N432 Postpartum Care Plan

Lakeview College of Nursing

Kade Thomas

Demographics (3 points)

Date & Time of Admission	Patient Initials KM	Age 25	Gender Female
Race/Ethnicity White, Non-Hispanic/latino	Occupation Car salesperson	Marital Status Married	Allergies No know allergies
Code Status Full Code	Height 5'1" (154.9cm)	Weight 228lbs (103.4kg)	Father of Baby Involved Yes

Medical History (5 Points)

Prenatal History: Gravida-2, Term-0, Preterm-0, abortion-1, living-1

She was pregnant early last year, however, at less than 20 weeks a spontaneous miscarriage occurred. She completed all prenatal visits and was compliant with prenatal medication regimens. She was diagnosed with pre-eclampsia because her blood pressure was consistently above 140/90.

Past Medical History: Iron deficiency anemia

Past Surgical History: Tonsillectomy, tympanostomy tube placement, IUD insertion

Family History: Client stated that she is not able to recall significant family history

Social History (tobacco/alcohol/drugs): Never used tobacco or drugs, not currently drinking alcohol

Living Situation: Lives at home with her husband

Education Level: High school diploma, no college credits earned

Admission Assessment

Chief Complaint (2 points): Elevated blood pressure (she monitored blood pressure daily)

Presentation to Labor & Delivery (10 points):

The patient is a 25-year-old female who was 34 weeks pregnant. She presented to the unit because of elevated blood pressure, she is pre-eclamptic and was home monitoring her blood pressure. She stated that it was "extremely" elevated in the afternoon on 11/01/21, she called the unit and was advised to come in immediately. Upon arriving to the unit, labs were taken and admission procedures were in motion. The practitioner determined that the fetus was in breech position, the doctor determined that her pre-eclampsia and fetal position were indicators that a c-section was the only option. The client was prepped immediately for cesarean section and the fetus was delivered at 1313.

Diagnosis

Primary Diagnosis on Admission (2 points): Pre-eclampsia

Secondary Diagnosis (if applicable): NA

Postpartum Course (18 points)

The fourth and final stage of labor consists of postpartum and recovery, during this phase the female reproductive system undergoes changes to return to pre-pregnancy stage (PhD Rn et al., 2020). The reproductive system constantly fluctuates and remodels (PhD Rn et al., 2020). After delivery and post-partum, the uterus returns to its normal size, this

is called involution (PhD Rn et al., 2020). The cervix additionally returns to normal and closes back up, the function of the ovaries also returns and estrogen production resumes. The perineum muscles return to the previous state (PhD Rn et al., 2020). Systemically there is a change that is in addition to the reproductive system, the cardiovascular, urinary, GI and the remaining systems return to baseline before pregnant state (PhD Rn et al., 2020). Cardiac output and stroke volume will reduce after the placenta is delivered, this is because the demand for increased circulation was decreased (PhD Rn et al., 2020). The uterus continues to contract to prevent excessive bleeding. This is related to the dangers that postpartum hemorrhage possesses (PhD Rn et al., 2020). PP hemorrhage is extremely life-threatening, and a major risk following childbirth, post-partum hemorrhage is the leading cause of deaths worldwide for laboring mothers (PhD Rn et al., 2020). My patient was a 25-year-old white female who was admitted for pre-eclampsia and breech fetus. During my care, she was in the fourth and final stage of labor, because she had a c-section she did not go through the previous stages. She had postpartum complications that were common, she had mild contractions, small clots of the lochia that progressed to light-scant bleeding that didn't soak the pad. She did not have any signs of infection related to the incision from the cesarean section. Signs of infection are redness, erythema, elevated temperature, drainage from the wound site (Mayo clinic, 2020). The patient was pre-eclamptic, after delivery the clients blood pressure returned to a normal baseline. Following discharge, the patient will need to monitor her blood pressure, make sure that she follows post-partum/ cesarean section teachings.

Postpartum Course References (2) (APA):

Mayo Clinic Staff. (2019, April 6). *Postpartum complications: What you need to know*. Mayo Clinic. https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/postpartum-complications/art-20446702?reDate=25092021

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and Pediatric Nursing* (4th ed.). LWW.

