N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 1744 02/12/2022	**Patient Initials** M.D	**Age** 29	**Gender** F
Race/Ethnicity African American	**Occupation** Amazon Delivery Driver	**Marital Status** Single	**Allergies** Hydrocodone-Hives
Code Status Full	**Height** 162.6 cm	**Weight** 70.8 kg BMI- 26.8	**Father of Baby Involved** Yes, but not present today

Medical History (5 Points)

Prenatal History: This patient is Gravida-2, Term-0, Preterm-0, Abortion-1, Living-0. She had a spontaneous miscarriage in 2012.

Past Medical History: Hypertension-unmanaged

Past Surgical History: This patient has no past surgical history.

Family History: Mother- HTN, Father- No known medical history

Social History (tobacco/alcohol/drugs): This patient has smoked marijuana since she was thirteen years old. She admitted to taking ecstasy one week ago at a party. She reported that she had recently taken her significant other's pain medication to relieve her back pain. Her drug screen performed during her admission was positive for cannabis, opiates, and cocaine.

Living Situation: She lives alone in a single-family home.

Education Level: This patient graduated high school and attended college for one year. However, she did not obtain a degree.

Admission Assessment

Chief Complaint (2 points): Urinary frequency, pain with urination, abdominal pain, backache, spontaneous vaginal delivery

Presentation to Labor & Delivery (10 points):. This patient presented to the emergency department (ED) at OSF on 02/12/2022 with complaints of urinary frequency, burning, lower abdominal pain, and backache. She reported that she had these symptoms for two weeks but decided to go to the emergency department because her pain had become a 10/10. She stated: "I thought that it was just a urinary tract infection (UTI), but I have never had one before." The emergency department staff drew labs and analyzed her urine, which revealed a UTI and a human chorionic gonadotropin level of 6.657.9, indicating that she was pregnant. They administered intravenous fluids and Rocephin to treat the UTI. Radiology performed an internal ultrasound which confirmed that she was 26w4d pregnant and the fetus was in the vertex position. This patient reported that she had no idea she was pregnant. She thought the back pain was related to a UTI or carrying heavy packages at work. Her last period was in October, but she reported that her cycles have been irregular since she was twelve. She was transferred to labor and delivery and admitted. The staff placed external monitors and performed a vaginal exam, which revealed leaking fluid, abnormal discharge, no vaginal bleeding, intact membranes, cervical dilation of 6 cm, effacement of 70%, and a category one fetal heart rate. The nursing staff administered 12 mg of betamethasone intramuscular and began an infusion of magnesium sulfate at a rate of 1gm/hr.

Diagnosis

Primary Diagnosis on Admission (2 points): UTI, Spontaneous vaginal delivery

Secondary Diagnosis (if applicable):.

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	3.8-5.3 x 10^6/mcL	This patient did not receive prenatal care.	3.4	3.35	This value although decreased, is an expected finding during pregnancy due to fluid retention and inadequate nutrition (Pagana et al., 2021).
Hgb	12-15.8 g/dL		10.7	10.6	This value although decreased, is an expected finding during pregnancy due to fluid retention and inadequate nutrition (Pagana et al., 2021).
Hct	36-47%		31.4	31.1	This value although decreased, is an expected finding during pregnancy due to fluid retention and inadequate nutrition (Pagana et al., 2021).
Platelets	140-440 x 10^3/mcL		272	315	
WBC	4-12 x x 10^3/mcL		16.7	13.5	WBCs can increase due to bacterial infections and tissue trauma during the labor process (Pagana et al., 2021; Ricci et al., 2021). My patient has a severe urinary tract infection and is in active labor.
Neutrophils	47-73%		82.6	74.1	Neutrophils can increase due to bacterial infections and tissue trauma during the labor process (Pagana et al., 2021; Ricci et al., 2021). My patient has a severe urinary tract infection and is in active labor.
Lymphocytes	18-42%		9.1	16.8	Reduced lymphocytes are

