N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission	**Patient Initials**	**Age**	**Gender**
03/06/2022 @ 0716	BD	28	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Hispanic/Latino	Unemployed	Single	No known allergies
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full Code	5’ 0”	156lbs	Yes

Medical History (5 Points)

Prenatal History: Gravida - 1, Term - 0, Preterm - 0, Abortion - 0, Living births - 0. She is positive for herpes simplex type II, she has gestational diabetes, obesity, and group beta streptococcus is unknown.

Past Medical History: Dysmenorrhea and fibrocystic breast changes

Past Surgical History: Wisdom tooth extraction

Family History: Dad - History of alcohol abuse. Mom and sister - hypertension

Social History (tobacco/alcohol/drugs): Formerly smoked half of a pack of cigarettes for nine years. She quit on 8/19/21. The patient denies drug and alcohol use.

Living Situation: The patient lives at home with her boyfriend (the father of the baby).

Education Level: Graduated high school

Admission Assessment

Chief Complaint (2 points): Premature preterm spontaneous rupture of membranes at home around 0400 on 3/6/22

Presentation to Labor & Delivery (10 points): The patient is a 28-year-old female who is 35 weeks and 0 days gestation. She presented to the emergency room at OSF at 0600 on 3/6/22 due

to preterm premature spontaneous rupture of membranes she experienced at home around 0400 on 3/6/22. She is Gravida - 1, Term - 0, Preterm - 0, Abortion - 0, Living births - 0. The patient has risk factors: her first pregnancy, gestational diabetes, obesity, an unknown group beta streptococcus, and herpes simplex virus type 2. The emergency department transferred her to labor and delivery at 0716 on 03/06/2022. Upon admission, she was in the latent phase of the first stage of labor.

Diagnosis

Primary Diagnosis on Admission (2 points):. Preterm premature spontaneous rupture of membranes (PPROM).

Secondary Diagnosis (if applicable): Gestational diabetes

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	3.86	3.51	3.51	A common reason for a decrease in red blood cells in a pregnant woman is the additional fluid that will dilute the red blood cells (Pagana et al., 2021). There was no indication of anemia in my patient. However, not consuming enough dietary iron could also cause this value to be low (Pagana et al., 2021).
Hgb	12.15.8	13	12.2	12.2	
Hct	36-47%	37.3	35.2	35.2	Hematocrit is the volume of RBCs in the blood (Pagana et al., 2021). If the RBCs are decreased, this value will also be decreased (Pagana et al., 2021).

Platelets	140-440	269	228	228	
WBC	4-12	9.7	10.2	10.2	
Neutrophils	47-73%	73.7	74.1	74.1	Neutrophils can increase due to tissue trauma during labor (Pagana et al., 2021).
Lymphocytes	18-42%	19.3	17.9	17.9	Lymphocytes are decreased due to lower immune system function that prevents the fetus from being rejected during pregnancy (Ricci et al., 2021)
Monocytes	4-12%	6.1	7.0	7.0	
Eosinophils	0-5%	0.3	0.7	0.7	
Bands	0-5%	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	AB	AB	AB	
Rh Factor	+/-	Positive	Positive	Positive	
Serology (RPR/VDRL)	Negative	N/A	N/A	N/A	
Rubella Titer	Immune/not immune	Immune	Immune	immune	
HIV	+/-	Negative	Negative	negative	
HbSAG	+/-	Negative	Negative	negative	
Group Beta Strep Swab	+/-	Unknown	Unknown	unknown	My patient's group beta streptococcus was unknown since she went into labor at 35 weeks and 0 days. Group beta streptococcus is a gram-positive bacterium that can cause a serious infection in babies (Ricci

					et al., 2021).
Glucose at 28 Weeks	<140	235	87	87	My patient was confirmed to have gestational diabetes. Gestational diabetes is glucose intolerance during pregnancy (Ricci et al., 2021). She was told to limit her carbohydrate and sugar intake and was given a prescription for Glyburide.
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
No other lab tests indicated					

