N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 6/9/2022, 21:07	**Patient Initials** E.K.	**Age** 31 yrs	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Special Ed Teacher	**Marital Status** Married	**Allergies** Sulfa, Septra
Code Status Full code	**Height** 162 cm	**Weight** 73.1kg	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: Gravida: 3, Term: 2, Preterm: 0, Spontaneous abortion: 1, Living: 2, History of pre-eclampsia and group b strep, previous successful vaginal delivery

Past Medical History: Asthma, Scoliosis

Past Surgical History: Wisdom tooth extraction (2010)

Family History: Mother: Blood-clotting disorder, Maternal grandfather: Glaucoma, skin cancer

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

Living Situation: The patient owns a home in Ogden where she lives with her husband, and children.

Education Level: The patient has a master's degree and works as a special education teacher.

Admission Assessment

Chief Complaint (2 points): Worsening, painful, and consistent uterine contractions

Presentation to Labor & Delivery (10 points):

The patient presented to the labor and delivery unit on 6/9/2022 in the evening with regular and painful uterine contractions. The patient had her membranes swept on the morning of 6/9/2022 and began having contractions later that afternoon. The patient described the

contractions as an intense tightening of her stomach coming every 2-4 minutes. The patient stated, “I knew I was in active labor when the contractions continued to get worse and did not go away with rest.”. The patient stated the contractions continued to worsen and nothing would relieve the pain. The patient knew it was time to go into the hospital and receive pain medication and treatment to ease the pain.

Diagnosis

Primary Diagnosis on Admission (2 points): The patient was admitted for being in active labor, with consistent painful contractions.

Secondary Diagnosis (if applicable): N/A

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	3.5-5.2x10^6/ mcL	3.87	4.27	N/A	N/A
Hgb	11-16 gm/dL	12.2	13.4	N/A	N/A
Hct	34-47%	35.4	38	N/A	N/A
Platelets	140-400/mm3	197	218	N/A	N/A
WBC	4-11 K/mcL	10.4	14.38	N/A	Due to the excessive amount of physical stress and inflammation on the body during labor and delivery, leukocytosis can occur within the first 24 hours postpartum (Barlow et al., 2019).
Neutrophils	1.6-7.7	5.27	10.01	N/A	White blood cells will

					elevate after the delivery to protect the body against infection and to promote healing (Barlow et al, 2019).
Lymphocytes	1.0-4.9	2.4	2.81	N/A	N/A
Monocytes	0.4-1.1%	0.82	0.98	N/A	N/A
Eosinophils	0.0-0.5%	0.14	0.12	N/A	N/A
Bands	0.0-0.9%	N/A	0.15	N/A	An elevated bands level can be due to the sudden inflammation and physical stress on the body after childbirth. A rise in WBCs is common postpartum (Barlow et al., 2019).

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+, A-, B+, B-, O+, O-, AB+, AB-	A-	A-	N/A	N/A
Rh Factor	Positive	Negative	Negative	N/A	The patient's blood type is A-, which means the patient lacks the RH protein (Capriotti, 2020).
Serology (RPR/VDRL)	Nonreactive	Nonreactive	Nonreactive	N/A	N/A
Rubella Titer	Positive	Positive	Positive	N/A	N/A
HIV	Non-detected	Non-detected	Non-detected	N/A	N/A
HbSAG	Non-reactive	Non-reactive	Non-reactive	N/A	N/A
Group Beta Strep Swab	Negative	Positive	Positive	N/A	Group B streptococcus was found upon testing of the patient's vaginal and anal area (Barlow et al., 2019).
Glucose at 28	70-99	N/A	84	N/A	N/A

Weeks					
MSAFP (If Applicable)	N/A	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
SARS-COV-2	NEG	NEG	NEG	POSITIVE	The patient tested positive for the SARs COVID virus through a blood test upon admission. The healthcare team believed that her test may have come back positive due to the antibodies still being in her system from her having covid during her first trimester.
Urine analysis	Colorless, clear, odorless	Colorless, clear, odorless	Mucus and blood present in the urine	Blood present in the urine	Mucus and blood are both normal findings in the urine after childbirth. Mucus comes from the mother losing her mucus plug, and blood is from the delivery and recovery process (Barlow et al., 2019).

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)	0.6-2.5	1.35	N/A	N/A	Normal findings, no concerns

Lab Reference (1) (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.

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis.

