N432 Labor & Delivery Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 10/30/21 0530	**Patient Initials** R. M.	**Age** 29 years old	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Stay at home mom	**Marital Status** Married	**Allergies** NKA
Code Status Full Code	**Height** 162.6 cm	**Weight** 110.7 kg	**Father of Baby Involved** Involved

Medical History (5 Points)

Prenatal History: This patient is a G2P1001. She had anemia throughout her last pregnancies and current pregnancy. She had an emergency cesarean section with her first pregnancy.

Past Medical History: The patient has a medical history of type II diabetes, polycystic ovary syndrome, and asthma.

Past Surgical History: The patient had a cesarean section on 11/16/10 and a cholecystectomy on 02/14/11.

Family History: On her maternal side, she has a family history of esophageal cancer, breast cancer, cervical cancer, and ovarian cancer. On her paternal side, she has a family history of hypertension, diabetes, high cholesterol, dementia, stoke, and cervical cancer.

Social History (tobacco/alcohol/drugs): The patient denies use of tobacco, alcohol, and drugs.

Living Situation: The patient lives at home in Mahomet with her husband and 11-year-old son.

Education Level: The patient has 12 years of schooling from kindergarten to 12th grade. There are no learning barriers.

Admission Assessment

Chief Complaint (2 points): Patient is admitted for a scheduled cesarean section.

Presentation to Labor & Delivery (10 points): The 29-year-old female was brought to OSF by her husband at 0530 on October 13th. She was in a stable condition. She was brought in for a scheduled cesarean section due to a complication with her last pregnancy. She was then admitted to the labor and delivery unit. Upon arrival to the unit, the patient states that she has no pain and rates it a 0/10.

Diagnosis

Primary Diagnosis on Admission (2 points): Scheduled cesarean 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:

There are four stages of labor in the labor process. The first stage includes the latent phase, active phase, and transitional phase. The first stage is described as going from 0 cm to 10 cm dilation. Within the latent phase, the cervix dilates from 0 cm to 6 cm, cervical effacement reaches 40%, and contractions occur every 5 to 10 minutes and last for 30 to 45 seconds (Ricci e al., 2021). Within the active phase, the cervix dilates from 6 cm to 10 cm, cervical effacement reaches 100%, and contractions occur every 2 to 5 minutes and last for 45 to 60 seconds. If the mother wants pain medication, this phase is the last time that it can occur without affecting the fetus. After that, nonpharmacological pain interventions may be put in place. The transitional phase is the period between the active phase and the second stage of labor.

The second stage of labor begins when the cervix is completely dilated at 10 cm and ends with the birth of the newborn (Ricci et al., 2021). This stage of labor may last for a long period of time. It includes the pelvic phase and the perineal phase. During the pelvic phase, the fetus goes through fetal descent. During the perineal phase, the mother is doing active pushing to help

get the fetus out. Contractions occur every 2 to 3 minutes and lasting up to 60 and 90 seconds. The contractions during this stage are strong, and the mother may feel a strong urge to push.

The third stage of labor involves the separation and delivery of the placenta. This stage can take anywhere from 5 to 30 minutes to happen (Holman et al., 2019). Placental separation can be indicated by the uterus rising upward, the umbilical cord lengthening, a sudden trickle of blood from the vaginal opening, and the uterus changing its shape to globular. Normal blood loss during the placental expulsion is 500 mL for a vaginal birth and up to 1,000 mL for a cesarean birth. During the third stage, the ideal placement for the baby to be is on the mother's abdomen for skin-to-skin contact to promote a positive transition from intrauterine to extrauterine life.

Lastly, the fourth stage of labor begins with the completion of placental expulsion. This phase typically lasts for 1 to 4 hours after birth. During this time, the mother adjusts to the physiologic and psychological changes that had just occurred. The baby adjusts from intrauterine life to extrauterine life. During this stage of labor, the nurse will be doing routine fundal assessments to make sure it is contracted and doing its job.

This patient was different than a typical four-stage of labor process due to the scheduled cesarean section. The only stage that was no different for her was placental separation and expulsion.

