N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 09-28-2022 0800	**Patient Initials** J.F.	**Age** 29	**Gender** Female
Race/Ethnicity African American	**Occupation** Unemployed	**Marital Status** Single	**Allergies** No known allergies
Code Status Full	**Height** 5'7" 170 cm	**Weight** 215 lbs. 97.5 kg	**Father of Baby Involved** Yes, he's incarcerated.

Medical History (5 Points)

Prenatal History: G7 T5 P5 A2 L5, the patient has never had any known problems with past pregnancies but did a meconium and shoulder dystocia with the most recent neonatal during delivery.

Past Medical History: The patient has no past medical history.

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

Family History: The patient's maternal and paternal grandmother has diabetes, and heart disease, and MI. The patient's maternal grandmother has hypertension.

Social History (tobacco/alcohol/drugs): The patient did not drink or smoke cigarettes but did smoke marijuana five times per week during her pregnancy.

Living Situation: The patient lives at home with her five kids.

Education Level: The patient's highest level of education is a high school graduate.

Admission Assessment

Chief Complaint (2 points): Scheduled induction

Presentation to Labor & Delivery (10 points): The patient is a 29-year-old female that came in for her scheduled induction on 09-28-2022 at 0800. The patient is a G7 T5 P5 A2 L5 with

current meconium, and shoulder dystocia neonate at delivery. The patient also has no previous complications with her other pregnancies. The patient is positive for GBS, trichomonas, and marijuana. The patient has come to the hospital alone, and the father of the baby is involved but incarcerated.

Diagnosis

Primary Diagnosis on Admission (2 points): Scheduled induction

Secondary Diagnosis (if applicable): The patient does not have a secondary diagnosis.

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	4.6 m/uL-6.0 m/uL	5.2 m/uL	4.9 m/uL	5.5 m/uL	Within normal limits.
Hgb	13.8 g/dL-18 g/uL	10.8 g/uL-18 g/uL	13.9 g/uL	14.2 g/uL	Within normal limits.
Hct	40%-54%	31.6%	33.1%	33.4%	Decreased Hct level due to blood loss post-delivery (Pagana, 2018).
Platelets	150,000 uL-400,000 uL	244,000 uL	243,000 uL	223,000 uL	Within normal limits.
WBC	4.5 uL-10.0 uL	12.0 uL	11.30 uL	17.40 uL	Increased WBC due to active trichomonas infection (Pagana, 2018).
Neutrophils	55 uL-70 uL	N/A	62 uL	59 uL	Within normal limits.
Lymphocytes	20 uL-40 uL	N/A	23 uL	26 uL	Within normal limits.

Monocytes	2 uL-8 uL	N/A	6 uL	6.3 uL	Within normal limits.
Eosinophils	1 uL-4 uL	N/A	1 uL	2.1 uL	Within normal limits.
Bands	50%-65%	N/A	N/A	N/A	Not completed on this admission.

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	O, A, B, AB	B	B	B	Within normal limits.
Rh Factor	-/+	+	+	+	Within normal limits.
Serology (RPR/VDRL)	Non-reactive	Non-reactive	Non-reactive	Non-reactive	Within normal limits.
Rubella Titer	Immune/not immune	Immune	Immune	Immune	Within normal limits.
HIV	+/-	-	-	-	Within normal limits.
HbSAG	Non-reactive	Non-reactive	Non-reactive	Non-reactive	Within normal limits.
Group Beta Strep Swab	+/-	+	+	+	Group beta strep is a normal and common condition present in women, and antibiotics are given to pregnant patients to keep neonates from developing harmful infections (Pagana, 2018).
Glucose at 28 Weeks	< 140 g/uL	106 g/uL	N/A	81 g/uL	Within normal limits.
MSAFP (If Applicable)	N/A	N/A	N/A	N/A	Not completed on this admission.

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
Nucleic acid amplification test (NAAT)	-	+	+	+	The patient tested positive for a sexually transmitted infection called trichomoniasis. Trichomoniasis, caused by a parasite, is spread through unprotected sexual intercourse (Pagana, 2018).
Cannabinoid urine drug screen	-	+	+	+	The patient tested positive for active cannabinoid done by a urine drug screen (Pagana, 2018).