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	**3.80-5.30**	**4.32**	**NA**	**3.25**	
Hgb	**12.0-15.8**	**12.8**	**NA**	**9.0**	**The patient is iron deficient anemic, therefore the hemoglobin in the blood is decreased (PhD Rn et al., 2020)**
Hct	**36-47%**	**38.3**	**NA**	**27.5%**	**Due to the client's diagnosis of iron deficiency anemia, hematocrit and hemoglobin are related, hematocrit will be lowered if hemoglobin is decreased (PhD Rn et al., 2020).**
Platelets	**140-440**	**252**	**NA**	**175**	
WBC	**4-12**	**9.90**	**NA**	**8.30**	
Neutrophils	**47-73%**	**57.6%**	**NA**	**65.2%**	
Lymphocytes	**18-42%**	**33.8%**	**NA**	**26.3%**	
Monocytes	**4.0-12.0%**	**7.3%**	**NA**	**7.9%**	
Eosinophils	**0.0-5.0%**	**0.4%**	**NA**	**0.4%**	

Bands			**NA**		

*****Per OSF epic (admission was the same day as the delivery, so the value are the same)**

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

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	**A,B,O, AB**	**A**	**A**	**A**	
Rh Factor	**(+) or (-)**	**+**	**+**	**+**	
Serology (RPR/VDRL)	**Neg**	**Neg**	**Neg**	**Neg**	
Rubella Titer	**Immune**	**Immune**	**Immune**	**immune**	
HIV	**Neg**	**Neg**	**Neg**	**Neg**	
HbSAG	**Neg**	**Neg**	**Neg**	**Neg**	
Group Beta Strep Swab	**Neg**	**Neg**	**Neg**	**Neg**	
Glucose at 28 Weeks	**70-99**	**88**	**70**	**70**	
MSAFP (If Applicable)	**0.5-2.0**	**NA**	**NA**	**NA**	

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
Sodium	**135-145**	**138**	**NA**	**137**	
Potassium	**3.5-5.1**	**3.8**	**NA**	**3.8**	
Chloride	**98-107**	**107**	**NA**	**106**	

T-Bili	**0.2-08**	**0.4**	**NA**	**0.5**	
Albumin	**3.5-5.7**	**3.6**	**NA**	**4.0**	
Calcium	**8.6-10.3**	**8.9**	**NA**	**8.9**	
AST	**13-39**	**13**	**NA**	**17**	
ALT	**7-52**	**7**	**NA**	**8**	

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)	**120-160**	**NA**	**NA**	**NA**	

Lab Reference (1) (APA):

PhD Rn, P. K. D., Facs, M. T. P. J., & Faaem, P. T. M. N. (2020). *Mosby's® Diagnostic and Laboratory Test Reference* (15th ed.). Mosby.

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

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous**	**The client did not labor, she was pre-eclamptic and the fetus was in breach position. Because of this, the client was taken to the operating room and an unplanned C section was**

Time in each stage	**performed.** **The first stage of labor typically lasts 8-12 hours** **The second stage of labor typically lasts 20 minutes to 2 hours** **The third stage of labor typically lasts 5-30 minutes**
Current stage of labor	**At this point after the cesarean section the client is in the fourth and final stage of labor, postpartum/recovery** (Ricci et al., 2020). The fourth stage begins with the expulsion of the placenta, membranes and the feeling of excitement and relaxation (Radhakrishnan, 2021). During this, the uterus contracts to push out remaining contents and to slow or stop bleeding (Ricci et al., 2020). The contraction from the uterus are stimulated by breastfeeding which facilitates production and release of oxytocin (Ricci et al., 2020). Postpartum, it is extremely common to have discomfort, pain, difficulty voiding and generalized weakness when standing up (Ricci et al., 2020). During my clinical experience, the client stated how anxious she was to meet her son, eat food and walk around again. She was having mild abdominal discomfort and mild bleeding.

Stage of Labor References (2) (APA):

Radhakrishnan, R. (2021, June 10). *What Are the 4 Stages of Labor? Childbirth*. MedicineNet. https://www.medicinenet.com/what_are_the_4_stages_of_labor/article.htm#stage_4_recovery

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and Pediatric Nursing* (4th ed.). LWW.