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

Holman, H.C., Williams, D., & Sommer, S. (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 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	3.75-5.0 million/mm^3	N/A	4.20 million/mm^3	4.20 million/mm^3	
Hgb	11.5-14 g/dL	N/A	11.2 (L)	11.2 (L)	The patient has a prenatal history of anemia, which lowers the hemoglobin levels (Ricci et al., 2021).
Hct	32%-42%	N/A	33.9	33.9	
Platelets	150-350 million/mm^3	N/A	222	222	
WBC	5.0-15 million/mm^3	N/A	13.1	13.1	
Neutrophils	47%-73%	N/A	70.3	70.3	
Lymphocytes	15%-40%	N/A	23.6	23.6	
Monocytes	4%-12%	N/A	4.6	4.6	
Eosinophils	0%-5%	N/A	0.5	0.5	
Bands	0%-1%	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, AB, O	O	O	O	
Rh Factor	Negative or Positive	Positive	Positive	Positive	
Serology (RPR/VDRL)	Non-reactive	Non-reactive	N/A	N/A	
Rubella Titer	Immune	Immune	N/A	N/A	
HIV	Negative	Negative	N/A	N/A	
HbSAG	Not detected	Not detected	N/A	N/A	

Group Beta Strep Swab	Negative	Negative	N/A	N/A	
Glucose at 28 Weeks	< 140 mg/dL	N/A	N/A	N/A	The patient states that this was not done at her 28-week appointment due to her being on metformin and doing Q6 glucose checks daily.
MSAFP (If Applicable)	Negative	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
Chlamydia	Negative	Negative	N/A	N/A	
Gonorrhea	Negative	Negative	N/A	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 protein/creatinine ratio (if applicable)	120-160 mL/min	N/A	N/A	N/A	

Lab Reference (1) (APA):

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

Electronic Fetal Heart Monitoring (16 points)

Component of EFHM Tracing	Your Assessment
What is the Baseline (BPM) EFH?	The baseline EFH is 135 beats per minute. Normal fetal heart rate

Has it changed during your clinical day? If yes, how has it changed?	is between 110 and 160 beats per minute (Ricci et al., 2021). It is active and has not changed during the clinical day.
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?**	There were accelerations noted. They rise 15 – 20 beats and last for 20 – 40 second intervals. The accelerations can be indicative of fetal movement in the uterus and are a normal finding (Ricci et al., 2021). The variability was moderate. This is a normal finding of 6 – 25 and indicates adequate oxygenation for the fetus (Ricci et al., 2021).
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 were no decelerations noted. This is a normal finding.
Describe the contractions at the beginning of your clinical day: **Frequency:** **Length:** **Strength:** **Patient's Response:**	The patient was experiencing some contractions in the morning. They occurred every 3 – 5 minutes. They lasted for 70 – 80 seconds. The strength of the contraction was mild. The patient did not respond to the contractions and expressed that she could not feel them.
Describe the contractions at the end of your clinical day: **Frequency:** **Length:**	The contractions only lasted for 30 minutes before going back for the cesarean section around 0715.

Strength: **Patient's Response:**	

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	metformin **(Glucophage)**	Aspirin **(Aspro Clear)**
Dose	500 mg	81 mg
Frequency	TID	Daily
Route	Oral	Oral
Classification	**Pharmacologic**: Biguanide **Therapeutic:** Antidiabetic	**Pharmacologic:** Salicylate **Therapeutic:** NSAID
Mechanism of Action	Promotes storage of excess glucose as glycogen in the liver, which reduces the glucose production.	Works by blocking prostaglandin synthesis, which causes the inflammatory symptoms to subside.
Reason Client Taking	The patient is a type II diabetic.	To relieve mild to moderate pain and reduce the risk for blood clots
Contraindications (2)	Hypersensitivity to metformin or its components, Metabolic acidosis	Active bleeding, Third trimester of pregnancy
Side Effects/Adverse Reactions (2)	Headache, Hypoglycemia	Decreased blood iron level, Hepatotoxicity
Nursing Considerations (2)	Give the medication with food to reduce the risk of GI upset Do not break or crush the tablets	Ask about tinnitus to assess for maximum dosage use Assess for pain before administration.
Key Nursing Assessment(s)/Lab(s	Monitor the patient's blood glucose levels prior to administration to assess	Assess for tinnitus