					expected in pregnancy due to the decrease in immune system function that prevents the mother from rejecting the fetus (Ricci et al., 2021).
Monocytes	4-12%		7.1	8.7	
Eosinophils	0-5%		1	0.2	
Bands	0-5%		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, AB, B, O	No prenatal care	A	A	
Rh Factor	+/-		Positive	Positive	
Serology (RPR/VDRL)	Negative		Negative	Negative	
Rubella Titer	Immune/Not immune		Not immune	Not immune	
HIV	+/-		Negative	Negative	
HbSAG	+/-		Negative	Negative	
Group Beta Strep Swab	+/-		Negative	Negative	
Glucose at 28 Weeks	<140 mg/dL		83	N/A	
MSAFP (If Applicable)	10-150 ng/ mL		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	Prenatal	Value on	Today's	Reason for Abnormal

	Range	Value	Admission	Value	
Hcg	**3640-117,000 mIU/mL**	No prenatal care	6.657.9	N/A	According to OSF's normal lab value range, this patient's level is expected for a 25–40-week pregnancy.
10-panel urine drug screen	**Negative**		Positive for cannabis, opiates, and cocaine.		According to the patient, she has smoked marijuana since she was 13. She reported taking ecstasy one week ago at a party and her significant other's pain medication a few days ago to relieve her back pain.

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)	**20-275 mg/dL**		n/a	n/a	

Lab Reference (1) (APA):

** Normal lab values obtained from EPIC

Pagana, K.D., Pagana, T. J., Pagana, T.N. (2021). *Mosby's diagnostic and laboratory test reference* (15th ed). Elsevier

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

Stage of Labor Write Up, APA format (30 points):

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	This 29-year-old patient was unaware of her pregnancy and only discovered it because she spontaneously went into labor on 02/12/2022. When she presented to labor and delivery, she was six centimeters dilated and seventy percent effaced. Cervical dilation between four and seven centimeters is indicative of the active phase of the first stage of labor (Ricci et al., 2021). At 0510 on 02/13/2022, dilation was complete, and she entered the second stage of labor (Ricci et al., 2021). During this stage, the mother pushes, and the fetus is born (Barlow et al., 2019). She began pushing at 0525, but her efforts were ineffective because her amniotic sac had not ruptured yet. It was bulging and leaking. At 0527, the physician artificially ruptured her membranes using an amnihook. At 0528, she welcomed a two-pound baby boy. Her entire labor from the active phase of stage one until birth was 11 hours and 43 minutes. She was in stage one for roughly 11 hours and 22 minutes, stage two for 18 minutes, and stage three for three minutes. During the third stage of labor, the mother delivers the placenta, which takes between five and thirty minutes (Barlow et al., 2019).

Current stage of labor	Following the delivery of the placenta, the mother enters the puerperium period and remains here for six weeks (Ricci et al., 2021). During this time, the mother undergoes various adaptations. She adapts to motherhood by entering the taking-in phase. This phase involves reliving the birthing process, relying on others to meet basic needs, and resting (Ricci et al., 2021). At the same time, the mother is undergoing physical adaptations. These include her pulse, blood pressure, and gastrointestinal system returning to their peripartum states. Her reproductive system also changes. Her uterus contracts, firms up, and slowly descend to its original location. The perineum and vagina are swollen and stretched, resulting in discomfort for the first few days following natural delivery (Ricci et al., 2021). The postpartum nurse is responsible for monitoring for complications, especially during the first four hours after delivery. The nurse must assess the mother's blood pressure and pulse every fifteen minutes for the first two hours following the birth (Barlow et al., 2019). The mother's temperature is taken every four hours for the first eight hours and every eight hours after that to monitor for infection (Barlow et al., 2019). A temperature of 100.4 degrees Fahrenheit and foul-smelling discharge indicate an infection (Barlow et al., 2019). The nurse must perform fundal assessments every fifteen minutes for the first hour to monitor for a soft,

