N432 Labor & Delivery Care Plan

Lakeview College of Nursing

Aleisa Gutierrez

Demographics (3 points)

Date & Time of Admission 9/22/21 0533	Patient Initials T.T.W	Age 29 y/o	Gender Female
Race/Ethnicity African American	Occupation Unemployed	Marital Status Single	Allergies No known allergies
Code Status Full code	Height 170.2 cm	Weight 73.9 kg	Father of Baby Involved Yes

Medical History (5 Points)

Prenatal History: G5T4L4.

Past Medical History: HSV infection, anemia.

Past Surgical History: Cesarean section (2/21/15, 3/9/16, 6/10/20).

Family History: None reported.

Social History (tobacco/alcohol/drugs): Denies alcohol use, smokes 5-6 cigarettes per day, smokes marijuana daily.

Living Situation: Lives with partner.

Education Level: High school graduate, some college.

Admission Assessment

Chief Complaint (2 points): Repeat C-section

Presentation to Labor & Delivery (10 points): A 29-year-old female presented at the labor and delivery unit with her significant other on 9/22/21. The patient states that they have a scheduled c-section. The patient appears to be in stable condition with no signs of distress. The patient denies any bleeding, vaginal leakage, and pain. The active fetal movement was palpated. The patient has had three C-sections in the past and one vaginal birth. The patient has had five pregnancies, including the current one.

Diagnosis

Primary Diagnosis on Admission (2 points):Repeat C-section

Secondary Diagnosis (if applicable):n/a

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:
Stage of Labor References (2 required) (APA):

The first stage of labor is the longest and has three subphases: latent, active, and transition. During the latent phase, the cervix dilates to 3cm and irregular, and mild contractions occur every 5 to 30 mins (Ricci et al., 2020). The patient may be talkative and eager. During this phase, nurses should monitor an increase in respiration, cardiac output, and WBC (Ricci et al., 2020). . When contractions become more regular, occurring every 3-5 mins, the patient enters the active phase (Ricci et al., 2020). Nurses should use comfort measures and encourage them to start feeling hopeless, anxious, and restless. The last subphase is called the transition stage; during this time, contractions become more intense and occur every 2-3 minutes (Ricci et al., 2020). This phase is the most challenging part. The urge to push begins, and an increase in the bloody show may even present. The patient had a scheduled c-section and a spinal anesthetic done. The patient did not have any strong contractions. They also have a spinal anesthetic done, so their vital signs decreased rather than increased.

The second phase of labor is identified by full dilation and ends with the baby's birth (Ricci et al., 2020). Contractions occur every 1-2 mins (Barlow et al., 2019). Pain is somatic due to the stretching of tissues and fetal descent, and fetal expulsion. The mother may start to shake, and the bloody show may increase. The nurse should continue to

encourage pushing efforts, however advising the client to avoid Valsalva type pushing. BP, pulse, and respiration should be taken every 5-30 mins, and fetal heart rate every 15 minutes after birth and perineal laceration should be assessed (Ricci et al., 2020). The newborn was born at 0859. During delivery, no assistive devices were used.

The third stage of labor, also known as afterbirth, is defined as the expulsion of the placenta. The Shultze or Duncan mechanism may be presented. The nurse should take vitals every 15 mins and note placenta separation (Ricci et al., 2020). The fourth stage of labor is the postpartum period. Nursing care is focused on the mother and its new patient, the newborn. The mother starts recovery, and her vitals return to her baseline. The nurse should assess the mother's fundus and lochia every 15 minutes and monitor scant to moderate Rubra (Ricci et al., 2020). The patient's fundus was observed postpartum and was at the umbilicus. The lochia was also observed, and vaginal bleeding was red and moderate. The patient's vitals were returning to baseline.

Barlow, M., Holman, H., Johnson, J., McMichael, M, Sommer, S., Wheless, L., Wilford, K., & Williams, D. (2019). ATI: RN *Maternal newborn nursing* (11th ed.). Assessment Technologies Institute, LLC.