) Prior to Administration	for hypoglycemia Assess the BUN and creatinine of the patient prior to administration because it is contraindicated in those with renal impairment	Look at clotting factor labs such as PT/ INR or PTT.
Client Teaching needs (2)	Emphasize the importance of checking the blood glucose level and recognizing hypoglycemia and hyperglycemia Report early signs of lactic acidosis which includes drowsiness, hyperventilation, malaise, and muscle pain	Take with food to avoid GI upset Stop taking the aspirin if noticing stomach or intestinal bleeding has occurred.

Hospital Medications (5 required)

Brand/Generic	acetaminophen **(Tylenol)**	Cefazolin **(Ancef)**	ondansetron **(Zofran)**	metoclopramide **(Reglin)**	Sodium citrate – citric acid **(Bicitrad)**
Dose	975 mg	2 g	4 mg	10 mg	500-324 mg/5mL 15 mL
Frequency	Once	Once	Q6 PRN	Q6 PRN	Once
Route	Oral	IV push	IV push	Oral	Oral
Classification	**Pharmacologic:** Nonsalicylate **Therapeutic:** Antipyretic; Nonopioid analgesic	**Pharmacologic:** First-generation cephalosporin **Therapeutic:** Antibiotic	**Pharmacologic:** Selective serotonin receptor antagonist **Therapeutic:** Antiemetic	**Pharmacologic:** Dopamine-2 receptor antagonist **Therapeutic:** Antiemetic, upper GI stimulant	**Pharmacologic:** **Therapeutic:** Urinary alkalinizes
Mechanism of Action	Blocks prostaglandin production and interferes with pain impulse generation in the peripheral nervous system.	Interferes with bacterial cell wall synthesis by inhibiting the final step in the cross-linking of peptidoglycan.	Blocks serotonin receptors centrally in the chemoreceptor trigger zone, which reduces nausea and vomiting by preventing serotonin	Antagonizes the inhibitory effect of dopamine on GI smooth muscle. This promotes gastric emptying and peristalsis and reduces gastroesophagea l reflux.	Citrate reacts with hydrochloric acid in the stomach to raise the pH. It further metabolizes to bicarbonate which then acts as a systemic alkalizing agent,

			release in the small intestine.		raising the pH of the blood and urine.
Reason Client Taking	To relieve mild to moderate pain due to the cesarean section	Prophylactic antibiotic due to the cesarean section	First line antiemetic for nausea post cesarean section	Second line antiemetic for nausea and vomiting post cesarean section	Prophylactic for nausea prior to cesarean section
Contraindications (2)	Severe hepatic impairment, Severe acute liver disease	Hypersensitivity to cefazolin, Hypersensitivity to other cephalosporins	Hypersensitivity to ondansetron or its components, Low amount of potassium or magnesium in the blood	Hypersensitivity to metoclopramide or its components, GI hemorrhage	Hypersensitivity to sodium citrate or its components, Hyperkalemia
Side Effects/Adverse Reactions (2)	Pulmonary edema, Hemolytic anemia	Nausea, Diarrhea	Headache, Constipation	Restlessness, Drowsiness	Muscle cramps, Weight gain
Nursing Considerations (2)	Maximum dose is 4000 mg from all sources in 24 hours Use cautiously in patients with severe hypovolemia.	Use cautiously in patients with impaired renal function or a history of a GI disease Push over 5 minutes and dilute with 20 mL of full-strength normal saline	Use injectable only if the patient is unable to tolerate the oral Dilute drug in 50 mL of D_5W or normal saline solution when indicated	Only give after ondansetron as a second line antiemetic Use cautiously in those with hypertension because it can increase the risk of suicidal ideation	Give 30 minutes before the cesarean section occurs Give after meals to minimize laxative effects.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess patient's kidney and liver function prior to administration, which would include AST, ALT, bilirubin, BUN, and creatinine levels.	Monitor BUN and creatinine for signs of nephrotoxicity	Assess potassium and magnesium labs prior to administration and correct them before administration	Assess for signs of intestinal obstruction, diarrhea, nausea, and vomiting prior to administration	Assess potassium and magnesium levels prior to administration.