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

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	The patient presented to the labor and delivery unit at 38 weeks and 4 days with worsening uterine contractions. The patient had a membrane sweep on the morning of June 9th and began experiencing worsening cramps throughout the afternoon. Reports stated the patient was 3 cm dilated and 80% effaced. After admission and receiving an epidural, the patient's water broke around 0139. The patient began pushing at 0311. The patient achieved spontaneous vaginal delivery without requiring the doctor to use tools to help deliver the newborn. The 1st stage of labor was 4hrs and 34 minutes, the 2nd stage was 19 minutes, and the third stage was 4 minutes. The patient was in labor for

	roughly 5 hours.
Current stage of labor	The first stage of labor includes the latent, active, and transition phases. When the patient presented to the labor and delivery unit, the patient was in the latent phase of delivery (Ricci et al., 2021). Although she contracted regularly, she was only 3 cm dilated and 80% effaced. The patient remained at 3 centimeters in dilation for roughly two hours before progressing to four centimeters in dilation. The patient reaches active labor. The patient chose to have an epidural placed for pain relief. The patient was rechecked at 0139 and was 5cm in dilation, 100% effacement, at 0 stations. The patient was not rechecked until she began to feel much pressure. Barlow et al. (2019) suggest that average values during the transitions phase are strong to intense, frequency is 2-3 minutes, and duration is 45-90 seconds. During the fourth hour of labor, the patient reached full dilation (10cm) and was ready to begin the pushing and birthing phase. According to Ricci et al. (2021), this phase is where contractions progress and intensify every 1-2 minutes. At the fifth hour of labor, the patient was in the third stage, which consisted of the neonate's delivery and the placenta (Barlow et al., 2019). In the last hour, the patient achieved the fourth stage of labor, and the placenta delivery was successful. Reports indicated the placenta was normal and intact. Lochia rubra, loss of fluids, pain, and exhaustion are normal

	findings the client experienced after delivery. The patient experienced no abnormal findings in the acute postpartum stage. The postpartum patient is at risk for hemorrhage, infection of the uterus, uterine inversion, or amniotic fluid embolism (Ricci et al., 2021). The patient was moved to the postpartum unit, where she is in the "taking-in" phase with her newborn.

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. (2022). *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	Albuterol HFA/ Ventolin	Prenatal Vitamin 27/ Multivitamins with Iron			
Dose	90mcg	27mg-0.8mg			
Frequency	1-2 puffs Q4H PRN	1 Tablet Daily			
Route	Actuation Inhaler	PO			
Classification	Adrenergic,	Prenatal vitamin			

	bronchodilator				
Mechanism of Action	Albuterol attaches to beta2 receptors on bronchial cell membranes, which stimulates intracellular enzymes to convert ATP to (cAMP). This reaction decreases intracellular calcium levels.	Iron becomes a part of one's hemoglobin and myoglobin which carries oxygen to one's tissues, organs, and muscles.			
Reason Client Taking	Asthma exacerbations	Treat or prevent vitamin deficiency due to poor diet or pregnancy			
Contraindications (2)	Hypersensitivity to albuterol or its components, Seizure disorders	Hypersensitivity to other vitamin/nutritional supplements, Overload of iron in the blood			
Side Effects/Adverse Reactions (2)	-Arrhythmias -Diarrhea	-Constipation -GI upset			
Nursing Considerations (2)	-Monitor serum potassium level due to this drug potentially causing transient hypokalemia -Monitor respiratory rate, oxygen saturation, and lung sounds before and after	-Encourage patient to sit up for 10 minutes after taking prenatal vitamins and assess for sensitivity or reaction to vitamins. -Administer prenatal vitamins daily as prescribed by provider.			

	administration				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-Respiratory rate, oxygen saturation, heart rate	-Monitor patient's CBC and chemistry labs to determine body's nutritional status			
Client Teaching needs (2)	-Instruct the patient to take albuterol exactly as prescribed. -Seek medical treatment if breathing problems are unrelieved by albuterol rescue treatments.	-Take medication on an empty stomach 1 hour before or 2 hours after meals. -Avoid antacids, dairy products, tea, or coffee within 2 hours before and after treatment.			

