N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 6-22-22 (1930)	**Patient Initials** K.J.I.	**Age** 30 y/o	**Gender** Female
Race/Ethnicity African American	**Occupation** Works at Carle as tech	**Marital Status** Single	**Allergies** -Peanuts (anaphylaxis) -Tree nuts (shortness of breath)
Code Status Full Code	**Height** 168.9 cm	**Weight** 144.7 kg	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: G:2, **T**:2, **P**:2, **A**:0, **L**:2, Two live vaginal births, the first 6-26-14: 41wks0days (7 lb., 11 oz) with only one complication GBS was positive, the second child born 6-24-22: 37wks2days (6 lb., 8 oz) with one complication cHTN, both pregnancies resulted in a healthy infant

Past Medical History: Eczema, seasonal allergies, asthma, nonspecific abnormal Papanicolaou smear (7-31-2013), HSV (3-23-2018), HPV (4-10-2018), Chlamydia (11-22-21), Trichomonas (11-22-21)

Past Surgical History: Femur surgery (2001), Femoral Fx, open Tx (2003), Colposcopy (12-5-2013)

Family History: Mother: hypertension, Father: history unknown

Social History (tobacco/alcohol/drugs): Former smokeless tobacco user- quit for pregnancy used prior for about 3-4 years, not currently using alcohol, but for prior use reports 2-3 drinks per week and has used alcohol for 10 years, no other recreational drug use reported

Living Situation: Patient lives at home with her boyfriend and daughter, and her mother watches daughter while she works

Education Level: Highschool educated, currently attending college, no barriers to learning

Admission Assessment

Chief Complaint (2 points): Abdomen and back cramping

Presentation to Labor & Delivery (10 points): On June 22nd, a 37wks2days pregnant female arrived at Carle Foundation hospital for a planned induction due to hypertension affecting the pregnancy. The patient reported increasing abdominal and back cramping, stating, "it's been hard for me to get comfortable." She notes the duration of the cramping as about 1-2 weeks. The character of the pain is not sharp but "dull," and she states that it comes and goes. She reports no aggravating factors but states "changing positions" helps with the pain. She reported taking no medications to treat the pain and rated the severity a 7/10 on the numeric scale.

Diagnosis

Primary Diagnosis on Admission (2 points): Induction to labor

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	3.50-5.20 x10^6 u/L	4.57	4.60	N/A***no labs today	
Hgb	11-16 g/dL	11.4	11.6	N/A	
Hct	34-47%	36.2	36.6	N/A	
Platelets	140-400 x10^3 u/L	271	291	N/A	
WBC	4.0-11.0	7.84	8.82	N/A	

	x10^3 u/L				
Neutrophils	1.60-7.70 x10^3 u/L	N/A	5.86	N/A	
Lymphocytes	1.00-4.90 x10^3 u/L	N/A	2.05	N/A	
Monocytes	0.00-1.10 x10^3 u/L	N/A	0.62	N/A	
Eosinophils	0.00-0.50 x10^3 u/L	N/A	0.19	N/A	
Bands	0-4%	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	4 main blood groups	Type A	N/A	N/A	
Rh Factor	Positive or negative	Positive	N/A	N/A	
Serology (RPR/VDRL)	Non-reactive	Non-reactive	N/A	N/A	
Rubella Titer	≥10.00 IU/mL	16.00 IU/mL positive for antibodies	N/A	N/A	
HIV	Non-reactive	Non-reactive	N/A	N/A	
HbSAG	Non-reactive	Non-reactive	N/A	N/A	
Group Beta Strep Swab	Negative	Negative	N/A	N/A	
Glucose at 28 Weeks	60-140 mg/dL	91	N/A	N/A	
MSAFP (If Applicable)	0.5-2.5 MoM	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
Albumin	3.5-5.0 g/dL	2.8	N/A	N/A	A low albumin in the third trimester of pregnancy may be caused by edema, which is associated with preeclampsia and high blood pressure during pregnancy (Jewell, 2019).
AST	5-34 u/L	43	N/A	N/A	Elevated liver enzymes can be the result of the patient's gestational hypertension injuring the liver (Cleveland Clinic, 2021).
ALT	0-55 u/L	76	N/A	N/A	Elevated liver enzymes can be the result of the patient's gestational hypertension injuring the liver (Cleveland Clinic, 2021).
Protein urine	1.0-14.0 mg/dL	20.8	N/A	N/A	A high level of protein in the urine can indicate kidney issues and is an indication of preeclampsia when paired with high blood pressure which the patient has (Seladi-Schulman, 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)	47-110.0 mg/dL	N/A	247.28	N/A	A high urine creatinine in this patient could be the result of her gestational hypertension harming the kidneys (Seladi-Schulman, 2019).

