N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 2/27/22 21:30	**Patient Initials** DW	**Age** 24	**Gender** F
Race/Ethnicity African American	**Occupation** A worker at Flex N Gate	**Marital Status** Single	**Allergies** Azithromycin
Code Status Full Code	**Height** 157.5 cm	**Weight** 83.9kg	**Father of Baby Involved** yes

Medical History (5 Points)

Prenatal History: G4P3003. This is the patient's fourth cesarean section.

Past Medical History: The patient's past surgical history includes anemia.

Past Surgical History: The patient's past surgical history includes a previous cesarean section.

Family History: None Listed

Social History (tobacco/alcohol/drugs): The patient has denied any alcohol, tobacco, or drug use**.**

Living Situation: The patient lives at home with her children and boyfriend.

Education Level: The patient has a high school diploma.

Admission Assessment

Chief Complaint (2 points): The patient was admitted for a rupture of membranes.

Presentation to Labor & Delivery (10 points): The patient is a 24 y/o female. The patient is presented G4P3003. The patient is at 37 weeks and five days. The patient was admitted to the emergency department on 2/27/21. The patient presents to labor and delivery with the above cesarean section.

Diagnosis

Primary Diagnosis on Admission (2 points): The patient's primary diagnosis is labor and delivery upon admission.

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	4.19	4.26	n/a	n/a
Hgb	12-15.8	8.4	8.6	n/a	The patient could have low Hgb today due to recent blood loss during the cesarean (Pagana & Pagana, 2018).
Hct	36-47	30.2	28.4	n/a	The patient could have low Hct today due to recent blood loss during the cesarean (Pagana & Pagana, 2018).
Platelets	140-440	265	188	n/a	n/a
WBC	4-12	13.72	16.70	n/a	This patient most likely has a high WBC due to her positive Group Beta Strep swab at her prenatal appointment. Admission value could be increased due to the stress and inflammation her body has been through from the cesarean (Pagana & Pagana, 2018).
Neutrophils	1.6-7.7	n/a	7.6	n/a	n/a
Lymphocytes	1.3-3.2	n/a	1.72	n/a	n/a

Monocytes	0.2-1.0	n/a	0.3	n/a	n/a
Eosinophils	0-0.40	n/a	0.4	n/a	n/a
Bands	<6%	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, B, AB, O**	A	A	A	
Rh Factor	**+/-**	Positive	Positive	Positive	
Serology (RPR/VDRL)	**Positive or Negative**	Nonreactive	Nonreactive	Nonreactive	
Rubella Titer	**Immune or nonimmune**	Immune	Immune	Immune	
HIV	**Positive or Negative**	Not detected	Not detected	Not detected	
HbSAG	**Positive or Negative**	**Negative**	**Negative**	N/A	
Group Beta Strep Swab	**Negative**	Positive	N/A	N/A	This patient had a positive GBS test which means she had a bacterium present and needed antibiotics before delivery (Pagana & Pagana, 2018).
Glucose at 28 Weeks	**<140mg/dL**	**103**	**92**	**n/a**	
MSAFP (If Applicable)	**n/a**	**n/a**	**n/a**	**n/a**	

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

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Drug Screen	**Negative**	Negative	Negative	Negative	

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)	**Normal**	**n/a**	**n/a**	**n/a**	

Lab Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2018). *Mosby's diagnostic and laboratory test reference* (14th ed.). Mosby.

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

	Your Assessment
History of labor:	The patient had a spontaneous rupture of membranes. The patient

Length of labor **Induced /spontaneous** **Time in each stage**	was in no length of labor due to the patient having a cesarean section. The patient was in the third stage of labor for 7 minutes, and the baby was delivered at 00:02. The average time of the third stage of work is around 15-16 minutes (Ricci et al., 2021).
Current stage of labor	The patient is currently in the fourth stage of labor which is the initiation of the postpartum phase (Ricci et al., 2021). Her fundal height was midline and approximately 2" under the umbilicus when performing her assessment. She had a scant amount of bleeding. Lochia was Rubra and was without clotting. These are normal findings for the postpartum stage of labor (Ricci et al., 2021). After her fundal assessment was completed, the abdominal binder was placed and retightened to her comfort. The patient presented to be tired, and she was placed in a calm environment with her baby to rest. During this stage, vital signs should remain stable and return to normal. The patient should be up moving at this time and beginning to do things independently. Some pain is expected but should not be restricting movement (Ricci et al., 2021). Blood loss during childbirth is average. The patient's hematocrit will drop after birth but should return to nonpregnant levels by eight weeks postpartum (Holman et al., 2021). Diaphoresis and diuresis

	may occur after childbirth to eliminate excess fluids accumulated during the last part of pregnancy (Holman et al.,2021).