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

Laboratory Data (15 points)

CBC <mark>Highlight All Abnormal Labs</mark>—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	3.90-4.98	4.13	4.31	4.31	n/a
Hgb	12.0-15.5	11.5	11.1	11.1	Low levels of Hgb and Hct is expected in patients with anemia (Capriotti, 2020).
Hct	35-45	34.1	34.0	34.0	Low levels of Hgb and Hct is expected in patients with anemia (Capriotti, 2020).
Platelets	130-400	188	136	136	
WBC	4.0-9.0	9.0	10.8	10.8	Pt. is in the process of labor, stress can stimulate the rise in the number of WBCs in the bloodstream (Capriotti, 2020, p. 247).
Neutrophils	40-70	n/a	70.7	70.7	Pt. is in the process of labor, stress can stimulate the rise in the number of WBCs in the bloodstream (Capriotti, 2020, p. 247).
Lymphocytes	10-20	12.2	18.7	18.7	n/a
Monocytes	4.4-12.0	7	9.5	9.5	n/a
Eosinophils	0-6.3	0.8	0.8	0.8	n/a
Bands	0-5.1	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+ A- B+ B AB+ AB- O+ O-	A+	A+	A+	n/a
Rh Factor	+ / -	+	+	+	n/a
Serology (RPR/VDRL)	+ / -	-	-	-	n/a
Rubella Titer	+ / -	+	+	+	n/a
HIV	+ / -	-	-	-	n/a
HbSAG	+ / -	-	-	-	n/a
Group Beta	+ / -	-	-	-	n/a

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Strep Swab					
Glucose at 28 Weeks	**<140**	**66**	**n/a**	**n/a**	**n/a**
MSAFP (If Applicable)	**0.5 to 2.0 or 2.5 MoM**	**n/a**	**n/a**	**n/a**	**n/a**
n/a	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
n/a	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
n/a	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**

Additional Admission labs <mark>Highlight All Abnormal Labs</mark>—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	**-**	**-**	**-**	**n/a**	**n/a**
n/a	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
n/a	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
n/a	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
n/a	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
n/a	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
n/a	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
n/a	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
n/a	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**

<mark>Highlight All Abnormal Labs</mark>—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	**0.4 to 0.8 mg/ dl**	**n/a**	**n/a**	**n/a**	**n/a**

applicable)					

Lab Reference (1) (APA):

Capriotti, T., & Frizzell, J.P. (2020). *Pathophysiology: Introductory Concepts and Clinical*

Perspectives **(2nd ed.). F.A. Davis Company.**

Lakeview College of Nursing, "Tab: Diagnostics: Lab"

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH? **Has it changed during your clinical day? If yes, how has it changed?**	**130 BPM** **Fetal EFH has changed throughout the day. The BPM slightly decreased by 10. It dropped from 130 BPM to 120 BPM.**
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** **Accelerations are defined as 15 beats per 15 seconds in the fetal heart rate. Acceleration of 15 x 30 was observed. Throughout the day, the baby's accelerations slightly increased to 25 x 30.** **Moderate**
Are there decelerations? If so, describe them and explain the following: What do these mean? o **Did the nurse**	**None**

perform any interventions with these? o Did these interventions benefit the patient or fetus?	
Describe the contractions at the beginning of your clinical day: Frequency: Length: Strength: Patient's Response:	Irregular uterine contractions and patterns were observed. The patient only had one significant contraction. 1x 120 sec Mild Comfortable
Describe the contractions at the end of your clinical day: Frequency: Length: Strength: Patient's Response:	Irregular uterine contractions and patterns were observed. The patient only had one significant contraction. 1x 120 sec Mild Comfortable

EFM reference (1 required) (APA format):

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)

Brand/Generic	Aleve / Naproxen	Ferrous sulfate / Ferrous	n/a	n/a	n/a

		sulfate			
Dose	**500 mg**	**325 mg**	**n/a**	**n/a**	**n/a**
Frequency	**2x daily**	**1x daily**	**n/a**	**n/a**	**n/a**
Route	**PO**	**PO**	**n/a**	**n/a**	**n/a**
Classification	**NSAID**	**Iron products**	**n/a**	**n/a**	**n/a**
Mechanism of Action	**Blocks the enzyme cyclooxygenase and inhibits the synthesis of prostaglandins which decreases inflammation, pain, and vasodilation**	**Combines with porphyrin and globin chain to form hemoglobin**	**n/a**	**n/a**	**n/a**
Reason Client Taking	**Pain relief**	**Anemia**	**n/a**	**n/a**	**n/a**
Contraindications (2)	**Pregnant women at 30 weeks gestations due to the risk of premature closure of ductus arteriosus, GI bleedings**	**Gastritis, stomach ulcers**	**n/a**	**n/a**	**n/a**
Side Effects/Adverse Reactions (2)	**Bronchospasms, renal failure**	**Diarrhea, nausea**	**n/a**	**n/a**	**n/a**
Nursing Considerations (2)	**Use with caution with patients with history of GI bleeding, Drug may worsen anemia due to decreased hemoglobin and hematocrit**	**Take 1 hour before meal or 2 hour after meals, Avoid taking antibiotics 2 hours**	**n/a**	**n/a**	**n/a**