Lab Reference (1) (APA):

Elevated liver enzymes: What is it, causes, prevention & treatment. Cleveland Clinic. (2021, June 28). Retrieved June 29, 2022, from https://my.clevelandclinic.org/health/symptoms/17679-elevated-liver-enzymes

Jewell, T. (2018, September 2). *Hypoalbuminemia: Causes, treatment, and more*. Healthline. Retrieved June 29, 2022, from https://www.healthline.com/health/hypoalbuminemia#symptoms

Seladi-Schulman, J. (2019, July 24). *High creatinine symptoms: What may occur when your levels are off*. Healthline. Retrieved June 29, 2022, from https://www.healthline.com/health/high-creatinine-symptoms#causes

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

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	This patient came in for a planned induction due to her gestational hypertension. The patient's length of labor was 16 hours and 36 minutes from the start of the Pitocin (6-23-22 at 1100) to delivery (6-24-22 at 0336). The patient was in the first stage of labor for around 14 hours and the second stage for 2 hours. The infant was then delivered within 5 minutes, completing the third stage. After another couple of minutes, the placenta followed, finishing the fourth stage of labor.
Current stage of labor	This patient was currently in the postpartum period of labor during my care. The postpartum period is from the birth of the infant to around six weeks, when the effects of pregnancy on

	many body systems have returned to the pre-pregnancy state (Barlow et al., 2019). The patient I cared for was around 3-4 hours into postpartum. Normal postpartum findings at this stage include the uterus fundus descending 1-2 cm below the umbilicus and firming from uterine contractions (Barlow et al., 2019). The patient I cared for was about 2 cm below the umbilicus, and their uterus felt firm to touch. Lochia or post-birth uterine discharge is also expected 2 hours after delivery and then gradually decreases (Barlow et al., 2019). This patient had dark red lochia, called rubra, which generally lasts 1-3 days after delivery. After massaging the patient's uterus, her rubra contained minimal clots, which is healthy because large clots can signify hemorrhage. Edema caused by birth can also cause pain and difficulty with the client's ability to void and the patient's epidural, making walking to the restroom a challenge (Barlow et al., 2019). Luckily the patient I treated had no issues getting up to the bathroom and had minimal pain. This patient's adaptation stage is currently the acquaintance phase, which includes the mother's physical restoration, and focuses on competently caring for the newborn (Barlow et al., 2019). During the first 24-48 hours after birth, the mother generally focuses on personal health needs, needs others for assistance, and shows excitement, often being very talkative

	(Barlow et al., 2019). The patient I cared for fit this phase quite well and was very chatty, calling all her family members to show them her new addition to the family. Postpartum complications most commonly include hemorrhage and infection during the first 24 hours after delivery. Lochia color, odor, and consistency can be beneficial to monitor for these complications. Lochia with large clots or excessive lochia, a saturation of one pad in 15 minutes, can indicate a hemorrhage (Barlow et al., 2019). Lochia that smells foul along with an increased temperature, chills, or fatigue can indicate infection, likely caused by retained placental fragments. Another significant postpartum complication is a mood disorder called postpartum depression. During the recovery period, hormones in the body fluctuate, and mood shifts can occur. Risk factors for postpartum depression include a history of depression or bipolar disorder, family history of depression, stressful events like illness during pregnancy, having a baby with health issues or special needs, difficulty breast-feeding or bonding, a weak support system, and financial problems (Mayo Clinic, 2022). The patient I cared for had no signs of infection or hemorrhage. She also seemed to be bonding quite well with her baby and wanted to hold him constantly.