Stage of Labor References (2) (APA):

Holman, H., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., McMichael, M., & Barlow, M. (2021). *RN maternal newborn nursing* (11th ed.). ATI.

Ricci, S., Kyle, T., & Carman, S. (2021). *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	Prenatal vitamin	Simethicone (Alka-Seltzer)			
Dose	1 tablet	80 mg			
Frequency	Daily	4xdaily Post meals & nightly			
Route	PO	PO			
Classification	Vitamin	GI agent			
Mechanism of Action	Prenatal vitamins are used to provide additional vitamins and minerals needed during pregnancy.	Relieves painful pressure caused by excess gas in the stomach and intestines.			
Reason Client Taking	Pregnancy/postpartum	Gas			
Contraindications (2)	1.Low-salt diet	1.Hypersensitivi			

	2.Potassium supplements	t y to simethicone 2.Phenylketonuri a			
Side Effects/Adverse Reactions (2)	1.Upset Stomach 2.Headache	1.Allergic reaction 2.Upset stomach			
Nursing Considerations (2)	1.Store away from moisture and heat. 2.Do not crush or break the tablets.	1.Always follow instructions on the label. 2.Store away from moisture and heat.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Potassium levels and iron levels.	Monitor for signs of an allergic reaction.			
Client Teaching needs (2)	1.Take with a full glass of water. 2.Do not take with milk or another dairy products. (Multum, 2021)	1.Works best if you take it after meals and at bed time. 2.You may need to follow a special diet or increase your exercise while using. (Multum, 2020b)			

Hospital Medications (5 required)

Brand/Generic	Ketorolac	Metoclopramide	Ondansetron	Polyethylene	Lactated

	(Toradol)	(Reglan)	(Zofran)	glycol (Miralax)	Ringer
Dose	30mg	10mg	4mg	17g	1000ml
Frequency	Every 6 hours.	Every 6 hours	Every 6 hours PRN	PRN daily	500 ml per hour
Route	Intravenous	Intravenous	Intravenous	PO	Intravenous
Classification	NSAID	Dopamine antagonist	5-HT3 antagonist	Laxative	Fluid and electrolyte replacement
Mechanism of Action	Ketorolac is used during the latter part of pregnancy may cause premature closure of the fetal ductus arteriosus, fetal renal impairment, inhibition of platelet aggregation, and delayed labor and delivery. (Jones & Bartlett, 2020).	Blocks dopaminergic receptors in the chemoreceptor r trigger zone, preventing nausea and vomiting. (Jones & Bartlett, 2020).	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at the vagal nerve terminals in the intestines (Jones & Bartlett, 2020)	Increases the amount of water in the intestinal tract to stimulate bowel movements. (Jones & Bartlett, 2020).	Delivered intravenousl to replace the loss of fluids and electrolytes.
Reason Client Taking	To delay labor and delivery.	To prevent nausea and vomiting associated with surgery.	Nausea	Constipation	The patient had blood loss during surgery.
Contraindications (2)	Risk of fetal kidney problems that may result in low amniotic fluid. Hypersensitivit y and possibly high risk for	GI hemorrhage and hypersensitivity to metoclopramide de or its components. (Jones &	The patient does not have any contraindications to this medication. Contraindications would include hypersensitivity and congenital	1.Bowel Obstruction 2.Eating Disorders (Jones & Bartlett, 2020).	Liver failure and renal disease. (Jones & Bartlett, 2020).