	boggy uterus which places the patient at risk for postpartum hemorrhage (Ricci et al., 2021). He/she must monitor the mother's psychological status for signs of postpartum depression, including loss of appetite, difficulty sleeping, tearfulness, and anxiety (Ricci et al., 2021). The nurse also encourages the patient to partake in activities that decrease post-birth discomfort and complications, such as voiding regularly and using the peribottle, heating pads, and cold compresses (Barlow et al., 2019). A physical assessment of this patient determined that she was hypertensive, which is a typical finding for her. She was also tachycardic, which warranted an electrocardiogram to determine the cause. A fundal assessment revealed a firm fundus that was one fingerbreadth below the umbilicus, an expected finding for the first postpartum day (Ricci et al., 2021). She had a scant amount of lochia rubra on her perineum pad which is the first stage of lochia and is typically present for the first three to four postpartum days (Ricci et al., 2021). Her perineum was free of lacerations or edema, and she denied pain. Her skin was moist, and she vocalized that she was sweating profusely, which is expected for the first seven postpartum days because the body is excreting excess fluid retained during the pregnancy (Ricci et al., 2021). She reported that she had a bowel movement this morning but was experiencing some difficulty producing a bowel

	movement, which can occur following delivery. An assessment of her mood determined that she did not exhibit any signs of postpartum depression. She was talkative, appeared happy, and was enjoying her breakfast. She is in the taking-in phase, evidenced by her excitement about becoming a mother. She informed all that entered her room about her birthing process.

Stage of Labor References (2) (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.

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

Home Medications (2 required)

Brand/Generic	Tylenol/acetaminophen	Prenatal vitamins/ Prenatal Vit-Fe Fumarate			

Dose	500 mg	27 mg			
Frequency	Q6H, PRN for pain	Daily			
Route	Oral	Oral			
Classification	Nonsalicylate/ paraaminophenol derivative/nonopioid analgesic/antipyretic	Vitamin/ mineral			
Mechanism of Action	Blocks prostaglandin production and interferes with pain impulse in the peripheral nervous system	Multivitamin and iron supplement to prevent vitamin deficiency related to poor diet and pregnancy Contains folic acid to prevent neural tube defects			
Reason Client Taking	To relieve mild pain	To prevent vitamin deficiencies and neural tube defects			
Contraindications (2)	Hepatic impairment Hypersensitivity to acetaminophen	Hemochromatosis Liver problems			
Side Effects/Adverse Reactions (2)	Hepatotoxicity Hypotension/ hypertension	Nausea Constipation			
Nursing Considerations (2)	Use cautiously in patients with hepatic impairment Use caution in malnourished or hypovolemic patients	Administer this medication one to two hours before meals to increase absorption Do not administer within two hours of an antacid			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor AST and ALT before and during therapy Monitor blood pressure because this drug can increase or reduce it	Monitor patient's bowel sounds and output for signs of constipation Monitor AST and ALT for signs of liver damage and hemochromatosis			
Client Teaching needs (2)	Educate patient to read OTC labels carefully to prevent overdose Teach patient that this medication is passed into breastmilk	If stomach upset occurs, you can take this medication with food Increase fluids and fiber to prevent constipation			

Hospital Medications (5 required)