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.

Mayo Foundation for Medical Education and Research. (2022, May 24). *Postpartum depression*. Mayo Clinic. Retrieved June 29, 2022, from https://www.mayoclinic.org/diseases-conditions/postpartum-depression/symptoms-causes/syc-20376617

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

Home Medications (2 required)

Brand/Generic	Proair/albuterol	Oxeze Turbuhaler/formoterol	**N/A*** patient only taking two home meds plus her prenatal vitamin**		
Dose	90 mcg/puff, 2 puffs	4.5 mcg/puff, 2 puffs			
Frequency	Every 4 hours as needed	Every 12 hours as needed			
Route	Inhalation	Inhalation			
Classification	Pharm: adrenergic, Thera: bronchodilator	Pharm: selective beta2 adrenergic agonist, Thera: bronchodilator			
Mechanism of Action	Attaches to beta2 receptors, which stimulates intracellular enzyme adenylate cyclase to convert ATP to cAMP. This decreases intracellular calcium, leading to relaxation of bronchial	Converts enzyme adenyl cyclase to cAMP resulting in increased cAMP intracellular levels, inhibiting histamine release, relaxing bronchial smooth-muscle cells, and stabilizing mast cells.			

	smooth-muscle cells, and inhibits histamine response.				
Reason Client Taking	The patient is taking this to treat her asthma.	The patient takes this for her asthma as a long-term treatment.			
Contraindications (2)	- Hypersensitivity to albuterol -Patients with hypertension	-Acute asthma -Hypersensitivity to formoterol fumarate			
Side Effects/Adverse Reactions (2)	-CV: angina, hypotension -RESP: bronchospasm	-CV: hypotension -RESP: asthma exacerbation			
Nursing Considerations (2)	-Monitor serum potassium for hypokalemia -Albuterol can worsen cardiac disorders, diabetes, hypertension, hyperthyroidism, and seizures	-This medication should not be taken if asthma is already controlled with long term medications -May interfere with uterine contractility and should be used during labor only when the benefit clearly outweighs the risk			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-Monitor blood pressure for hypertension -Monitor serum potassium	-Monitor blood pressure and pulse rate -Monitor respiratory status closely for worsening			
Client Teaching needs (2)	-Discard ProAir inhaler within 13 months from opening or by expiration date, whichever comes first -Wait one minute between inhalations	-Notify provider of chest pain, nervousness, palpitations, rapid heart rate, and tremors -Inform formoterol increases the risk of asthma related death, and should not be used long-term			

Hospital Medications (5 required)