	bleeding. (Jones & Bartlett, 2020).	Bartlett, 2020).	long QT syndrome. (Jones & Bartlett, 2020)		
Side Effects/Adverse Reactions (2)	This medication could cause headache and dizziness (Jones & Bartlett, 2020).	Tachycardia and hypotension. (Jones & Bartlett, 2020).	Hypotension and Serotonin syndrome (Jones & Bartlett, 2020)	1.Bloating 2.Dizziness (Jones & Bartlett, 2020).	Agitation and back pain.
Nursing Considerations (2)	This medication should be used cautiously in patients with hypertension because it worsens the severity of hypertension. (Jones & Bartlett, 2020). This medication is also present in the patient's breast milk, so you should check with the provider before continuing the medication at home (Jones & Bartlett, 2020).	It should not be used in patients with depression. (Jones & Bartlett, 2020). Use cautiously in patients with hypertension. (Jones & Bartlett, 2020).	Monitor the patient closely for rash or difficulty breathing, which could indicate an allergic reaction. (Jones & Bartlett, 2020). Confusion, chills, and fever may be signs of serotonin syndrome. (Jones & Bartlett, 2020)	1.Poor the powder into 4- 8 oz of a cold or hot beverage (Jones & Bartlett, 2020). 2.Do not use a larger or smaller amount or for longer than recommended (Jones & Bartlett, 2020).	Monitor for signs of fluid volume deficit, such as confusion in older adul and dizziness (Jones & Bartlett, 202 Continuously monitor the patient's fluid and electrolyte status to evaluate the infusion's effectiveness and avoid potential complication of fluid overload and electrolyte imbalance. (Jones & Bartlett, 202
Key Nursing Assessment(s)/Lab(s)	Monitor the patient's liver	Vital signs such as heart	If the patient's potassium levels	Monitor the patient for	Blood sugar should be

Prior to Administration	enzymes and monitor the patient's hypertension for adequate fluid balance because this medication can cause fluid retention. (Jones & Bartlett, 2020).	rate and blood pressure should be assessed prior to administration. (Jones & Bartlett, 2020). The patient should be assessed for abdominal pain. (Jones & Bartlett, 2020).	are low, there is an increased risk for prolonged QT intervals. If the patient's magnesium levels are low, there is an increased risk for prolonged QT intervals. (Jones & Bartlett, 2020).	nausea, vomiting, or stomach pain. (Jones & Bartlett, 2020).	assessed before administratio on. Blood pH levels should be assessed before administratio on. (Jones & Bartlett, 2020).
Client Teaching needs (2)	1.Advise the patient not to take other NSAIDs and consult with the provider beforehand. (Jones & Bartlett, 2020). 2.Caution the patient to avoid hazardous activities. (Jones & Bartlett, 2020).	Advise against activities that require alertness. (Jones & Bartlett, 2020). Immediately report involuntary movements of face, eyes, tongue, and hands. (Jones & Bartlett, 2020).	Report any signs of hypersensitivity, such as a rash. Seek medical attention immediately if experiencing persistent, severe, unusual, or worsening symptoms. (Jones & Bartlett, 2020)	1.This medication should produce a bowel movement in 1-3 days. 2. Do not take more than once a day. (Multum, 2020a).	Educate the patient to notify the provider if increased urination or thirst occurs. (Jones & Bartlett, 202 The patient should notify the provider of swelling due to overhydratio (Jones & Bartlett, 202

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). 2020 *Nurse's Drug Handbook* (19th ed.).

Multum, C. (2020a, March 26). Polyethylene glycol 3350. Drugs.Com. Retrieved October 27, 2021. https://www.drugs.com/mtm/polyethylene-glycol-3350.html

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient appears alert and oriented x person, place, and time. The patient is well-groomed with no acute distress. The patient seems tired.
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin color is pink/white. Skin warm and dry upon palpation. No rashes or lesions. Small bruising on the abdomen at the shot site. The cesarean incision on the lower abdomen and some scratches across the abdomen. Normal quantity, distribution, and texture of hair. Nails without clubbing or cyanosis. Skin turgor normal mobility. Capillary refill less than three seconds fingers and toes bilaterally. The patient's Braden Score is 21.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and Neck: Head and neck are symmetrical, the trachea is midline without deviation, thyroid is not palpable, no noted nodules. Bilateral carotid pulses are palpable and 2+. No lymphadenopathy in the head or neck is noted. Eyes: Bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink, no visible drainage from eyes. Bilateral lids are moist and pink without lesions or discharge noted. PERRLA bilaterally. Ears: Bilateral auricles no visible or palpable deformities, lumps, or lesions. Bilateral canals clear with pearly grey tympanic membranes. Nose: Septum is midline, turbinates are moist and pink bilaterally, and there is no visible