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		before or after ferrous sulfate			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Asses BP drug may cause hypertension or worsen it, Monitor CBC for decreased hemoglobin and hematocrit**	**Asses RBC count, Asses for abdominal pain**	**n/a**	**n/a**	**n/a**
Client Teaching needs (2)	**Teach patient to take Aleve with food, instruct patient to avoid alcohol and corticosteroids when taking Aleve**	**Best taken on an empty stomach, Use with orange juice in aid of absorption**	**n/a**	**n/a**	**n/a**

Hospital Medications (5 required)

Brand/Generic	Lactated ringers / sodium chloride	Tylenol / acetaminophen	Zofran / ondansetron	Oxytocin / Pitocin	Reglan / metoclopramide
Dose	**125 mL / hr**	**975 mg**	**4 mg / 2 mL**	**60 – 300 mL / hr**	**10 mg / 2 mL**
Frequency	**Continuous**	**1x daily, PRN**	**1x daily, PRN**	**1x**	**1x daily**
Route	**IV**	**PO**	**IV**	**IV**	**IV**
Classification	**Alkalizing agents / Intravenous nutrition products**	**Nonnarcotic Analgesic Antipyretic**	**Selective serotonin (5-HT3) receptor antagonist**	**Oxytocic hormones**	**Prokinetic agent**
Mechanism of Action	**Restores fluid and electrolyte balance**	**Reduces the production of prostaglandi**	**Reduces nausea and vomiting by blocking**	**Increases the concertation of**	**Dopamine D2 antagonist and**

	and promoting diuresis.	ns causing analgesia and antipyretics properties	serotonin receptors of the vagal nerve terminals in the intestines	calcium inside muscle cells in the uterus causing contractions	serotonin 5-HT3 agonists in the brain
Reason Client Taking	**Prevent dehydration**	**Pain relief**	**Prevent nausea**	**Promote uterine contractions**	**Prevent nausea/vomiting**
Contraindications (2)	**Severe metabolic acidosis, Sever metabolic alkalosis**	**Liver impairment, Renal Impairment**	**Hypokalemia, heart arrythmia**	**Fetal distress, placenta previa**	**GI obstruction, high prolactin level**
Side Effects/Adverse Reactions (2)	**Agitation, back pain**	**Hepatotoxicity, Renal impairment**	**Hypotension, bronchospasms**	**Nausea, vomiting**	**Headache, confusion**
Nursing Considerations (2)	**Monitor for hypervolemia, caution with those with hyperkalemia**	**Do not exceed 4,000 mg a day, Use as prescribed**	**Do not administer fast, Avoid those with heart arrythmias**	**May cause ICH in fetus, may cause seizures in mother**	**Monitor BP, monitor for extrapyramidal symptoms**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Assess potassium balance, asses IV site before administering**	**Assess pain, Assess liver enzymes**	**Asses for frequency in nausea and vomiting, Asses for abdominal pain**	**Monitor uterine activity, Monitor fetal heart rate**	**Asses for abdominal pain, assess frequency in nausea and vomiting**
Client Teaching needs (2)	**Report swelling or redness at IV site, do not move/irritate IV site**	**Take with food to prevent GI upset, Monitor for signs of overdose**	**Take with a full glass of water, can be taken with or without food**	**Educate patient on the use of Pitocin, educate patient to notify provider**	**Can cause drowsiness avoid activities, Avoid alcohol**

				when adverse effects occur	

Medications Reference (1 required) (APA):

Jones & Bartlett Learning. (2019). *2019 Nurse's Drug Handbook*. **Burlington, MA**

<div align="center">

Assessment

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Physical Exam (18 points)