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)	79-107 mL/min	80.6	N/A	N/A	Within normal limits.

Lab Reference (1) (APA): Pagana, K.D., & Pagana, T. J., Pagana, T. N. (2018). *Mosby's manual of diagnostic and laboratory test reference* (14th Ed.). Mosby.

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 OB unit for induction of labor on 09/28/22 at 0800. The patient is a 29-year-old African American female with no known complications from past deliveries. The patient presents today with a positive GBS and positive for trichomonas and cannabis. The patient was dilated at 3 ½ cm upon arrival. The patient's membranes ruptured at 1853 on 09/28/22. The patient was started on Oxytocin/Pitocin and antibiotics intravenously. The patient did not receive an epidural for pain. The patient's vitals during labor were BP: 127/82, RR: 20, HR: 78, T: 98.2 F, and O2: 99%. The patient's vitals were stable and were taken every 15 minutes, and fetal heart rate was measured continuously. There were no significant decelerations throughout the patient's progress in contractions. The patient did not have an episiotomy or occur and lacerations post-delivery. The patient lost 850 mL of blood and had to get vaginal packing due to the active bleeding. The first stage of labor is usually seen at home but may be seen in a healthcare setting (Ricci et al., 2021). The second stage of labor is the most significant transitional time labor (Ricci et al., 2021). The patient was successfully able to birth a 3800 g neonate. However, this

	neonate did have a meconium delivery and shoulder dystocia but is doing fine; no breathing treatment is needed. The third stage of labor is when the placenta is successfully birthed (Ricci et al., 2021). The placenta then was then delivered intact and sent off to pathology. The patient spent 16 minutes of labor in the first stage, 14 minutes of labor in the second stage, and 5 minutes of labor in the third stage. The total time spent in labor was 35 minutes.
Current stage of labor	The patient is in the fourth stage of labor. The fourth labor stage occurs right after delivery of the placenta and up to 12 weeks after the neonate is born (Ricci et al., 2021). The patient requests to leave as soon as possible as she has four other children to attend to. She is 24 hours postpartum and is doing well. The patient has minimal bleeding and is urinating and passing gas accordingly. Her lochia color is bright red but scant. Vitals have remained stable, but blood pressure does sit on the higher side; the provider was notified. The patient has not reported pain in over 13 hours. The patient's fundal heights were 1 cm above the umbilicus. The patient is at a higher risk for postpartum hemorrhage. Postpartum hemorrhages occur 2-6 hours post-delivery (Ricci et al., 2021). The patient is also at a higher risk for infection and postpartum mood disorder. The signs and symptoms of postpartum hemorrhage, mood disorder, and infection were explained to the patient. The symptoms of

	postpartum hemorrhage include passing clots more prominent than a size of an egg, dizziness, and trouble breathing (Ricci et al., 2021). The signs and symptoms of mood disorder in postpartum women are loss of appetite, trouble sleeping, anxiety, depression, irritability, and fatigue (Ricci et al., 2021). These symptoms are felt nearly every day for more than two weeks. Postpartum mood disorder or "postpartum blues" can affect up to 83% of new-time moms and 92% of moms who have had postpartum depression before (Christaki et al., 2022). Postpartum infection is common and can happen. The symptoms of postpartum infection include febrile of 100.4 F, swelling, pain, and warmth. The stage that the postpartum mother is in is the taking hold phase.

Stage of Labor References (2) (APA):

Christaki, V., Ismirnioglou, I., Katrali, A., Panagouli, E., Tzila, E., Thomaidis, L., Psaltopoulou, T., Sergentanis, T., & Tsitsika, A. (2022). Postpartum depression and ADHD in the offspring: Systematic review and meta-analysis. *Journal of affective disorders*, *318*, 314–330. https://doi.org/10.1016/j.jad.2022.08.055

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

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

Home Medications (2 required)