	bleeding or polyps. Bilateral frontal sinuses are nontender to palpation. Throat: Posterior pharynx and tonsils are moist and pink without exudate noted. Tonsils are 2+. The uvula is midline; the soft palate rises and falls symmetrically. The hard palate is intact. Dentition is good; oral mucosa overall is moist and pink without lesions noted. .
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 without murmurs, gallops or rubs. PMI palpable at 5th intercostal space at MCL. Regular rate and rhythm. Pulses 2+ throughout bilaterally. Capillary refill less than 3 seconds fingers and toes bilaterally. No edema present in lower extremities. Homan's sign is negative bilaterally.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Average rate and pattern of respiration symmetrical and non-labored, lung sound clear throughout anterior/posterior bilaterally, no wheezes, crackles, 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:**	The patient's diet at home and current diet are both regular. The patient's height is 5'2, and her weight is 185lbs (83.9kg). The patient's abdomen is soft and tender due to incision, with no organomegaly or masses noted upon palpation of all four quadrants. The patient's bowel sounds are normoactive in all four quadrants; her last bowel movement was on 2/27/22. The patient has no CVA tenderness noted bilaterally. The patient has a low transverse incision reported from a recent cesarean section.

GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The patient can ambulate independently to the restroom without assistance—The average quantity of urine without pain. Genital is as expected post-delivery—no swelling, rash, or sores.
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 11** **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	The patient can ambulate on her without assistance. The patient's fall score is 11.
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:**	All extremities have a full range of motion (ROM). Hand grips and pedal pushes and pulls demonstrate normal and equal strength. Balanced and smooth gait. Patient alert and oriented to person, place, and time. PERRLA. Deep tendon reflexes (DTRs) all locations 2+ bilaterally. Speech and mental status are normal for age and development. The patient is negative for clonus, and patellar is 2+—no LOC.
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):**	The patient enjoys listening to music and reading when coping. Her development level is appropriate for her age. The patient is a high school graduate. The patient has no religious affiliation. The patient has a great support system with her family members.
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	Fundal height is 2 cm under and midline. The scant amount of bleeding. Lochia is Rubra. No clotting. No episiotomy/lacerations.
DELIVERY INFO: (1 point) **Rupture of Membranes:** **Time:** **Color:** **Amount:**	The patient had spontaneous rupture of the membranes at 21:00 on 2-27-22. The color was clear and pink. The amount was 1404ml. Odor was normal

Odor: **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	The patient delivered 2/28/22 at 00:02 The patient had a cesarean. The patient had 767 mL of blood loss. The patient delivered a female. The infant's Apgar was 3,8. The infant weighed 6lbs 2.4oz at birth. The mother is bottle feeding.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	77	104/57	20	97.5	100
Labor/Delivery	74	118/53	18	97.5	99
Postpartum	77	124/59	18	98.5	100

Vital Sign Trends: This patient's vital signs were stable throughout.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
08:43	Numeric 0-10	None Zero pain	None Zero pain	None Zero pain	None Zero pain
11:15	Numeric 0-10	Incision pain	2	Aching	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 R Peripheral Date of IV: 2/27/22 Patency of IV: 20 Patients' IV access is intact and clean with no redness or drainage was noted at the site. Flushes without difficulty.

Intake and Output (2 points)

Intake	**Output (in mL)**
Pt had 2000ml of fluid intake.	Unable to measure the amount, the patient states she is urinating an average amount.

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.**
Tylenol (T)	Q6h	Tylenol was given q6h to help relieve the patient's pain from her cesarean section.
Ibuprofen (T)	Q8h	Ibuprofen was given q8h to help relieve the patient's pain from her cesarean section.
Calm, quiet environment (N)	Constantly	Having a quiet and peaceful environment can help the patient relax which promotes healing. This was used due to the patient is just having a major procedure and need to rest to recover.
Abdominal binder (N)	As needed	This intervention was used to help the patient be more mobile. Using an an abdominal binder can take some pressure away from her incision, leading to slightly less discomfort.

