time 24-48 hours after birth when the mother needs sleep and depends on others to meet her needs. The patient was interacting with her newborn and becoming familiar with being a new mom. While the baby was not feeding, the patient spend time catching up on sleep and allowing the nurse to make decisions for her about activities and care.

Discharge Planning (2 points)

Discharge location: Patient will be discharged home with her husband and newborn.

Equipment needs (if applicable): N/A

Follow up plan (include plan for mother AND newborn): The patient should follow up with obstetrician-gynecologist in 2 weeks for a check up on her incision from the cesarean section. The patient will then need to follow up with obstetrician-gynecologist in 6 weeks for her postpartum exam. Lastly, the newborn will need to follow up with the pediatrician in 24-48 hours.

Education needs: Patient was educated on proper feeding techniques and care for her newborn. Patient was also educated on sudden infant death syndrome and ways to prevent it. Patient was educated on postpartum bleeding and proper care for keeping her incision clean and dry.

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. Risk for electrolyte imbalance related to nausea and	I chose this diagnosis because the patient is not eating or	1.Monitor the patient's mental status every 2 hours. Rationale: This is important because dehydration and electrolyte imbalances can	Patient responded well to treatment plan. Patient was assessed every 2 hours to check mental status. Goal was

vomiting as evidenced by patient not being able to keep anything down.	drinking due to throwing up everything she eats or drinks.	cause severe changes to the body and conscious level (Ricci et al., 2020). 2.Administer IV fluids continuous Rationale: This is important because it will help the patient maintain normal levels which will reduce further complications (Ricci et al., 2020).	met with IV medications. Patient will advance to proper diet when it is tolerated.
2. Risk for infection related to urinary retention as evidenced by insertion of urinary catheter	I chose this diagnosis because the patient had a urinary catheter put in for her cesarean section and she is also experiencing urinary retention.	1. Perform peri care every 4 hours Rationale: This is important because keeping the area clean and dry will help kill off bacteria (Ricci et al., 2020). 2. Monitor for elevated temperature every 4 hours. Rationale: Monitoring the patient's temperature will help identify if the body is fighting an infection (Ricci et al., 2020)	Goal met. Patient was taught peri care and the proper way of wiping front to back to prevent any further infections. Temperature was monitored and the patient was assessed if it was elevated.
3. Deficient knowledge related to proper care of a newborn as evidenced by first-time parents	I chose this diagnosis because a newborn is a lot to care for especially as a new set of parents.	1. Educate the parents on proper feeding techniques. Rationale: This is important to educate parents on to prevent their baby from aspirating during feeding (Ricci et al., 2020). 2. Educate the parents on the risk of sudden infant death syndrome. Rationale: This is important because parents should know the proper way to position their newborn when sleeping and what can cause sudden infant death syndrome (Ricci et al.,	The verbal teach back method was used to ensure the parents understood the proper feeding techniques and all the risk factors of sudden infant death syndrome. Goal met. Parents were feeling more confident than before.

		2020).	
4. Risk for falls related to feeling tingly and nauseous as evidenced by the cesarean medications still wearing off.	I chose this diagnosis because it is important to educate the patient on fall risks to avoid injury.	1. Move cords and other trips hazards under the bed. Rationale: This is important because it will prevent the patient from tripping over anything while walking (Ricci et al., 2020). 2. Encourage the patient to use nonskid socks when walking. Rationale: Nonskid footwear provides sure footing for the patient when walking (Ricci et al., 2020).	Goal met. Patient ensured everything was out of the way before beginning to walk. Patient also kept on nonskid socks to ensure a good grip when walking.

Other References (APA)