GENERAL (0.5 point): Alertness: Orientation: Distress: Overall appearance:	Alert and responsive ANO x4 No signs of distress Appearance is appropriate
INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: Drains present: Y☐ N ☒ Type:	 Skin color usual for ethnicity Moist Warm Elastic turgor No rashes No bruises No wounds 23 n/a
HEENT (0.5 point): Head/Neck: Ears: Eyes: Nose: Teeth:	 Normocephalic, no deviation of trachea No drainage, grey-pink tympanic membrane No drainage, symmetrical, pink conjunctiva No septum deviation, polyps, turbinate Teeth intact, no visible dental caries

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:**	**Normal S1/S2 heart sounds heard** **No murmur or gallops heard** **Normal steady rate and rhythm** **Peripheral pulses 3+** **Capillary refill 2 sec** **n/a**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Respiration pattern is regular** **Bronchovesicular breath sounds heard** **bilaterally in all 4 quadrants** **Equal lung aeration**

GASTROINTESTINAL (4 points):
Diet at Home:
Current Diet:
Height:
Weight:
Auscultation Bowel sounds:
Last BM:
Palpation: Pain, Mass etc.:
Inspection:
   Distention:
   Incisions:
   Scars:
   Drains:
   Wounds:
	
	Regular diet at home
	Clear diet
	170.2 cm
	73.9 kg
	Active in all 4 quadrants
	9/21/21
	No pain/masses detected upon palpation
	Skin warm and color usual for ethnicity
	No distention observed
	Abdominal and uterine incision observed
	Abdominal and uterine scar observed
	No drains observed
	No wounds deserved

GENITOURINARY (2 Points):
Bleeding:
Color:
Character:
Quantity of urine:
Pain with urination: Y ☐   N ☒
Inspection of genitals:
Catheter: Y ☒   N ☐
   Type:
   Size:
	
	None
	Yellow
	Clear
	100 mL
	
	Appropriate
	
	Foley
	12 FR

MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 0** **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐**	 **5 Equal active range of motion against full** **resistance on all 4 extremities** **Up ad lib**

Needs support to stand and walk ☐	n/a n/a
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:**	 ANO x4 Normal cognition Clear Sensory perception appropriate Alert and responsive 2+ Brisk response
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 seeks support through family and significant other. The patient's developmental level is appropriate The patient does not have any religious affiliations Patient lives at home with their significant other and four children. The patient's mom often visits and helps at home.

Reproductive: (2 points)
Rupture of Membranes:
   o **Time:**
   o **Color:**
       Amount:
   o **Odor:**
Pain medication or Epidural:
Assistive delivery:
Episiotomy/Lacerations:
Immediate Postpartum:
   o **Fundal Height & Position:**
   o **Bleeding amount:**
   o **Lochia Color:**
   o **Character:**
	
	0858
	Clear
	n/a
	n/a
	
	Spinal tap
	No
	C-section
	
	Midline at the umbilicus UU
	Small flow
	Rubra, dark red
	Fundus is firm

DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female**	 9/22/21 0859 Cesarean 662 mL Female

Apgars: Weight: Feeding Method:	1 min: 9, 5 min: 9 73.9 kg Formula

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	86 bpm	115/67 mmHg	16 bpm	97.5 F	98%
Admission to Labor/Delivery	67 bpm	99/54 bpm	12 bpm	96.8 F	100%
During your care	73 bpm	115/63	14 bpm	95.0 F	99%

Vital Sign Trends and pertinence to client's condition in labor:

The patient's vital signs remained within defined limits throughout pregnancy. The patient's prenatal vitals were all regular. However, upon labor/delivery period, the patient's BP was reported slightly lower. Nonetheless, it is still within defined limits of a normal BP, as hypotension is defined as a systolic pressure less than 90 mmHg. The patient's respirations were also on the lower side. These results were probably due to the spinal anesthesia done to the patient, as these are all side effects. During care, the patient's vitals were all relatively normal.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

10:30 am	numeric	abdomen	7/10	Achy, sore	Offering pain medication
12:05 pm	numeric	abdomen	7/10	Achy, sore	Offering pain medication

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:	20 gauge Right forearm 9/22/21 Aspirated, flushes easily No signs of erythema, phlebitis Dry, intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1,900 mL	762 mL

Nursing Interventions and Medical Treatments during Labor & Delivery (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.
Administering pain medication - MT	2x daily, PRN	Administering pain medications alleviates patient discomfort.
Assessing location, height, and firmness of fundus - N	During 1st hour: Q15 mins During 2nd hour: Q30 mins During first 24 hrs: Q4 hrs	Assessing the fundus postpartum helps determine the uterine size, firmness, and rate of descending.