Client Teaching needs (2)	Caution patient not to exceed recommended dosage due to the risk of liver damage Inform the patient that acetaminophen may cause reduced fertility in both females and males.	Complete the prescribed course of therapy Report water, bloody stools immediately, even up to 2 months after drug therapy has ended	Advise patient to immediately report signs of hypersensitivity Advise patient to seek immediate medical attention if patient experiences persistent, severe, unusual, or worsening symptoms	Advise against activities that require alertness for about 2 hours after each dose Avoid alcohol and CNS depressants while taking this medication	Call your provider if you experience long term diarrhea, nausea, and vomiting Watch for signs and symptoms of an anaphylactic reaction such as hives, itching, or peeling skin.

Medications Reference (1 required) (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 A&O x4 to person, place, time, and situation Patient is in no distress Patient is well groomed, put together nicely
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Usual for ethnicity Moist and intact Warm Edematous in the legs bilaterally, elastic overall No rashes No bruises Patient has a transverse incision from the cesarean section across her lower abdomen. 22 No drains present
HEENT (0.5 point):	

Head/Neck: **Ears:** **Eyes:** **Nose:** **Teeth:**	Symmetry of the skull and face, no tracheal deviation No hearing changes No vision changes, PERRLA, no jaundice Patent, moist mucous membranes White teeth, moist mucous membranes .
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 and S2 sounds present Not applicable 3+ peripheral pulses bilaterally Capillary refill less than 3 seconds in the upper and lower extremities bilaterally No neck vein distention No edema present .
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	 No Regular respiration rate, regular respiratory pattern, bronchial/vesicular breath sounds present in the upper lobes and lower lobes bilaterally
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:**	 Diabetic diet at home NPO 162.6 cm 110.7 kg Active/Present in RLQ, RUQ, LUQ, and LLQ 10/12/2021 No pain, no masses No distention Patient has a transverse incision from the cesarean section across her lower abdomen. No scars No drains No wounds
GENITOURINARY (2 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:**	 No blood in urine Amber Clear 50 mL No pain with urination Indwelling catheter

Size:	16 French
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	 No Yes 40 Bedrest
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:**	 Yes Yes Yes Both Orientated to person, place, time, and situation Alert, normal cognition Clear Sensitive to touch, sound, and light Alert – awake and answers questions appropriately 2+ bilaterally biceps reflex, 2+ brachioradialis reflex, 2+ triceps reflex, 2+ patellar reflex, 2+ achilles tendon reflex
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):**	 Quality family time Patient can read, write, and from full sentences; No delay Christian Close and loving family, available for support and living in Rantoul
Reproductive: (2 points) **Rupture of Membranes:** o **Time:** o **Color:** **Amount:** o **Odor:** **Pain medication or Epidural:** **Assistive delivery:** **Episiotomy/Lacerations:** **Immediate Postpartum:**	 0803 Clear Large, copious amount No odor Epidural No No

o **Fundal Height & Position:** o **Bleeding amount:** o **Lochia Color:** o **Character:**	U-1, midline Moderate Rubra Dark, thick, clots present
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	 10/13/21 0804 Cesarean 829 Female 1 minute: 8 5 minutes: 8 4080 grams Bottle feeding

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	N/A	120/68 mmHg	N/A	N/A	N/A
Admission to Labor/Delivery	89 BPM	123/78 mmHg	16	98.4 F	94% on room air
During your care	69 BPM	107/60 mmHg	18	96.8 F	99% on room air

Vital Sign Trends and pertinence to client's condition in labor: The patient had a normal blood pressure during her prenatal visit. After delivery, her blood pressure, temperature, and heat rate decreased. This is due to the blood loss that she had experienced during the cesarean section. Will continue to monitor during her stay.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0630	Numerical	N/A	0/10	N/A	N/A