Brand/Generic	Cytotec/misoprostol	Procardia XL/nifedipine	Magnesium sulfate/ MgSO4	Motrin/ ibuprofen	Colace/Docusate sodium
Dose	800 mcg	60 mg	1gm/hr	800 mg	100 mg
Frequency	Once	Daily	Continuous	Q6H, PRN for pain	BID
Route	Rectal	PO	I.V	PO	PO
Classification	Prostaglandin E¹/Antiulcer	Calcium channel blocker/ antihypertensive	Mineral/electrolyte replacement/tocolytic	NSAID/ analgesic/anti-inflammatory/ antipyretic	Surfactant/ laxative/stool softener
Mechanism of Action	Stimulates uterine contractions to reduce bleeding	Prevents calcium release from the sarcoplasmic reticulum which inhibits smooth muscle cell contraction and dilates coronary arteries	Central nervous system depressant that relaxes smooth muscles which inhibits uterine contractions	prevents prostaglandin synthesis by blocking activity of cyclooxygenase, thus reducing pain and inflammation	Decreases surface tension between oil and water in stool which allows water to penetrate stool and soften it
Reason Client Taking	To prevent postpartum hemorrhage	To manage hypertension, this patient will be taking this drug after discharge	To stop preterm labor	To relieve mild postpartum pain	To treat postpartum constipation
Contraindications (2)	Hepatic disease Cardiovascular disease	Hypersensitivity to calcium channel blockers Second- or third-degree heart blocks	Cervical dilation greater than 6 cm Do not give with nifedipine	Hypersensitivity to ibuprofen or its components Impaired kidney function	Fecal impaction Undiagnosed abdominal pain
Side Effects/Adverse Reactions (2)	Arrhythmia Thromboembolism	Hypotension Arrhythmias	Arrhythmias Respiratory depression	Acute renal failure Hemorrhage	Dizziness Palpitations
Nursing Considerations (2)	Apply SCDs and compression stockings to prevent thromboembolism Do not place pillows under the patient's knees which can cause venous pooling	Do not give with magnesium sulfate or after a beta-adrenergic agonist Give drug one hour before or two hours after meals to increase absorption	If given via continuous infusion, the newborn may exhibit signs of magnesium toxicity such as respiratory depression Observe for signs of hypermagnesemia: bradycardia, depressed DTRs, dyspnea, hypotension, and slurred speech	Monitor patient closely for thrombotic events because NSAIDs increase the risk of stroke and MI Use cautiously in patients with hypertension because this drug can make it worse	Do not give to patients experiencing abdominal cramping, rectal bleeding, nausea, or vomiting This drug can cause electrolyte and vitamin deficiencies
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Perform fundal assessments every fifteen minutes for the first hour after birth Assess for vaginal bleeding and weigh pads Monitor for signs of thromboembolism	Assess blood pressure and pulse rate and rhythm before administering and throughout therapy	Assess uterine contraction characteristics every fifteen minutes Monitor mother for signs of respiratory depression and fetal heart rate for reduced variability	Monitor blood pressure closely before giving and during therapy Monitor creatinine and liver enzymes	Monitor output and stool characteristics Monitor electrolyte levels

	such as calf pain and difficulty breathing				
Client Teaching needs (2)	Monitor and report signs of bleeding Perform leg exercises and increase fluids to prevent thromboembolism	Measure blood pressure daily and notify provider if systolic blood pressure falls below 90 mm Hg Adhere to lifestyle modifications such as reducing alcohol consumption, low-fat and low- sodium diet, smoking cessation, and stress reduction	Notify the nurse of changes in vision, headache, nausea, or difficulty breathing Increase fluids and fiber intake to prevent constipation	Take this medication with food to prevent GI upset Report signs of GI bleeding, swelling, or vision changes	Take this medication with a full glass of water Notify provider if you experience light-headedness, muscle cramps, weakness, or unrelieved constipation

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2020 Nurse's Drug Handbook.*

Prenatal vitamin 27 mg-0.8 mg tablet - uses, side effects, and more. (n.d.). WebMD. https://www.webmd.com/drugs/2/drug-19981-280/prenatal-vitamin-oral/multivitamins-w-iron-includes-prenatal-vitamins-oral/details

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Alert Oriented to person, place, time, and situation. No acute distress noted. Well groomed and appropriate for her age.
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** .	 Appropriate for ethnicity Moist Warm Skin turgor assessed with immediate recoil No rashes, bruises, wounds, or incisions noted.

Braden Score: **Drains present: Y☐ N ☒** **Type:**	21 due to moisture
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck symmetrical. Trachea midline without deviation. No lymphadenopathy inspected or palpated. Thyroid is nonpalpable. Bilateral auricles are pink without drainage or lesions noted. Bilateral PERRLA. Intact EOMs bilaterally. Sclera is white. Conjunctiva is pink. The nose is free of discharge and lesions. Dentition is good. Throat is pink, moist, and without lesions. Tonsils 1+.
CARDIOVASCULAR (2 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	Clear S1 and S2 heart sounds. No audible murmur, gallops, or rubs noted. Pulses 2+ throughout bilaterally. Capillary refill normal, less than 3 seconds. No edema inspected or palpated in extremities.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Breath sounds even, regular and nonlabored bilaterally. No crackles, wheezes, or rhonchi noted.
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:**	Regular Regular 162.6 cm 70.8 kg Normoactive in all four quadrants This morning. Abdomen is soft, and nontender to palpation. No masses or organomegaly noted. No abdominal distention, incisions, scars, drains, or wounds noted observed.

GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Patient reports normal output of urine that is clear and pale yellow in color. She denies increased frequency of urination or pain. Genitalia is without lesions or rashes.
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☐**	0 Patient is up and ad lib She ambulates to and from the restroom without difficulty
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:**	A&O x 4 Clear No sensory deficits noted. Reflexes 2+
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):**	This patient stated: “I watch tv, eat, and play games to handle stress.” Appropriate for age, no delays observed. She is Christian but does not actively practice. This patient lives five minutes away from her significant other and her sister. She reports that she has a strong support system to help her adjust to being a new mother.
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	Firm, 1 fingerbreadth below the umbilicus Scant Rubra Normal No lacerations or episiotomy noted.
DELIVERY INFO: (1 point) **Rupture of Membranes:** **Time:**	AROM 0527

Color:	Meconium
Amount:	Not specified
Odor:	None
Delivery Date:	02/13/2022
Time:	0528
Type (vaginal/cesarean):	Vaginal
Quantitative Blood Loss:	300 mL
Male or Female	Male
Apgars:	6, 7
Weight:	2 pounds
Feeding Method:	Pumping

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal 1356	125	132/86	20	99.3 F Temporal	100% Room air
Labor/Delivery 0436	137	162/64	22	99.6 F Oral	100% Room air
Postpartum 0920	115	133/83	18	99.7 F Oral	100% Room air

Vital Sign Trends: This patient's pulse rate and blood pressure are outside of the normal range. Her blood pressure is typically elevated because she has hypertension. She tested positive for cocaine which causes tachycardia. These values increased significantly during labor which can occur due to severe pain. Following delivery, her pulse rate should have decreased. Since it did not, the physician ordered an ECG to determine if her drug use had caused permanent damage.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

0124	Numerical	Abdomen, back	4/10	Cramping, intermittent	Ibuprofen given every six hours; heating pad offered
0920	Numerical	Perineum	0/10	Patient reported no pain	Patient denied pain. She is receiving ibuprofen every six hours as needed and is using a peribottle when voiding.

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:**	This patient does not have an IV in place.

Intake and Output (2 points)

Intake	**Output (in mL)**
She has a regular diet, and her intake is not being measured.	She is voiding on her own. Her output is not being measured.

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.**
Ibuprofen (analgesia)- T	Q6H	To alleviate perineal discomfort following vaginal delivery.

Peribottle- N	While voiding and before applying a new perineal pad (Ricci et al., 2021).	A peribottle helps keep the perineum clean to aid in faster healing (Ricci et al., 2021). It also helps relieve vaginal and perineum discomfort (Ricci et al., 2021).
Fundal and lochia assessments	Every 15 minutes for the first two hours after birth and once a shift after that	These assessments are essential for detecting postpartum hemorrhage early (Ricci et al., 2021).

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? This mother is in the taking-in phase.

What evidence supports this? She is excited and reliving her labor by sharing it with anyone that enters her room. She vocalized being tired and resting as needed. Her sister is helping her ambulate to the restroom. Her newborn is at a different hospital. Therefore, her interaction with him was not able to be assessed.

Discharge Planning (3 points)

Discharge location: This patient will discharge home today.

Equipment needs (if applicable): N/A

Follow up plan (include plan for mother AND newborn): This mother will follow up with her physician in six weeks. Her newborn will remain in the NICU for a long time.

Education needs: She will require education about breastfeeding and consuming a low-sodium diet for her hypertension. She needs to be informed about post-delivery spotting, which is

normal. She will need resources for Women, Infants, and Children to help her care for her newborn.