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

Home Medications (2 required)

Brand/Generic	**Zofran Ondansetron**	**Motrin Ibuprofen**			
Dose	**4mg**	**800mg**			
Frequency	**Q6H-PRN**	**Q8H**			
Route	**ODT (oral disintegrating tablet)**	**Oral**			
Classification	**Antiemetic / 5HT-3 antagonist**	**NSAID**			
Mechanism of Action	**Central effects are mediated by the antagonism of 5HT-3 serotonin receptors in the area postrema; this zone senses neurotransmitters like serotonin, toxins, and other signals and plays a role in mediating the sensation of nausea and subsequently vomiting (Jones & Bartlett**	**Inhibition of the enzyme cyclooxygenase (COX); cyclooxygenase is required to convert arachidonic acid into thromboxane's, prostaglandins, and prostacyclin's (Jones & Bartlett Learning, 2019)**			

	Learning, 2019)				
Reason Client Taking	**Patient is taking to treat nausea as needed**	**Patient is taking for mild to moderate pain relief**			
Contraindications (2)	**-serotonin syndrome -low amounts of magnesium or potassium in the blood**	**-high blood pressure -an increased risk of bleeding**			
Side Effects/Adverse Reactions (2)	**-dizziness -constipation**	**-stomach pain -tinnitus**			
Nursing Considerations (2)	**-instruct patient to report bothersome side effects -patient should avoid over the counter cold medications**	**-assess for allergies -administer with food**			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**-monitor fluid and electrolyte status -assess lung sounds**	**-be aware this may cause increased risk of bleeding -assess for indications of bleeding**			
Client Teaching needs (2)	**-Place tablet in the cheek or under tongue until dissolved, -Do not crush or chew**	**-Take only as prescribed, -Do not combine with alcohol**			

Hospital Medications (5 required)

Brand/Generic	**Toradol**	**Normodyne**	**Ancef**	**Cytotec**	**Lovenox**

	Ketorlac	Labetolol	Cefazolin	Misoprostol	Enoxaparin
Dose	**30mg**	**20mg**	**2g**	**800mcg**	**40mg**
Frequency	**Q6H**	**Once daily**	**Once daily**	**Once daily**	**Q24H**
Route	**IV Push**	**IV**	**IV**	**Rectal**	**Sub-Q**
Classification	**NSAID**	**Beta-Blocker**	**Cephalosporin antibiotics**	**Gastrointestinal Agents, Prostaglandins, Endocrine**	**Low molecular weight heparin / anticoagulant**
Mechanism of Action	**Inhibition of the enzyme cyclooxygenase (COX); cyclooxygenase is required to convert arachidonic acid into thromboxane's, prostaglandins, and prostacyclin's (Jones & Bartlett Learning, 2019)**	**Non-selectively antagonizes beta-adrenergic receptors, and selectively antagonizes alpha-1 adrenergic receptors; this leads to vasodilation and decreased vascular resistance (Jones & Bartlett Learning, 2019)**	**Inhibits cell wall biosynthesis by binding penicillin binding proteins which stops peptidoglycan synthesis (Jones & Bartlett Learning, 2019)**	**Binds to myometrial cells to cause strong myometrial contractions leading to expulsion of tissue; also causes cervical ripening with softening and dilation of cervix (Jones & Bartlett Learning, 2019)**	**Binds to and potentiates antithrombin, a circulating anticoagulant, to form a complex that irreversibly inactivates clotting factor Xa (Jones & Bartlett Learning, 2019)**
Reason Client Taking	**Patient is taking for mild to moderate pain relief**	**Patient is taking to manage blood pressure**	**Patient is taking as a prophylactic prevention for infection**	**Patient is taking to help reduce blood loss during and after C-section**	**Patient is taking to help prevent blood clots during C-section and postpartum**
Contraindications (2)	**-anemia -high blood pressure**	**-diabetes -sinus bradycardia**	**-hypersensitivity to cephalosporin**	**-pelvic bleeding -sepsis**	**-active major bleeding -thrombo**