Brand/Generic	Tylenol/ acetaminophen	Dialume/ aluminum carbonate	Advil/ ibuprofen	Vantrela/ hydrocodone	Zofran/ondansetron
Dose	1,000 mg	30 ml	600 mg	15 mg	4 mg
Frequency	Every 6 hours	Every 2 hours	Every 6 hours	Every 12 hours	Every 6 hours
Route	Oral	Oral suspension	Oral	Oral	IV push
Classification	Pharm: non salicylate, Thera: antipyretic, nonopioid analgesic	Pharm: aluminum salt, Thera: antacid	Pharm: NSAID, Thera: analgesic, anti-inflammatory, antipyretic	Pharm: opioid, Thera: opioid analgesic	Pharm: selective serotonin receptor antagonist, Thera: antiemetic
Mechanism of Action	Blocks prostaglandin production interfering with pain impulse generation in the peripheral nervous system. Also acts directly on temperature regulating center in hypothalamus by inhibiting synthesis of prostaglandin E2.	Neutralizes and reduces gastric acidity, increasing stomach and duodenal alkalinity. Protects stomach and duodenum lining by inhibiting pepsin's proteolytic activity.	Blocks activity of cyclooxygenase, the enzyme needed to synthesis prostaglandins, which mediate inflammatory response to local pain, swelling, and vasodilation.	Binds to and activates opioid receptor sites in the periaqueductal and periventricular gray matter, the ventromedial medulla, and the spinal cord to provide pain relief.	Blocks serotonin receptors centrally, which reduces nausea and vomiting by preventing serotonin release in the small intestine.
Reason Client Taking	The patient is taking this for pain relief following vaginal birth.	The patient is taking this to treat heartburn.	The patient is taking this for pain relief from her vaginal birth.	The patient is taking this for pain relief for vaginal birth.	The patient was prescribed this in case of any nausea or vomiting.
Contraindications (2)	-Hypersensitivity to acetaminophen -Severe hepatic impairment	-Hypersensitivity to aluminum -Constipation may be worsened	-Asthma -Bronchospasm	-Acute asthma -Suspected paralytic ileus	-Hypersensitivity to ondansetron -Long QT syndrome
Side Effects/Adverse Reactions (2)	-GI: hepatotoxicity -HEME: hemolytic anemia	-CNS: encephalopathy -Electrolyte imbalance	-GI: bleeding -GU: renal failure	-RESP: respiratory depression -CV: hypotension	-CNS: hypotension -RESP: bronchospasm
Nursing Considerations (2)	-Use cautiously in hepatic, or renal impairment -Ensure daily dose from all sources does not exceed maximum daily limit, including over the counter acetaminophen	-Do not give within 1 to 2 hours of other oral drugs -Know that two 0.6 g aluminum hydroxide tablets can neutralize 16	-Should not be used in pregnant women starting at 30 weeks gestation -Use in extreme caution in	-May cause constipation, increase fiber and fluids -Use with extreme caution in those with chronic obstructive pulmonary	-Hypokalemia/ hypomagnesemia should be corrected before use -Monitor for serotonin syndrome

	containing medications	mEq of acid	those with history of GI bleeding, use shortest amount of time possible	disease, respiratory depression occurs faster in these individuals	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-Monitor AST, ALT, bilirubin, and creatinine levels -Monitor urine for blood or albumin, signs of nephritis	-Monitor electrolytes -Monitor phosphate level	-Monitor liver enzymes -Monitor BUN, and serum creatinine levels	-Monitor vitals for hypotension, and decreased respiratory rate -Monitor for signs of serotonin syndrome: sweating, diarrhea, fever	-Monitor electrolytes -Monitor ECG for prolonged QT interval
Client Teaching needs (2)	-Medication may be crushed -Inform of signs of hepatotoxicity like bleeding, bruising easy, and malaise	-Chew fully, then drink full glass of water -Prevent constipation with high fiber diet	-Take with food to reduce GI distress -Avoid taking two NSAIDs at the same time -Avoid alcohol	-Should be taken whole, never crush or chew -Avoid alcohol and benzodiazepines due to increased respiratory depression	-Educate on symptoms of serotonin syndrome: agitation, chills, confusion, sweating, diarrhea, fever, hyperactive reflexes -Reassure patient with transient blindness that it will resolve within a few minutes to 48 hours