Brand/Generic	acetylsalicylic acid (Bayer)	Prenatal vitamin			
Dose	81 mg	0.8-28 mg			
Frequency	Once daily	Once daily			
Route	Orally	Orally			
Classification	Pharmacological class: salicylate Therapeutic class: NSAID	Pharmacological class: Iron product and mineral combination. Therapeutic class: Vitamin supplement.			
Mechanism of Action	Blocks the activity of the cyclooxygenase and its components.	Adequately gives the proper amount of vitamins and minerals to support a postpartum mother.			
Reason Client Taking	Blood thinner	Promote adequate neonatal growth and supplementation in the patient's pregnancy.			
Contraindications (2)	Active bleeding and/or breastfeeding.	Hypersensitivity to the vitamins and hemochromatosis.			
Side Effects/Adverse Reactions (2)	Stomach pain and prolonged bleeding time.	Stomach discomfort/constipation and nausea.			
Nursing Considerations (2)	Assess the patient neuro status and cardio status.	Increase seizures in patients and decrease the effectiveness of certain antibiotics.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess that the mother is only wanting to bottle feed and assess patient's pain.	Assess patients comfort on taking the prenatal and assess the patients CBC/CMP levels.			
Client Teaching	Advise patient	If nausea occurs advise			

needs (2)	to never crush or chew medication and never take more than the advised dosage.	the patient to take at night or switch a gummy prenatal and tell the provider if any new symptoms like constipation occur.			

Hospital Medications (5 required)

Brand/ Generic	Oxytocin/ Pitocin	carboprost (Hemabate)	ketorolac (Toradol)	metronidazole (Flagyl)	labetalol hydrochloride (Normodyne)
Dose	30 units/500 mL	250 mcg	40 mg	500 mg	100 mg
Frequency	Continuous	Every 15 minutes.	Every 6 hours	Every 8 hours.	Twice daily.
Route	Intravenous	IM	Intravenous	Orally	Orally
Classification	Pharmacological: Oxytocic hormones No therapeutic option.	Pharmacological: Prostaglandin/abortifacient No therapeutic option.	Pharmacological: NSAID Therapeutic: analgesic	Pharmacological: nitroimidazole Therapeutic: antiprotozoal	Pharmacological: non-cardio selective beta-blocker/alpha-blocker Therapeutic: antihypertensive
Mechanism of Action	Helps to contract the uterus.	Helps treat uterine hemorrhage.	Blocks the enzyme cyclooxygenase.	Breaks down the bacterial nucleic acid that causes cell death.	Blocks the alpha and beta receptors in the vascular smooth muscle to reduce blood pressure levels.
Reason Client	Contract the	Bleeding	Pain and inflammati	Trichomonas	Hypertension post delivery

Taking	patient's uterus and reduce the blood loss.		on		
Contraindications (2)	Hypersensitivity to oxytocin and its components and/or hypertonic uterus.	Hypersensitivity to Hemabate or its components and/or anemia disorder.	Rhinitis and/or hypersensitivity to NSAIDs	Hypersensitivity to metronidazole and its components and/or avoiding alcohol containing substances.	Bronchial asthma and cardiogenic shock.
Side Effects/ Adverse Reactions (2)	Difficulty thinking and dyspnea.	Nausea and headache.	Seizures and headache.	Dark urine and metallic taste.	Dyspnea and wheezing.
Nursing Considerations (2)	Assess the patient's uterus and note in changes in bleeding and assess the patient's IV patency.	Monitor uterine bleeding and send all clots to the laboratory to analyze.	Monitor the patient's liver enzymes and assess patients pain level.	Obtain liver function levels and monitor CBC levels.	Monitor the patient's blood pressure levels and monitor symptoms of cardiogenic shock.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess the patients chuck pads for bleeding and check patients Hct levels.	Assess the patient vitals every 15 minutes and assess the uterus for active bleeding.	Check the patient's enzyme levels and assess Hct levels.	Assess patients discharge and assess patients' urine output/color.	Assessing the patient's vitals and monitoring patients cardiovascular/neurological status.
Client Teaching needs (2)	Educate the patient on the different adverse reactions and educate the	Educate the patient to tell the nurse if they feel gushes of blood and educate the patient on the signs of blood loss.	Advise patient to not take any other NSAIDs and not to take on an empty	Educate the patient on safe sex and advise them to tell the provider if they have	Advise the patient to report confusion or trouble breathing. Caution the patient to never skip doses or double doses.

	patient on the importance of oxytocin.		stomach.	new or worsening symptoms.	