1000	Numerical	N/A	0/10	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV:** Right metacarpal vein (Top of hand) **Date on IV:** 10/13/21 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** No signs of erythema, drainage, or infiltration **IV dressing assessment:** Clean, dry, intact	Lactated Ringers at 125 mL/hr Oxytocin at 60 mL/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
250 mL of Lactated Ringers 20 mL of Oxytocin in 500 mL normal saline *Total = 770 mL*	50 mL of urine (indwelling catheter) 829 QBL *Total = 879 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.
Electronic fetal monitoring (N)	Continuous up until birth	This intervention was provided to this patient because she is scheduled for a cesarean section and when this happens, we like to see what is going on with the baby before opening her up. If the baby is having decelerations, we need to know prior to opening her up.
Fundal height assessment (N)	Q15 minutes for the first hour then Q1	This intervention was provided to assess where the uterus was located. We want

	hour	the fundus to be firm and continuing to descent into the pelvis at a rate of 1 cm per day and should be nonpalpable by day 14.
Oxytocin (M)	Once	This medical treatment is provided to contract the uterus to slow down the bleeding post cesarean section.

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. Risk for bleeding related to labor and delivery as evidenced by a cesarean section.	This nursing diagnosis was chosen as the top priority because the patient underwent a big surgery and that increases her chance of bleeding complications.	**1.**Monitor physiological responses such as vital signs and LOC. **Rationale** Changes to vital signs and LOC indicate a potential fluid volume deficit such as bleeding in surgery (Phelps, 2020). **2.**Examine the surgical dressings. **Rationale** Examining the dressings of the incision will indicate if it is bleeding or not (Phelps, 2020).	The patient responded well to the monitoring of her vital signs and LOC. The goal is to find the early signs of bleeding if it is to occur for a better chance of stopping it. The patient responded well to the examination of the dressing site. The goal is to see no saturation and compare the blood loss to the previous assessment.

2. Risk for falls related to labor and delivery as evidenced by the postoperative recovery period.	This nursing diagnosis was chosen because the mother is a 40 for a fall risk due to the epidural from the cesarean section.	**1.** Explain to the patient that she must remain bedrest. **Rationale** The patient will not fall if they do not get up out of bed (Phelps, 2020). **2.**Improve environmental safety factors as needed. **Rationale** Using all of the fall safety precautions will help to prevent falls. Such as the patient having her call light, keeping side rails up, and educating the patient on the importance of remaining in bed (Phelps, 2020).	The patient responded well to being bedrest. She is alert and oriented and understands she cannot get up. She had her call light, had her side rails up, and understood that she cannot get out of bed. The goal is to prevent her from falling.
3. Deficient knowledge related to insufficient information as evidenced by a 10-year gap between children.	This nursing diagnosis was chosen because the patient has not had a newborn for 10 years and needs more information on the changes that will occur and need to be implemented.	**1.** Establish an environment of mutual trust and respect. **Rationale** Trust and respect from the client will enhance the relationship and allow teaching to occur (Phelps, 2020). **2.** Assess the patient's level of knowledge. **Rationale** This will provide information as to whether or not the mother can make appropriate decisions regarding the care of the newborn baby (Phelps, 2020).	The patient responded well to a trusting and respectful environment. The goal is to provide comfort and receptiveness to sharing concerns about being a new mom again. The patient responded well to the questions regarding her level of education. The goal is to determine whether the patient requires basic information ore reinforcement from previous learning.
4. Ineffective breast-feeding	This nursing diagnosis was	**1.** Educate the mother on breast care and	The mother was open to hearing about the

related to maternal obesity as evidenced by the maternal status of obesity	chosen because the mother is choosing to bottle-feed instead of breast-feeding.	breastfeeding techniques. **Rationale** Mom may change her mind and want to breast-feed. If she does, she should be educated on how to do so (Phelps, 2020). **2.** Encourage the mother to ask questions. **Rationale** Being available to answer questions for the client offers her a resource she may not have had yet (Phelps, 2020).	possibility of breast-feeding. However, with her diabetes she decided it was still best to bottle-feed. The goal is to reduce anxiety and enhance proper nutrition of the neonate. The mother appreciated that she was able to openly ask questions regarding the feeding of the neonate. The goal is to reduce anxiety and increase the mother's understanding.

Other References (APA)

Phelps, L. L. (2020). *Nursing diagnosis: Reference manual* (11th ed.). Wolters Kluwer.