Hospital Medications (5 required)

Brand/Generic	Zofran ODT/ ondansetron	Colace/ docusate	Norco/ Hydrocodone-acetaminophen	Dermoplast/ benzocaine topical	Advil/ ibuprofen
Dose	4mg	100mg	5-325mg	1 Spray	800mg
Frequency	Q6H PRN	Daily Q8H	Q4H PRN	Q4H PRN	Q8H PRN
Route	Sublingual	PO	PO	Topical	PO
Classification	Antiemetic, antivertigo	Laxative, stool softener	Opioid agonist/ non-opioid analgesic combination	Antipruritic, local anesthetics	NSAID, Analgesic, anti-inflammatory
Mechanism of Action	Blocks serotonin receptors in the chemoreceptor or trigger zone and peripherally at vagal nerve	Surfactant that softens stool by decreasing surface tension	Hydrocodone relieves pain by changing the way the brain and the nervous system respond	Binds to sodium channels and reversibly stabilizes neuronal membrane to	Blocks activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins,

	terminals in the intestines. This reduces nausea and vomiting by preventing serotonin release in the intestine.	between oil and water in feces. More fluid penetrate stool, forming a softer fecal mass.	to pain Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone.	decrease permeability to sodium ions. Depolarization of the membrane blocks the initiation and conduction of nerve impulses.	which mediate inflammatory response and cause local pain, swelling, and vasodilation
Reason Client Taking	Nausea and vomiting	To prevent post-birth constipation	Moderate to severe pain	Providing numbing sensation and pain relief to perineal area	Mild to moderate pain
Contraindications (2)	Concomitant use of apomorphine, long QT syndrome	Fecal impaction, intestinal obstruction	Hypersensitivity to acetaminophen or hydrocodone, severe asthma or breathing problems	Known sensitivity to ingredients, decreased lung function and heart rhythm	Hypersensitivity to ibuprofen and its components, angioedema
Side Effects/Adverse Reactions (2)	-Headache -Abdominal pain	Palpitations, abdominal cramps	Vomiting, nausea, slowed or irregular breathing	Severe burning and swelling, warmth, or redness	Hypertension, peripheral edema
Nursing Considerations (2)	-Monitor patient for signs and symptoms of hypersensitivity to ondansetron because hypersensitivity reactions like anaphylaxis and bronchospasm. -Monitor patient's electrocardiogram because treatment can prolong QT intervals resulting in life-threatening arrhythmias	-Expect excessive or long-term use of treatment cause dependence on laxative for bowel movements -Assess for laxative abuse syndrome	Assess patient's risk for opioid addiction, abuse, or misuse Monitor patient for signs of respiratory depression	Assess for redness and swelling on areas applied to repeatedly or extensive areas. Monitor patient's sensitivity to the treatment by noting abnormal reactions to provider	Monitor patient for signs and symptoms of hypersensitivity to ondansetron because hypersensitivity reactions like anaphylaxis and bronchospasm. Monitor patient's electrocardiogram because treatment can prolong QT intervals resulting in life-threatening arrhythmias
Key Nursing Assessment(s)/Lab(s	-Monitor patient's heart	-Assess cause for	Monitor liver functioning	Assess skin integrity prior to	Assess patient's heart rate and

) Prior to Administration	rhythm	constipation, assess skin turgor for dehydration	tests, assess for signs of liver damage. Assess respiratory rate	administration.	pulse.
Client Teaching needs (2)	Advise patients to report signs of hypersensitivity like rash to provider. Advise patients to seek medical attention if patient experiences persistent, severe symptoms	Encourage patient drink 6-8 glasses of water daily to prevent constipation. Instruct patient to notify prescriber about symptoms of electrolyte imbalance, dizziness, and light-headedness	Instruct the patient to not exceed the recommended dosage or take other drugs containing acetaminophen at the same time Teach patient to recognize signs and symptoms of hepatotoxicity such as bleeding, easy bruising and malaise	Discontinue medication if symptoms worsen or irritate the skin. Use benzocaine preparation only as prescribed or recommended by provider or manufacturer	Instruct patient to take tablets with full glass of water and caution them not to lie down for 15-30 minutes to prevent esophageal irritation. Advise patient to take drug with food or after meals to reduce GI distress

Medications Reference (1) (APA):