Medications Reference (1) (APA): Jones & Bartlett Learning. (2020). *2021 Nurse's Drug Handbook* (19th Ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented x4. No known distress and overall appearance is suitable per situation. Patient was tired.
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Patient has dark complexed skin that is moist and warm to touch. Turgor tested on patient and is normal. No rashes, wounds, incision, or bruises present. Patients Braden score is 18. No drains are present.
HEENT (1 point):	Head, and neck symmetrical, no tracheal

Head/Neck: **Ears:** **Eyes:** **Nose:** **Teeth:**	deviation, non-palpable thyroid, non-palpable lymph nodes. Pallor, TM bilateral, bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink, no visible drainage or discharge present from eyes. Bilateral lids are moist and pink without lesions or discharge noted. PERRLA bilaterally. Septum is midline, turbinates are moist and pink bilaterally and there are no visible bleeding or polyps present. Bilateral frontal sinuses are nontender to palpate. Oral cavity is pink and moist. Dentition intact.
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. S3 and S4 were clear in all lobes. Peripheral pulses were a +2. Capillary refills were less than 3. Neck vein distention is not noted. No edema present.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	No wheezes, rales, rhonchi noted in all four lobes. All four lobes are clear. No accessory muscle use.
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 has normal diet at home and at the hospital. The patient is 170.2 cm, 5’7”, and weighs 97.5 kg, 215 lbs. Normal active bowel sounds in all four quadrants. The patients last bowel is unknown. No pain or masses noted. Inspection of abdomen is normal. No distention noted. No incisions, scars, wounds, or drains present.
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Color of urine is straw. Character of urine is odorless and clear. No pain with urination. Inspection of genitals are normal. No catheter is present.

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 did not need ADL assistance and was not a fall risk. Fall score 0. The patient is independent and active with no assistance needed. The patient does not have any equipment.
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:**	Orientation of patient is x4. Mental status is good. Mental status is good. Patient is happy. Speech is normal and fluent. The patient presents PERLA and MAEW. Equal strength in all extremities. No LOC. Sensation is present and normal. Deep tendon reflexes are not assessed on this assessment.
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):**	Patient uses no method of coping inside the hospital. The patient's development level is normal per stated age. The patient is not religious. The patient does not have a good support system at home. The patient lives at home with her four other kids. The patient does speak to the FOB while he is incarcerated.
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	The patient's fundal height is 1 above the umbilicus. Scant/light bleeding noted upon inspection. Lochia is bright red with few small clots. The patient did not have an episiotomy or laceration.
DELIVERY INFO: (1 point) **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:**	The patient's membranes ruptured at 1853 on 09/28/22. The color of the membranes had thin meconium that was odorless. The membrane fluid was a large amount. The delivery date was 09/28/22 at 2129. The patient had an induction that was vaginal. The patients blood loss was 850 mL. The APGAR score was 8, and 9. The neonate weighted 3800 g/8 lbs. 6 oz. and is solemnly bottle fed.

Weight: **Feeding Method:**	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal 0900	89	135/95	19	98.3 F	98%
Labor/Delivery 2045	78	127/82	20	98.2 F	99%
Postpartum 0800	92	152/90	18	98.1 F	99%

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	0-10	N/A	0-10	N/A	N/A
1000	0-10	N/A	0-10	N/A	N/A

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 did not have an IV upon assessment. The size of the prior IV was a 20G located in the left distal posterior forearm. There are no signs of erythema, or drainage. The IV flushes without resistance. The area is clean, dry and intact.

Intake and Output (2 points)

Intake	**Output (in mL)**
240 mL	The patient is up and voiding on their own with no complaints of difficulty.

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 "M" after you list them.)	**Frequency**	**Why was this intervention/ treatment provided to this patient? Please give a short rationale.**
Ice packs (N)	PRN	Ice packs are applied to the vaginal area to relieve the swelling and discomfort from a vaginal delivery.
Hot packs (N)	PRN	Hot packs are applied to the patient's stomach to relieve cramping and discomfort.
Peri bottle (N)	After every void (PRN)	A peri bottle is a good device to thoroughly clean the vaginal area.
Witch Hazel (N)	PRN	Witch Hazel is applied to the vaginal area to relieve mild discomfort and swelling.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in?