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	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 28-year-old patient presented at 0600 on 3/6/2022 at 35 weeks 0 days gestation. She had a spontaneous preterm premature rupture of membranes at home at approximately 0400. She presented in the first stage of labor, but there was no documentation indicating her dilation, effacement, or progress from latent to active to transition, other than the third stage lasting about two minutes. At 0851, she was put on oxytocin to augment her labor due to ineffective contraction patterns. Dilation was complete at 2300, and she was at the second stage of labor (Ricci et al., 2021). She began pushing at 2340 on 3/6 until she delivered her son at 0048 on 3/7. Her labor was approximately 20 hours and 48 minutes from when her water broke until the baby was born. The delivery of the placenta occurs in the third stage of labor and usually takes five to ten minutes but can take up to thirty minutes (Holman et al., 2019).
Current stage of labor	The patient is currently in the puerperium period, also known as the "fourth trimester," which begins after the delivery of the placenta and lasts for about six weeks (Ricci et al., 2021). The transition period into motherhood begins with the taking-in phase, where the mother sleeps and relies on others to meet her

	basic needs as her body begins to change back to the peripartum state (Ricci et al., 2021). She appears to be tired but happy and excited about her new role of being a mom to her first baby. The uterine involution has begun at this point, and the patient's fundus was assessed midline, firm, and at the umbilicus. Lochia was scant, and rubra, which is an expected finding at this stage (Ricci et al., 2021). During the postpartum period, the nurse will be caring for the mom and the baby. The nurse will monitor for complications, assess blood pressure, pulse every fifteen minutes for the first two hours after birth, temperature every four hours for the first eight hours, and then every eight hours (Ricci et al., 2021). In addition to the patient's physical well-being, the nurse will monitor for the patient's psychological well-being and adjustment. Signs of postpartum depression include anxiety, tearfulness, difficulty sleeping, and loss of appetite (Ricci et al., 2021). The patient reported a pain level of 7 out of 10. The patient used ice packs and took Tylenol and Ibuprofen as needed to help control and reduce the pain from her episiotomy. She fears having a bowel movement due to discomfort in the perineal area. The nurse explained that difficulty having bowel movements was normal after birth (Ricci et al., 2021). The nurse provided Colace to help soften her stool and make her more comfortable. The patient's

	vital signs were within normal limits and have remained stable. The patient decided not to breastfeed, and proper bottle-feeding techniques were demonstrated and taught.

Stage of Labor References (2) (APA):

Holman, H. C., McMichael, M., Johnson, J., Williams, D., Sommer, S., Wheless, L. K., McMichael, M. G., & Barlow, M. S. (2019). *Rn Maternal newborn nursing: Review module*. Assessment Technologies Institute.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing*. 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	glyburide/DiaBeta	Prenatal vitamins/Vit-Fe/ Fumate			
Dose	2.5mg	27 mg			
Frequency	Daily	Daily			
Route	Oral	Oral			
Classification	Sulfonylurea Antidiabetic	Vitamin/Mineral			
Mechanism of Action	Stimulates insulin release from beta	Used to give women enough vitamins and iron to support a healthy pregnancy			

	cells in the pancreas	and baby.			
Reason Client Taking	Gestational diabetes – to control her glucose level	Prenatal care			
Contraindications (2)	Hypersensitivity to glyburide. Diabetic ketoacidosis.	Hemolytic anemia Hypersensitivity to any of the drug's components			
Side Effects/Adverse Reactions (2)	Hypoglycemia Hepatic failure	Constipation Stomach upset			
Nursing Considerations (2)	Monitor CBC closely. Give as a single dose before the first meal of the day.	The patient should take it daily. Not to be taken with antacids or dairy			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor fasting glucose levels to determine the patient's response to glyburide.	Check iron and calcium levels			
Client Teaching needs (2)	Take right before the first meal of the day. Do not skip any doses.	Antacids should not be taken at the same time. Drink plenty of water when taking this medication. Take with crackers if stomach upset occurs			

Hospital Medications (5 required)