Jones, D.W. (2021). *Nurse's drug handbook*. (A. Bartlett, Ed.) (20th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient was alert and oriented to person, place, time, and situation. (x4) Patient was relaxed and in good spirits during assessment. Patient showed no signs of distress. Overall appearance was clean and well groomed.
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** 20 **Drains present: Y☐ N ☒** **Type:**	Patient's skin color was appropriate for ethnicity. Skin was warm, dry, and intact. Skin turgor was loose. Patient had no rashes, bruises, or wounds present. Patient's Braden score was 20. Patient had no drains present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head appears normocephalic. Neck appeared symmetrical with trachea at midline. Patient claims no hearing loss or pain in the ears. Eyes exhibited PERRLA. Extraocular movements were intact. Eyes appeared symmetrical with no drainage present, conjunctiva was pink and not inflamed. Patient's nose was symmetrical and deviated septum was not detected. Patient has good oral hygiene, tongue appeared pink and midline with no sores. No dental carries were present. Buccal mucosa was pink and moist. .
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:**	S1 and S2 heard. S3 and S4 not heard. Normal rate and rhythm were heard upon auscultation. Upper and lower peripheral pulses were palpable at 3+. No jugular vein distention was noted. Capillary refill was less than 3 seconds. No edema present.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Breath sounds were clear and equal bilaterally. Patient has no chest deformities. Respirations were observed to be even, calm, and regular. No

	accessory muscles were used.
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 eats a regular diet at home. Her current diet during admission is a regular diet. The patient's height is 162cm, and weight is 73.1kg. Bowel sounds were hyperactive in all four quadrants. The patients last bowel movement was 6/9/2022. Patient denies pain upon palpation. No masses present. No presence of distention, incisions, scars, wounds, or drains.
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient states there was no pain, urgency, or frequency upon urination. During shift, urine was clear, with no odor. Patient is not on dialysis and did not have a catheter. Inspection of genitals was not performed during shift.
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 0** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	The patient ambulated well without assistance. Patient did not use any supportive devices. Upper extremity strength is 5/5 on right side and 5/5 on the left side. Lower extremity strength is 5/5 on right side and 5/5 on the left side. Patient exhibited equal strength in both arms and legs. Patient exhibited full ROM in both arms and legs. Fall risk score was 0.
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:**	Patient is alert and oriented x4. Eyes exhibit PERLA signs. Patient's speech is well articulated and clear. Patient moves all extremities well and displays no signs of paralysis. Patient displayed equal strength in all extremities. Patient senses touch in both arms and legs. Patient's reflexes were present.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):**	Patient talks to husband for support Patient's developmental level was appropriate for age. Patient was alert and oriented x4.

Developmental level: **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient is Christian. Patient depends on husband and family for support when taking care of the newborn.
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	Fundal Height & Position: 3 cm above the umbilicus Bleeding amount: Moderate bleeding Lochia Color: Reddish brown Character: Normal for postpartum bleeding Episiotomy/Lacerations: No lacerations or episiotomy
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: Spontaneous Time: 0315 Color: Clear Amount: Not documented Odor: No odor present Delivery Date: 6/10/2022 Time: 0331 Type (vaginal/cesarean): Vaginal Quantitative Blood Loss: 90mL Male or Female: Female Apgar's: 8 & 9 Weight: 6 lbs 9.5oz Feeding Method: Breastfeeding

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	96bpm	122/85mmhg	16/min	36.7C (Oral)	99% RA
Labor/Delivery	94bpm	108/60mmhg	18/min	37.2 C (Oral)	97% RA
Postpartum	72bpm	127/73mmhg	18/min	37.0 C (Oral)	95%RA

Vital Sign Trends:

The patient's vital signs stayed consistent throughout her pregnancy, labor/delivery, and postpartum. The patient's pulse, respiration rate, blood pressure, oxygen saturation, and temperature all remained within normal range. During labor and delivery, the patient's blood pressure did drop slightly due to the pain medications through her epidural. The blood pressure returned within normal ranges after delivery.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0835	Numerical	N/A	0/10	N/A	N/A
1230	Numerical	Uterus	2/10	Cramping, achy	The patient was given acetaminophen for the pain.

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:**	The patient had a 18gauge IV in the right posterior hand. It was inserted on 6/9/2022 at 2235. There is currently a saline lock in place. The IV showed no signs of erythema, redness, infiltration, or drainage. IV dressing is clean, dry, and intact.

Intake and Output (2 points)

Intake	Output (in mL)
8 oz of water 8 oz of strawberry drink from Starbucks	The patient urinated 300 mL during the shift.

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify	Frequency	Why was this intervention/ treatment provided to this patient? Please give a

nursing interventions with "N" after you list them, identify medical treatments with "T" after you list them.)		**short rationale.**
Monitor/Assess Vital Signs (N)	Q2H	Monitor should be closely monitored in postpartum patients due to the blood loss that has occurred, medications they are on, as well as the risk for infection.
Providing Pain Relief: benzocaine menthol (T)	Q4H PRN	Benzocaine menthol can provide a numbing sensation and pain relief to the patient's perineal area after childbirth.
Providing Pain Relief: Hydrocodone-acetaminophen (Norco) (T)	Q4H PRN	This medication is used for moderate to severe pain. The patient is advised to take this only if the pain is unbearable and other pain medications are not providing enough relief.
Promoting Tissue Integrity: Ice Pack (N)	1-2 times daily PRN	Ice packs minimize edema, reduce inflammation, and reduce nerve conduction to the painful site.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in?