Phases of Maternal Adaptation to Parenthood (3 point)

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

What evidence supports this? This patient shows signs of being in the taking-in phase by experiencing excitement. She enjoys talking to others about her experiences. She still relies on assistance to get around and do things due to a recent cesarean section. She seemed tired before on her recovery and doing what she needed to for her health.

Discharge Planning (3 points)

Discharge location: The patient is being discharged to home with the father of her child.

Equipment needs (if applicable): n/a

Follow up plan (include plan for mother AND newborn): This patient will need to go to her OB doctor in approximately two weeks and again in 6 weeks to see how she is recovering post-delivery. The baby will need to be seen by her pediatrician about 24-48 hours after discharge to check weight.

Education needs: Some education given to this patient was about safe infant sleeping practices, feeding information, and adjusting to life with a newborn. She was also educated about what she could and could not do during her recovery**.**

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 complete nursing diagnosis with	**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	**Evaluation (2 pt each)** How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes,

"related to" and "as evidenced by" components		hours." List a rationale for each intervention and using APA format, cite the source for each of the rationales.	modifications to plan.
1. Acute pain related to cesarean section as evidenced by the patient reporting pain of 2 out of 10.	The patient reported her pain to be at 2 out of 10.	**1.**Pain levels should be assessed regularly to verify location and intensity. Rationale – Patient clarifying needs allows for appropriate intervention (Ricci et al., 2021). 2. Provide comfort measures. Rationale – The nurse can help the patient readjust in bed, provide a belly binder, and use pillows to give the mother support to help alleviate pain (Ricci et al., 2021).	1.Patient will remain Infection-free. 2.Patient will achieve wound healing without complications.
2. Risk for infection related to invasive procedure as evidenced by cesarean section.	This patient is at risk for infection due to her recent cesarean section. This risk occurs because she was opened up and still recovering from an incision.	**1. .**Assess for signs and symptoms of infection such as fever, elevated pulse and WBC, abnormal odor, or discharge color. Rationale – This intervention was chosen because patients should be monitored for infection after any procedure (Phelps, 2020). **2.**Know history for preexisting conditions or risk factors. Rationale - Rationale – This intervention was chosen because a history of diabetes or bleeding can increase the chances of infection or poor wound healing (Phelps, 2020)	1.Patient will remain Infection-free. 2.Patient will achieve wound healing without complications.
3. Deficient knowledge related to	The patient stated, "I wonder if this	**1.** Review the need for self-care encourages participation and self-care if	Expressing and understanding physiological changes,

cesarean section as evidenced by physiological changes.	scar is going to be worse to take care of than the previous one."	the client can afford it. Rationale – facility autonomy and help prevent infection and promote recovery. (Ricci et al., 2021). **2**. Pay attention to psychological status and response to cesarean birth and the role of motherhood. Rationale- Anxiety related to the ability to care for themselves and their children, disappointment on the birth experience hurts the learning ability and readiness of the client. (Ricci et al., 2021).	the needs of the individual, and the results expected. Activity and procedures that need to be done correctly and describe the reasons for the action.
4. Deficient knowledge readiness for enhanced parenting related to the birth of a new family member as evidenced by the newborn.	The patient stated, "I wonder what the kids and my boyfriend will think of her since they weren't here."	1. Initiate skin-to-skin contact between mother and newborn father and newborn in the delivery room within the first hour of birth. Rationale- To enhance parent-infant interaction and acquaintance with the newborn. (Ricci et al., 2021). 2. Encourage parent participation in care behaviors such as diapering, formula feeding, and bathing. Rationale - To promote familiarity with behaviors and decrease the parental feeling of contribution as newborn's primary caretaker. (Ricci et al., 2021).	Parents of newborns assume responsibility for the emotional and physical care and well-being of the new family member.

Other References (APA)

Phelps, L. L. (2020). Sparks & Taylor's nursing diagnosis reference manual (10th ed.). Wolters Kluwer.

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