Brand/ Generic	Tylenol/ acetaminophen	Dermoplast Spray Aero/ benzocaine-menthol	Colace/ docusate sodium	Motrin/ ibuprofen	Tums/calcium carbonate
Dose	650mg	1 spray	100mg	800mg	1000mg
Frequency	PRN Q4H	PRN Q4H	Daily	Q8 Hr PRN	PRN Q8H
Route	Oral	Topical	Oral	Oral	Oral
Classification	Non salicylate/Antipyretic, nonopioid analgesic	Dermatological agent/Topical analgesic	Surfactant/ laxative/ stool softener	NSAID/ analgesic/anti-inflammatory/	Calcium salts/ Antacid

				antipyretic	
Mechanism of Action	Nonsteroidal anti-inflammatory drug. Pain reliever/ Fever reducer. Blocks prostaglandin production and interferes with pain.	Blocks nerve signals in the body to reduce pain and discomfort	Decreases surface tension between oil and water in the stool to soften the stool	Blocks the activity of cyclooxygenase to reduce pain	Increases levels of calcium to maintain homeostasis. Helps regulate neurotransmitters and hormones
Reason Client Taking	For mild to severe pain. She is taking it to manage discomfort due to a second-degree laceration.	For pain relief due to hemorrhoids	To prevent constipation and make her stools softer and easier to pass	For mild to severe pain, of the second-degree laceration from the episiotomy	For heartburn relief
Contraindications (2)	Hepatic impairment Hypersensitivity to any of the drug's components	Asthma Heart disease	Fecal impaction Hypersensitivity to docusate salts	Hypersensitivity to ibuprofen. Asthma	Hypercalcemia hyperphosphatemia
Side Effects/Adverse Reactions (2)	hypotension hepatotoxicity	Headache tachycardia	Dizziness Abdominal cramping	GI bleeding Hepatic Failure	Hypotension Nausea/ vomiting
Nursing Considerations (2)	Use cautiously in patients with hepatic impairment. Ensure that the daily dose does not exceed the maximum dosing limits	Be aware of allergies to benzocaine or menthol. Should not be used by patients with a history of asthma	Avoid giving this drug to patients who are having abdominal cramping. Assess for laxative abuse syndrome	Be aware that the risk of MI or stroke increases the longer ibuprofen is used. Use with extreme caution in patients with a history of GI bleeding	Should not be given within 2 hours of other oral drugs due to risk of interactions. This medication should be stored at room temperature
Key Nursing Assessment(s)/Lab(s) Prior to	For long term use, liver function tests and creatinine levels should be done to monitor for hepatotoxicity	Monitor respiratory status, heart rate and rhythm	Monitor for bleeding Monitor for electrolyte imbalance	Monitor CBC for decreased hemoglobin and hematocrit Monitor liver enzymes for hepatic	Monitor serum calcium levels

Administration				reactions/failure	
Client Teaching needs (2)	Monitor for signs of hepatotoxicity such as bleeding, easy bruising, and malaise. Contact provider before taking other OTC medications	Do not use more than the recommended dose, as fatal side effects can occur if too much is absorbed through the skin. Seek emergency care if you experience a sudden onset of tachycardia	Take this with a full glass of water or milk. Increase fiber intake	Take this medication with a full glass of water. Take with food of after meals to reduce GI upset	The patient should take this drug 1-2 hours after eating. High fiber foods should be avoided since it may decrease calcium absorption

Medications Reference (1) (APA):

Dermoplast: Side effects, uses, and dosage. Drugs.com. (n.d.). Retrieved from https://www.drugs.com/dermoplast.html

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient was alert and oriented to person, place, time, and situation. She was eager to shower and get dressed. The patient was in mild pain but not in distress.
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Her skin was tan in color and normal for her ethnicity. The skin was dry and intact. The temperature was normal on the upper and lower extremities. Skin turgor is within normal limits, with normal recoil The Braden score is 21. She has a midline second-degree laceration of the perineum from the episiotomy and mild swelling No drains present

HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and Neck are symmetrical, no JVD, the trachea is midline without deviation. Ears are symmetrical bilaterally, and clear. Conjunctiva is pink and moist, the sclera is white, no draining or discharge was noted. The septum is midline. Dentition is good. .
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 and audible S1 and S2 sounds with no murmurs, gallops, or rubs noted. Normal rate and rhythm. Peripheral pulses are 2+ bilaterally throughout. Cap refill is less than 3 seconds. There is no neck vein distention and no edema inspected or palpated.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Normal rate and rhythm. Respirations are regular, nonlabored, and symmetrical bilaterally. Lung sounds clear bilaterally throughout, with 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:**	The patient stated she ate, “Mostly low carbohydrate and low sugar foods.” Her current diet in the hospital is a regular diet and she had just ordered breakfast 5’ 0” 156 lbs Her bowel sounds are normoactive in all four quadrants. Her last bowel movement was on 3/6 The abdomen was tender when doing the fundal assessment. Her uterus was midline, firm without massage, and at the umbilicus upon assessment. No drains or wounds are present.
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The patient is up adlib and urine is unmeasured. She ambulated to the bathroom to urinate during my assessment. She reported no pain with urination other than slight burning where the episiotomy incision is. The incision is a well-approximated midline second-degree laceration. There is normal swelling noted

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**☐	The patient is independent and up adlib Fall score is 2. She does not have any equipment and does not need any support to stand or walk .
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:**	The pupils are equal and reactive The patient moved all extremities well, strong grips bilaterally, strong legs bilaterally She is alert and oriented Her speech is good, clear, and easy to understand She had full awareness of what was happening around her and showed no signs of deficits. She is oriented to person, place, and situation A&O x4 No sensory deficits noted Deep tendon reflexes were 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):**	The patient's boyfriend was present at the bedside. She stated, "He, my mom, and my sister are my primary support." She stated, "He has been awake since we came in yesterday, so he is going to sleep first and then take care of the baby while I sleep."
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	Fundal height is midline at the umbilicus. Bleeding is scant. The color is Rubra. The character is dark red The episiotomy incision is a well-approximated midline second-degree laceration.
DELIVERY INFO: (1 point) **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female**	Preterm premature spontaneous rupture of membranes around 0400. The fluid was reported to be a moderate amount of clear fluid with no odor. She delivered on 3/7/22 at 0048 The vaginal delivery resulted in a quantitative blood loss of 300 mL and the successful birth of a 5lb 3oz male with Apgar scores of 8 at one minute and 9 at five minutes. The baby is being bottle-fed.

Apgars: **Weight:** **Feeding Method:**	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	73	131/78	N/A- not charted	N/A- not charted	N/A – not charted
Labor/Delivery	88	127/60	16	98.5 F (oral)	96 (room air)
Postpartum	100	115/69	16	98 F (oral)	100 (room air)

Vital Sign Trends: The patient's vitals were stable during the prenatal period and have remained stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0820	7/10 (Numeric scale)	Perineum, vaginal pressure	constant	Aching/burning	Reposition/ ice pack, alternating Tylenol, and ibuprofen
1130	3/10 (Numeric scale)	Perineum, vaginal pressure	mild	Aching/burning	Interventions are effective, the pain level is at a comfortable level

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock

Size of IV:	20-gauge saline locked
Location of IV:	Left top of hand in the metacarpal vein
Date on IV:	3/6/22 @ 0800
Patency of IV:	Patent
Signs of erythema, drainage, etc.:	No signs of erythema or drainage
IV dressing assessment:	Clean, dry, and intact.