			antibacterial drugs -chronic kidney disease		**cytopenia**
Side Effects/Adverse Reactions (2)	**-headache -dizziness**	**-itchy skin -weakness**	**-loss of appetite -nausea and vomiting**	**-abdominal pain -diarrhea**	**-bleeding gums -headache**
Nursing Considerations (2)	**-assess dizziness and drowsiness that might affect gait and balance -may be contraindicated for nursing mothers**	**-report any rhythm disturbances -check with physician if breastfeeding**	**-report any signs of reaction to medication -monitor if patient is breastfeeding**	**-advise patient to avoid foods that may cause an increase in GI irritation -may need to reposition patient, monitor closely**	**-do not eject air bubble prior to infection -administer in subcutaneous tissue**
Key Nursing Assessment(s)/Lab (s) Prior to Administration	**-assess rate of pain -obtain baseline electrolytes and liver function labs**	**-assess pulse and heart rate -check for interactions with other medications**	**-assess allergies before administration -monitor input and output rates and patterns**	**-obtain baseline vitals -monitor for bleeding**	**-assess for signs of bleeding and hemorrhage -obtain baselines for PT, PTT, INR**
Client Teaching needs (2)	**-take with food -follow all directions given by physician**	**-avoid getting up too fast from sitting or lying position -avoid driving**	**-instruct patient what this drug is used for -can be taken with or without food**	**-teach patient the use of this medication -instruct patient to inform nurse if feeling unwell**	**-ensure patient informs provider of any bleeding -teach patient the need for the medication**

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Alert and Oriented x 4** **No apparent distress** **Appears appropriate per situation**
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**Skin color is normal per ethnicity** **Skin is dry and intact** **Warm** **Good skin turgor** **No rashes, bruises, or wounds** **Incision site is closed (dressing is fresh, dry and intact)** **Braden score is 18 which indicates low risk** **NA**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is normocephalic and midline,** **Neck is midline without tracheal deviation, thyroid is non-palpable** **Ears are symmetric and non-tender; tympanic membrane is pearly grey with cone of light noted in the respective region** **Nose is symmetric, no deviation of septum, nasal mucosa is pink and moist with moist turbinates** **Teeth are well taken care of, oral mucosa is pink and moist, hard, and soft palate/uvula rises and falls symmetrically** .
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:**	**Heart sounds are audible in all locations S1 and S2, no presence of murmur, gallops or rubs** **NA** **Peripheral pulses are 2+ in all locations** **Capillary refill is <3seconds** **2+ pitting edema midcalf and below**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Respiratory system intact, no accessory muscle use, breath sounds are clear throughout bilaterally, without wheezes,**

	Ronchi, crackles or stridor
GASTROINTESTINAL (2 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	**Follows a regular diet at home, she is currently on a liquid diet as tolerated, if she tolerates liquids well she can move to solid foods.** **5'1"** **228lbs** **Bowel sounds are audible and mildly active in all four quadrants, discomfort was noted on** **Last bowel movement was on 10/31/21** **light palpation, abdominal distention is due to the pregnancy, the incision is new, no additional scars, no drains or wounds.**
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:**	**Inspection of genitals showed the area to be clean and free of lesions, quantity of urine was 500ml** **Foley** **14F**
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☐**	**She does not need assistance with ADL** **She is not a fall risk, she received an epidural therefore, she is unable to get out of bed** **Fall score of 25 for moderate risk** **She is currently immobile below the waist related to the epidural** **No assistance needed or equipment** **She will be independent after epidural wears off**
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:**	**She is alert and oriented x 4, mental status is baseline and intact as well as speech and sensory function.** **No loss of consciousness** **DTRs are 2+ bilaterally**
PSYCHOSOCIAL/CULTURAL (2	She talks to her husband and mother as a coping

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):**	method She is appropriate development level for her age She believes in Christianity however, she did not go in to detail about her faith She is in love with her husband and enjoys their life together, she has her mother, father, and In-laws for support people
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	**Fundal height and postion was 1cm below umbilicus at midline** **Bleeding amount was scant** **Rubra** **Thick/clots** **NA**
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:**	**Rupture of membranes occurred during the c-section (AROM)** **1313** **Clear** **600ml** **No odor** **11/01/21** **1313** **Cesarean** **200+641=841ml** **Male** **8@1min, 7@5min and 9@15 minutes** **2945g** **Breast**