The mother is in the taking-in phase (Ricci et al., 2021).

What evidence supports this?

Upon observation of the mother, it is evident that she is in the taking-in phase. The mother discussed events surrounding her birth, such as getting an epidural and feeling a lot of relief. The mother showed dependence on her spouse and the nurses as she asked for us to get

her things or asked for assistance with basic tasks. The patient also enjoyed bonding with her baby and talked about the baby and her resemblance to her older sibling.

Discharge Planning (3 points)

Discharge location: The patient will discharge to her home in Ogden with her family.

Equipment needs (if applicable): Electric breast pump

Follow up plan (include plan for mother AND newborn): Follow up care for the mother should be arranged soon after discharge. An office visit for vaginal birth should take place in 4 to 6 weeks after childbirth. Follow up care for examination and further diagnostic laboratory studies for newborns are scheduled within the first week of discharge.

Education needs: The patient will need education on breastfeeding, how to use a pump, and how to maintain her milk supply. This education will be best delivered from a lactation consultant or nurses that care certified in lactation support.

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 tissue damage as evidenced by pain in the perineal area	This nursing diagnosis was chosen due to the patient having a vaginal	**1.** **Rationale:** Perform pain assessment by identifying the pain's type, location, characteristic, severity, and duration. Use a numeric	The patient responded well to the nurse's actions and understood the purpose of fundal height assessments and massages.

(Martin, 2022).	delivery and experiencing soreness and pain in the perineal area (Martin, 2022).	pain scale (Martin, 2022). **2.** **Rationale:** Assess the patient's fundal height every two hours after delivery to monitor for subinvolution and perform fundal massages as needed (Martin, 2022).	Goal met: The patient's uterus remained firm as it began to return to its former size.
1. Fatigue related to labor and delivery as evidenced by verbalizations of exhaustion (Martin, 2022)	This nursing diagnosis was chosen because the patient expressed multiple times how exhausted and fatigued, she was after the transition phase (Martin, 2022).	**1.** **Rationale:** Fatigue can affect a patient's ability to provide self-care and care for a newborn (Martin, 2022). **2.** **Rationale**: Promoting relaxation and allowing the mother quiet periods will aid in rest and recovery (Martin, 2022). The nurse will not do a set of rounds on the patient until 12 pm to allow for a longer rest period.	1. The patient responded well to the nurse's actions because she wanted to have a period of uninterrupted sleep. **2.** Goal met: The patient was able to take an hour nap and reported feeling less fatigued and exhausted.
1. Knowledge deficit related to inability to recall as evidenced by multiple questions and confusion (Martin, 2022).	This nursing diagnosis was chosen because the patient had many questions regarding breastfeeding (Martin, 2022).	**1.** **Rationale:** Assess the patient's baseline knowledge surrounding breastfeeding and pumping (Martin, 2022). **Rationale:** Determine the patient's preferences regarding breastfeeding and assist the patient with breastfeeding every two hours or as needed (Martin, 2022).	The patient responded well to the nurse's actions because she felt she needed further education on breastfeeding and pumping. Goal met: The nurse provided education to the patient and assisted in answering questions and clearly up confusion for the patient.
2. Risk for infection related to tissue damage as evidenced by postpartum bleeding (Martin,	This nursing diagnosis was chosen because the patient is at risk for infection after a vaginal delivery	**1.** **Rationale:** Educate the patient on hand hygiene, self-care techniques, and the purpose of remaining abstinent until the uterus is fully healed (Martin, 2022). **2.**	The patient responded well to the nurse's actions and demonstrated an understanding of the teaching. Goal met: The patient

2022).	(Martin, 2022).	**Rationale:** Educate the signs and symptoms of an infection such as foul odor of lochia, chills, fever, or malaise (Martin, 2022).	demonstrated hand hygiene before and after perineal self-care.

Other References (APA)

Martin, P. (2022, March 31). *36 labor stages, induced and augmented labor nursing care plans*. Nurseslabs. Retrieved June 13, 2022, from https://nurseslabs.com/labor-stages-labor-induced-nursing-care-plan/

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