Intake and Output (2 points)

Intake	**Output (in mL)**
The patient is eating a regular diet and her intake is not being measured	She is up adlib to the bathroom and her output is not being recorded

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.**
Position Changes N	Frequent position changes are encouraged	Frequently changing positions is encouraged to relieve pressure and alleviate pain
Pain Medicine -Tylenol and Ibuprofen T	She receives Tylenol every 4 hours and Ibuprofen every 8 hours as needed	The pain medicine helps to relieve and stay ahead of the pain she is experiencing from a second-degree episiotomy

Stool Softeners - Colace T	Once per day, daily as needed	The stool softener will help prevent or relieve constipation and make it easier for the patient to have a bowel movement without having to strain. This will also reduce pain and 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? The taking-in phase is a timeframe immediately following birth when the mother needs to rest and relies on other people to care for her (Ricci et al., 2021). She also appears happy and excited to talk about her labor experience.

Discharge Planning (3 points)

Discharge location: The patient will discharge home with her boyfriend once the baby is able to be discharged.

Equipment needs (if applicable): No equipment is needed.

Follow up plan (include plan for mother AND newborn): The patient will follow the guidelines for follow-up with her obstetrician six weeks after vaginal birth. The baby will have a follow-up visit with a pediatrician within 24-48 hours from discharge.

Education needs: The educational needs include proper bottle-feeding techniques, successful maternal transitioning, proper incision care, and signs and symptoms of infection.

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. Acute pain related to second-degree episiotomy laceration as evidenced by the patient report of 7 out of 10 pain	The patient reported a 7/10 pain scale, constant severity characterized by aching and burning in the perineal area	**1.** Pain should be monitored and assessed regularly with vitals and rounding. **Rationale:** Pain is the fifth vital sign and should be assessed regularly (Ricci et al., 2021) **2.** Provide comfort, care, and pain relief **Rationale:** When the patient verbalizes or shows signs of pain or discomfort, we can provide appropriate interventions to make her more comfortable. comfortable (Ricci et al., 2021)	The patient will verbalize her pain and discomfort using the numeric scale. She will use pharmacological and non-pharmacological pain management to keep her pain level at 3/10 or below.
2. Knowledge deficit related to proper bottle-feeding as evidenced by lack of exposure	This is her first baby, and she has a lot of questions pertaining to bottle-feeding	**1.** Teach mom the proper position for feeding the baby, how to hold the bottle, and queues to look for from the baby. **Rationale:** Holding the baby in an upright position helps prevent choking and aspiration (Ricci et al., 2021) **2.**Teach mom to burp the baby regularly **Rationale:** Burping the baby every few ounces helps get rid of the air he swallowed (Ricci et al., 2021)	The Nursing Instructor demonstrated the proper feeding technique to the patient. She was alert, asked questions, and demonstrated an understanding of how to feed the baby, queues to watch for, and how often to burp him.

3. Knowledge deficit related to having a bowel movement as evidenced by verbalized fear of painful elimination	The patient did not want to take a stool softener and expressed fear of worsening pain in the perineal area if she had a bowel movement	**1.** Educate the patient on expectations for bowel elimination after giving birth **Rationale:** Constipation is common in postpartum patients. It is not uncommon for normal bowel patterns to take about a week to return after birth (Ricci et al., 2021). **2.** Ease the patient's anxiety by teaching her about the stool softener **Rationale:** Colace is the medication prescribed. It works by allowing more water in the stool to soften and allow it to pass more easily (Jones & Bartlett Learning, 2020).	We educated the patient on what to expect regarding bowel elimination. We described the purpose of Colace and how it would work. The patient was not ready to take the stool softener but agreed that she would take it after eating.
4. Risk for infection related to second-degree laceration as evidenced by episiotomy	The perineal area is a warm and moist area which makes it a more susceptible host for organisms and bacteria	**1.** Inspect the episiotomy regularly to determine the healing status **Rationale:** The perineum and anus should be inspected every eight hours for signs of infection (Ricci et al., 2021). **2.** Educate the patient on proper handwashing, and the signs and symptoms of infection **Rationale:** Redness and swelling are common signs of infection. A sign of infection with an episiotomy is a white line running down the episiotomy (Ricci et al., 2021)	The patient will demonstrate an understanding of signs and symptoms to look for and report. She will demonstrate proper handwashing, perineal care, and frequent changing of peri-pads to remain free from infection.

Other References (APA)

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

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