The patient is in the taking-hold phase due to being 24 hours postpartum.

What evidence supports this?

The patient is able to identify her needs and her neonates needs. The patient compares her newborns looks to hers. The patient is able to provide adequate care independently for her neonate.

Discharge Planning (3 points)

Discharge location: The patient is being discharged to her home where her four other children live.

Equipment needs (if applicable): The patient will be taking a home a blood pressure machine to monitor her blood pressure levels at home. No other equipment is needed at this time.

Follow up plan (include plan for mother AND newborn): The patient has a six-week appointment with her OB-GYN, and the newborn has a newborn appointment made for 09/30/22.

Education needs: The patient was given education on signs of infection, and newborn care. The patient was shown how to properly put her newborn in a car seat.

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. Ineffective peripheral tissue perfusion	The patients Hct levels were low due to postdelivery	**1.** Doing assessments on the patient every 8 hours for decreased tissue perfusion. **Rationale:**	• The patient will not have any abnormal factors relating to decreased tissue

related to decreased blood flow as evidence by low Hct levels.	bleeding.	While evaluating the patient often this will allow characteristics to define if symptoms steer off of baseline levels (Phelps, 2020). **2.**Use a pulse oximetry to monitor the patient's oxygen saturation levels. **Rationale:** The pulse oximetry device allows the nurse to identify any changes to the oxygenation in the patient's body (Phelps, 2020).	perfusion upon each assessment. • The patient will remain above 95% for her O2 saturation every two hours.
2. Ineffective coping skills related to substance abuse as evidence by positive marijuana urinalysis.	The patient does not show any positive signs of coping other than abusing drugs.	**1.** Encourage patient to stop using marijuana and be able to verbalize feelings/cope more effectively. **Rationale:** Allowing the patient to open up will help the patient resolve coping issues (Phelps, 2020). **2.** Encourage patient to explore relaxation skills, guided imagery, or soothing music. **Rationale:** Showing the patient that there are other healthier ways to deal with stress helps the patient cope better (Phelps, 2020).	• The patient stopped smoking marijuana and showed interest in opening up at six-week appointment. • The patient used soothing, relaxing music in times of stress and improved coping mechanisms within six weeks.
3. Deficit knowledge related to hemodynamics as evidence by high blood pressure levels.	The patient presents pre-delivery and post-delivery with higher-than-normal blood pressure levels.	**1.** Assess vitals every 2 hours and allowing the patient to demonstrate how to properly take their own blood pressure. **Rationale:** Assessing the patients blood pressure levels will allow the nurse to see the vital sign trends (Phelps, 2020). **2.** Educate the patient on the different healthier	• The patients blood pressure levels remained under 160/110. The patient was able to properly demonstrate the right technique of taking her own blood pressure. The patient brought

		nutrition options that are low in sodium, saturated fat, and cholesterol. **Rationale:** Giving the patient different healthier nutrition education allows the patient to better understand that eating healthier can decrease her blood pressure levels (Phelps, 2020).	in her blood pressure level chart and showed improving blood pressure levels at her six week appointment. • The patient showed interest in how the different food options and was able to pick healthier options for her next tray she ordered. The patient's blood pressure levels were significantly lower due to better nutrition at her six week appointment.
4. Deficit knowledge related to inadequate support as evidence by social history.	The patient does not have good support system at home.	**1.** Provide an opportunity for the patient to interact with you one-on-one. **Rationale:** Allowing the patient to use direct communication will help the patient build trust. **2.** Provide resources for the patient to help the patient feel secure (Phelps, 2020). **Rationale:** Providing education of outside resources will help the patient understand that they are struggling socially.	• The patient will show improvement in social skills and have developed a closer relationship with her mother for support for her and her neonate at her six week appointment. • The patient will use the resources given to her to make an appointment with WIC to help be healthier

			mentally. She has an appointment at the WIC office in two weeks to go over the different options.

Other References (APA): Phelps, L.L. (2020). *Sparks and Taylor's Nursing Diagnosis Reference Manual* (11th Ed.). Wolters Kluwer