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

2 points for correct priority

Nursing Diagnosis (2 pt each) Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational (1 pt each)** Explain why the nursing diagnosis was chosen	**Intervention/Rational (2 per dx) (1 pt each)** Interventions should be specific and individualized for his patient. Be sure to include a time interval such as Assess vital signs q 12 hours." List a rationale for each intervention and using APA format, cite the source for each of the rationales.	**Evaluation (2 pt each)** How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Decreased cardiac output related to substance use as evidenced by elevated pulse and blood pressure	This patient's drug use is straining her heart which can cause permanent damage.	**1.**Assess the patient's vital signs every 4 hours **Rationale:** Frequently assessing her vital signs will help detect a decrease in heart function early (Swearingen & Wright, 2019). **2.**Assess extremities for pulse rate and rhythm, capillary refill, color, temperature, and edema twice a shift **Rationale:** These assessments can identify vasoconstriction and fluid overload, indicating decreased heart function (Swearingen & Wright, 2019).	This patient was cooperative during my physical exam. Her vitals were assessed at 0920, which revealed hypertension and tachycardia. A physical exam revealed 2+ pulses, capillary refills of <3 seconds, warm skin, and no edema. These interventions should be repeated until discharge.
1. Constipation related to pregnancy as evidenced by patient's report of	Constipation can increase discomfort during the puerperium period. It also	**1.** Administer laxatives as prescribed **Rationale:** Colace will allow water to penetrate the stool, making it easier to pass (Jones & Bartlett	This patient asked for and received a laxative during my shift. She also received a prescription for Colace to take following

difficulty eliminating	increases the mother's fears of vaginal trauma after delivery (Ricci et al., 2021).	Learning, 2020). **2.**Encourage the patient to increase fiber and fluid intake **Rationale:** These measures provide bulk and soften the stool, making it easier to eliminate (Swearingen & Wright, 2019).	discharge. To my knowledge, she was not educated about increasing her fiber and fluid intake. However, I was not in the room when the nurse went over her discharge instructions and medications.
2. Knowledge deficit regarding breastfeeding related to first living baby as evidenced by mother asking questions	This mother is pumping to provide breast milk for her son. However, this is her first child. Therefore, she is unfamiliar with the process.	**1.** Teach the patient how to use a breast pump **Rationale:** To be successful with breastfeeding, this mother will need guidance from the nurse (Ricci et al., 2021). **2.** Have lactation visit the patient to help her increase her milk production and remain successful. **Rationale:** The lactation specialist is knowledgeable about breastfeeding and can share her wisdom with the mother (Ricci et al., 2021).	The nurse showed the mother how to use the breast pump. The patient was pumping throughout my shift. The lactation nurse talked to this patient before she was discharged.
3. Knowledge deficit regarding newborn care related to first living baby as evidenced by mother asking questions	This mother was unaware of her pregnancy, resulting in no preparation time. She will need guidance on how to care for her newborn.	**1.** Provide the patient with information about Women, Infants, and Children (WIC) **Rationale:** WIC provides nutritional assistance that will keep the mother and her baby healthy (*Women, infants, and children*, n.d.). **2.** Educate the mother about the newborn's sleeping habits. Teach her how to interpret crying cues and how to respond to them. Also, educate her about the symptoms of illness that warrant a call to the provider (Ricci et al., 2021). **Rationale:** Nurses can increase the mother's comfort and help her cope	The lactation nurse provided this mother with resources to help her meet her newborn's needs. These resources included SNAP, WIC, and places to obtain diapers. I was not in the room when this patient was discharged. Therefore, I do not know if the nurse educated her about the newborn's sleeping habits, interpreting crying cues, or the symptoms of illness.

		with her new role through education (Ricci et al., 2021).	

Other References (APA):

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

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier.

Women, infants, and children (WIC). IDHS. (n.d.). Retrieved from https://www.dhs.state.il.us/page.aspx?item=30513#:~:text=WIC%20is%20a%20food%20assistance,eat%20well%20and%20stay%20healthy.