	After 24 hrs: Q8 hrs	
Giving ice chips post-op - N	PRN	**Ice chips provide comfort and alleviate thirst post-op.**

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

2 points for the correct priority

Nursing Diagnosis (2 pt each)	Rationale (1 pt each)	Intervention/Rationale(2 per dx) (1 pt each)	Evaluation (2 pts each)
Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	Explain why the nursing diagnosis was chosen	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.	• How did the patient/ family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. **Risk for infection related to post-op C-section as evidenced by abdominal incision.**	**The patient is at risk for infection due to impaired tissue integrity from post-op cesarean section. The patient is recovering from abdominal surgery, and infectious microbes can affect the wound.**	**1. Administer antibiotic medications as prescribed, 2x daily, PRN** **Rationale** **Antibiotics will prevent infection from occurring (Ricci et al., 2020).** **2. Assess vitals and incision site Q15 mins postpartum. Monitor for signs of infection such as severe abdominal pain, redness, and swelling at the incision site.** **Rationale** **Close monitoring for signs and symptoms of infections and vital signs trends allows for quick and responsive interventions to prevent**	**1. Antibiotic administration allowed for proper wound healing. A systemic infection did not occur.** **2. Close observation of the patient's incision site allowed for timely wound healing. The patient's wound healed without any complications.**

		an impending systemic infection from occurring (Ricci et al., 2020).	
2. **Acute pain related to post-op C-section as evidenced by 7/10 pain score.**	**The patient is a post-op following a cesarean section. Post-op soreness is reported**	**1. Administer prescribed pain medication 2x daily, PRN Rationale The administration of pain medication will alleviate the patient's discomfort (Barlow et al., 2019).** **2. Implement guided imagery and distraction techniques Rationale Using nonpharmacological techniques can help alleviate the patient's discomfort (Ricci et al., 2020).**	**1. The patient's score on the numeric scale decreased to 2/10. The patient's discomfort was minimized.** **2. Using nonpharmacological techniques minimized pain and promoted comfort. The patient was able to return to regular activity.**
3. **Deficient knowledge related to newborn safety, as evidenced by having four other kids in the home.**	**The patient has had children before; however, they should be reminded on newborn care**	**1. Place newborn on their back Rationale Placing the newborn on their back prevents suffocation (Ricci et al., 2020).** **2. Keep small/sharp objects/ small toys out of reach from newborns. Rationale Keeping small objects away from newborns reduces the risk of aspirations. The patient has four other children; they may have toys/other small things lying around the home (Ricci et al., 2020).**	**1. The newborn was placed on their back, preventing suffocation. Newborn slept well.** **2. Small items/toys were kept out of reach of the newborn. The newborn did not aspirate on any small objects.**
4. **Deficient knowledge related to feeding to**	**The patient has decided to feed their baby with**	**1. Frequent observation of flow rate and nipple damage Rationale**	**1. The baby was able to receive the formula safely and adequately. The baby did not**

newborn, as evidenced by patient's choice to formula feed.	**formula. The patient should be educated on choosing the right formula, preparation, and feeding positions.**	**Monitoring the flow rate from the nipple and ensuring that the flow rate is one drop per second prevents aspiration due to fast delivery (Ricci et al., 2020).** **2. Teach client to support the newborn's head slightly raised and cradle the newborn in a semi-upright position during feedings** **Rationale** **The mother and baby should both be comfortable during feedings. Holding the baby close with its head slightly raised prevents choking and the formula from getting into the eustachian tubes, preventing the risk of ear infections (Ricci et al., 2020).**	**aspirate during feedings due to an adequate flow rate. The newborn's health and development were promoted through formula feeding.** **2. Both mother and baby were comfortable during feedings. Aspiration and ear infections were prevented. The newborn's health and development were promoted through formula feeding.**

Other References (APA)

Barlow, M., Holman, H., Johnson, J., McMichael, M, Sommer, S., Wheless, L.,

   Wilford, K., & Williams, D. (2019). ATI: RN *Maternal newborn nursing* (11th

    ed.). Assessment Technologies Institute, LLC.

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

    Wolters Kluwer.