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 **Alert to verbal/physical stimuli** **A&O x4** **Distress upon awakening** **Pt is well-groomed and nourished**
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 **Skin color appropriate for ethnicity** **Skin warm, dry, and intact** **Instant recoil less than 2 secs** **No rashes, bruising, or wounds** **14** **No drains noted**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Atraumatic, normocephalic, no tracheal deviation, rise and fall of thyroid present** **Lymph nodes non-palpable** **TMs normal bilaterally, normal hearing, no drainage or pain** **Pupils equal round reactive to light, EOMs intact, Nose clear of any drainage, no polyps** **Mouth mucosa pink and moist, no tonsil swelling**
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:**	**Regular rate and rhythm, no murmurs rubs or gallops, normal S1 and S2, Pedal pulses equal 3+, radial pulses equal 3+, cap refill <3 secs, No JVD, no edema**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Normal respiratory effort with no accessory muscle use, lungs clear to auscultation bilaterally, no wheezing rhonchi or crackles, rise and fall of chest equal**
GASTROINTESTINAL (2 points): **Diet at Home:**	**Regular diet at home** **Regular diet in hospital**

Current Diet: **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	**168.9 cm** **Bowel sounds heard in all 4 quadrants, 5 sounds per minute** **6-24-22** **No pain, guarding, or masses noted upon palpation** **Abdomen soft and nontender, no distention incision scars, drains, or wounds noted**
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☒ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	 **Yellow** **Clear** **600 ml** **No abnormalities of genitalia besides perineal laceration from vaginal birth**
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☐**	 **Alert, awake, and responsive** **Norm ROM moves all 4 extremities** **Strength in upper extremities equal 5+** **Strength in lower extremities equal 5+** **Fall score: 3, low risk** **Independent with one standby** **No assistance needed to stand and 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:**	 **A&O x4** **Strength equal in both upper and lower extremities 5+** **Speech appropriate for age** **Senses intact** **Awake and alert** **DTR 2+**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:**	 **Patient gets emotional support from family and boyfriend and that helps her cope** **Formal operational** **Patient is not religious**

Personal/Family Data (Think about home environment, family structure, and available family support):	**Patient lives at home with boyfriend and daughter, and her mother cares for her daughter while she's at work**
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	 **2 cm** **Less than 10 cm on pad** **Rubra** **No odor** **One perineal laceration noted**
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:**	 **AROM** **(1923)** **Clear** **Unknown** **No odor** **6-24-22** **(0336)** **Vaginal** **284 cc** **Male** **8** **6 lbs. 8 oz** **Breastmilk/ with formula substitution**

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**100 b/min**	**136/88 mmhg**	**20 r/min**	**36.9 C**	**99%**
Labor/Delivery	**85 b/min**	**127/75 mmhg**	**18 r/min**	**36.6 C**	**100%**
Postpartum	**84 b/min**	**111/75 mmhg**	**18 r/min**	**36.7 C**	**98%**

Vital Sign Trends:

The vitals show the patients gestational hypertension because the blood pressure is continually lowering after the birth of her infant. The rest of her vitals are within normal range and constant.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	**Numeric**	**Abdomen**	**3/10**	**Dull pain, worse when doing fundal assessment**	**-Give pain medication**
0900	**Numeric**	**abdomen**	**2/10**	**Dull pain still**	**-Encourage patient to ambulate**

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:**	**18G** **Lower posterior right forearm** **6-22-22** **IV patent, flushes easily** **No redness, or other signs of infection** **Dressing clean/dry/intact** **Saline locked**

Intake and Output (2 points)

Intake	Output (in mL)
	600 ml urine **200 ml delivery** **Voided x1**

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.

"N" after you list them, identify medical treatments with "T" after you list them.)		
Fundal assessment (N)	Every 8 hours after recovery period	To make sure the uterus is contracting back into the proper size and area.
Vitals (N)	Every 15 min the first 2 hours after birth then every 4 hours	Monitor for infection, especially important to take temperature.
Observe vaginal lochia (N)	Every 15 min the first hour, then every hour for the next 4 hours, then once every 4-8 hours	Clots can be a sign of hemorrhage, so lochia should be observed. Lochia can also show signs of infection like odor and color changes.
Give acetaminophen (T)	Every 6 hours as needed for pain	Helps to stay ahead of the pain from vaginal birth.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? Dependent phase

What evidence supports this? The patient is in the first 24 hours after delivery, and she is still relying on other for assistance as she's healing. The baby's father participated a lot in the infant's care to help her because she was fatigued. She is also very talkative and excited showing her baby off to her family over facetime.