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**105**	**179/108**	**18**	**98.7F oral**	**99% Room air**
Labor/Delivery	**100**	**134/78**	**17**	**98.7F oral**	**99% room air**
Postpartum	**101**	**130/78**	**18**	**98.8F oral**	**97% room**

					air

Vital Sign Trends: Vital signs improved throughout the pregnancy, after the baby was delivered the vital signs and blood pressure returned to normal baseline

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1400	**Numeric**	**Mid abdomen**	**3/10**	**"weird, uncomfortable"**	**Ketorolac i.v push**
1600	**Numeric**	**Abdomen**	**2/10**	**"pressure"**	**Ketorolac I.v Push**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:18g **Location of IV: Right AC** **Date on IV: 11/01/21** **Patency of IV: flushes without restriction** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Mag-sulfate 40g/1000ml (50ml/hr) Pitocin 30U/500ml (60mU/min) No signs of erythema, drainage or infiltration

Intake and Output (2 points)

Intake	Output (in mL)
3,652ml	**927ml**

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.

Ketorolac 30mg IV push (T)	**Push 30mg every 6 hours as need for mild/severe pain**	**Because Ketorolac is a strong NSAID, it is given for mild to severe pain, and it will decrease inflammation as well**
Abdominal binding (N)	**As tolerated**	**Abdominal binding keeps the incision site and abdomen secure and helps to reduce discomfort**
Assistance with pumping (N)	**As needed**	**Assist the client with education about pumping and teach the client how to properly use the pump.**

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? Taking-in-phase

What evidence supports this? Mom is currently focusing on recovery, sleep and eating.

Discharge Planning (2 points)

Discharge location: Home

Equipment needs (if applicable): NA

Follow up plan (include plan for mother AND newborn): The patient needs to be seen in one week for a follow-up visit. For Cesarean sections the follow up time is typically 7-14 days postpartum, because the client was pre-eclamptic she will need to be seen earlier than others.

Education needs: The patient will need to be educated on lactation and the holds to promote latching and proper breast feeding.

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. Deficient knowledge related to lack of information about C-section	**The client was not sure how a c-section is done. She is scared of needles and going under "the knife"**	**1. Establish environment of mutual trust a respect this will ensure comfort and an enhanced feelings of trust** (Phelps, 2020). **2.Assess the clients level of knowledge to determine whether patient requires increased information or reinforcement** (Phelps, 2020).	**The client was able to re-teach the procedure in lay-man's terms and understand the trusting and comforting environment provided.**
2. Risk for acute pain related to recovery from C-section	**C-sections are a surgical procedure that involves an incision on the lower abdomen**	**1. Assess signs and symptoms of pain via behavior cues or verbal indicators** (Phelps, 2020). **2.Use a pain flowchart to record the time of medication administered, and quality of pain** (Phelps, 2020).	**Patient identified most effective pain relief measures and articulates factors that intensify pain and modified behavior accordingly**
3. Risk for infection related to artificial rupture of membranes and C-section	**Because c-sections are an open wound via incision site, there is an increased risk for infection**	**1. Reduce the risk of infection by handwashing and using proper ppe** (Phelps, 2020). **2. Identify risk factors predisposing the patient to infection** (Phelps, 2020).	**The patient remained free of signs and symptoms of infection**
4. Anxiety	**The client**	**1. Use therapeutic**	**The client was able to**

related to c-section as evidence by increased pulse and client stating she was anxious	**stated that "she is extremely nervous and anxious about the procedure and epidural prior"**	**communication and be empathetic towards the clients concerns** (Phelps, 2020). **2. Give the client clear, concise explanations of any procedure or intervention that will be performed** (Phelps, 2020).	**control breathing and talk through concerns with the RN and identify relieving factors of anxiety.**

Other References (APA)

Phelps, L. (2020). *Sparks & Taylor's Nursing Diagnosis Reference Manual*. Lippincott Williams & Wilkins.