Discharge Planning (3 points)

Discharge location: Discharge to home

Equipment needs (if applicable): N/A

Follow up plan (include plan for mother AND newborn): Well-child visits for newborn to get proper vaccinations and checkups, and for the mother I would recommend she contact her health provider within 3 weeks to get ongoing medical care during the postpartum period

Education needs: Education needs include breastfeeding

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. Risk for hemorrhage related to vaginal birth, as evidenced by the patients 10 cm lochia on pad which is considered a moderate amount.	This diagnosis was chosen first because hemorrhage can occur up to a week after vaginal delivery and can easily cause the patient to bleed out.	**1.**Assess fundus for firmness location and position every eight hours. **Rationale** This massage irritates the uterus into contracting which helps stop excessive bleeding (Barlow et al., 2019). **2.**Assess lochia for color and signs of infection every 15 min the first hour, then every hour for the next 4 hours, then once every 4-8 hours**.** **Rationale:** This helps monitor for large clots in the lochia which can be a sign of hemorrhage (Barlow et al., 2019).	Fundus was massaged and presence of lochia color and amount was observed. Patient disliked this assessment but understood the reasoning.
2. Acute pain related to perineal injury from vaginal birth, as evidenced by the patient stating, "it still really hurts to go to the bathroom".	This diagnosis was chosen because the patient is still in a lot of pain, and it is important to stay on top of it so she can bond peacefully with her newborn.	**1.** Give acetaminophen medication for pain relief every six hours. **Rationale:** Acetaminophen is a good choice for analgesia, and fever reduction in nursing mothers because amounts in milk are much less than doses usually given (NCBI, 2022). **2.**Get the patient up to ambulate. **Rationale:** This helps with	Acetaminophen was given and pain went from a 3/10 numeric scale to a 2/10. Patient did start ambulating more to bathroom.

		uterine involution and leads to faster healing (Barlow et al., 2019).	
3. Deficient knowledge on breastfeeding related to poor understanding as evidenced by the patient letting the infant sleep even though they should eat every 2-3 hours.	This diagnosis was chosen because the mother had skipped a few feedings, and the nurse I shadowed educated her on this in clinical.	**1**. Inform the mother to fill out the feeding chart and keep track on how many dirty diapers produced a day. **Rationale:** Newborns should be feed every 2-3 hours and produce about 5 dirty diapers daily (Barlow et al., 2019). **2.** Teach different breast feeding holds, and how to help the infant latch and how to pump**.** **Rationale:** Flattened nipples and other barriers to latching may lead to frustration for the mother, a feeling of not bonding (Barlow et al., 2019).	Mother started to fill out the feeding chart and did not know she had to wake up the infant to feed it, she thought the newborn would just cry if hungry.
4. Deficient knowledge on vaccinations related to poor understanding as evidenced by the patient stating, "I don't want to give my baby the COVID-19 vaccination ever".	This diagnosis was chosen because vaccinations are highly recommended for children to keep them healthy, and if the mother is worried about the COVID vaccine then she might mistrust all vaccinations as well.	**1.** Teach parents what diseases vaccinations can prevent, as well as the prognosis of those diseases that are entirely preventable. **Rationale:** Whooping cough kills one of every 100 children under the age of 1 years old and is preventable with a vaccination that has minimal side effects (Barlow et al., 2019). **2.** Set up well-child visit appointments for the infant. **Rationale:** This will help to monitor the child's vaccination status and growth level (Barlow et al., 2019).	I did not actually perform this intervention, but I have a feeling it would not have gone over well, the mother was very strong in her views.

Other References (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.

Drugs and lactation database (lactmed) - NCBI bookshelf. (2022, March 21). Retrieved June 30, 2022, from https://www.ncbi.nlm.nih.gov/books/NBK501194/