N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 10/24/22 at 1515	**Patient Initials** S.W.	**Age** 26	**Gender** Female
Race/Ethnicity African-American	**Occupation** Unemployed	**Marital Status** Single	**Allergies** Aspirin
Code Status Full code	**Height** 5'1"	**Weight** 150 pounds	**Father of Baby Involved** Yes, he is at bedside.

Medical History (5 Points)

Prenatal History: Patient established prenatal care on June 18, 2022, indicating she was in her second trimester. Upon admission she was G7T3P4A3L4. Patient has never had a cesarean section before. Shoulder dystocia was relevant in her last vaginal birth. Patient has had 2 abortions. This pregnancy is complicated by asthma exacerbation and pneumonia.

Past Medical History: Preeclampsia, shoulder dystocia, spontaneous vaginal delivery, anemia, incomplete abortion, legally induced abortion, abnormal uterine bleeding, asthma.

Past Surgical History: Dilation and curettage of uterus and salpingo-oophorectomy

Family History: Mother had multiple sclerosis and father had hypertension and cancer.

Social History (tobacco/alcohol/drugs): The patient does not report any smoking, drinking, or drug use.

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

Education Level: The education level is unknown.

Admission Assessment

Chief Complaint (2 points): Transferred from OSF in Danville for asthma exacerbation and pneumonia in pregnancy.

Presentation to Labor & Delivery (10 points): This patient presented to OSF in Danville for pneumonia and asthma exacerbation during pregnancy. Patient was 35 weeks and 6 days gestation. She was admitted for IV antibiotic treatment. Patient began contracting with cervical change. She was then transferred to Urbana for diagnosis of preterm labor. Pitocin was administered but labor did not advance due to fetal intolerance to labor. The fetal heart rate monitored showed minimal heart rate variability. Patient was then prepared for an emergency cesarean section. It was her first cesarean section. A baby boy was delivered at 2315 on October 26, 2022.

Diagnosis

Primary Diagnosis on Admission (2 points): Pneumonia

Secondary Diagnosis (if applicable): Preterm labor

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	3.87	4.12	Not drawn	
Hgb	12-15.8	11.3	10.7	Not drawn	This client has anemia, which is why her hemoglobin levels are lower than normal.
Hct	36-47	33.4	32.8	Not drawn	This client has anemia, which is why her hematocrit is low.
Platelets	140-440	410	440	Not drawn	
WBC	4-12	7.4	9	Not drawn	

Neutrophils	47-73	60.4	84.5	Not drawn	Neutrophilia can occur from physical or emotional stress (Pagana et al., 2021)
Lymphocytes	18-42	30	8.1	Not drawn	Lymphocytopenia can occur from the result of the patient's drug therapy (Pagana et al., 2021)
Monocytes	4-12	0.6	4.9	Not drawn	Low monocyte level is normal in pregnancy (Pagana et al., 2021).
Eosinophils	0-5	1.3	1.7	Not drawn	
Bands	0-5.0	Not drawn	Not drawn	Not drawn	

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, or O	A	A	A	
Rh Factor	(+) or (-)	+	+	+	
Serology (RPR/VDRL)	Non reactive	Non Reactive	Non Reactive	Non Reactive	
Rubella Titer	Immune	Immune	Immune	Immune	
HIV	Not detected	Not detected	Not detected	Not detected	
HbSAG	Not detected	Not detected	Not detected	Not detected	
Group Beta Strep Swab	Negative	Moderate strep results	Moderate strep results	Moderate strep results	An increased amount of strep could put the baby at risk.
Glucose at 28 Weeks	50-139	101	113	NA	
MSAFP (If Applicable)	10-150	NA	NA	NA	

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
Sodium	136-145	135	133	NA	Deficient sodium may result from poor dietary intake (Pagana et al., 2021).
Lactic acid	0.7-2	2	2.3	NA	Increase in lactic acid production may be caused by impaired tissue oxygenation. She had pneumonia which would be the reason it was elevated (Pagana et al., 2021).
CO2	22-30	22	20	NA	Decreased CO2 levels could indicate shock (Pagana et al., 2021).

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)	0.59-1.04	NA	NA	NA	

Lab Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2021). *Mosby's diagnostic & laboratory test reference* (15th 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**	Patient did not go through stages of labor. Patient was 35 weeks when she was hospitalized for pneumonia during pregnancy. She started contracting with cervical change. Patient was given Pitocin and upon assessment of the fetal monitor showed minimal heart rate variability. She was then prepared for an emergency cesarean section.
Current stage of labor	This client was in the postpartum period. The postpartum period begins with the expulsion of the placenta and continues with the stabilization of vital signs (Ricci et al., 2021). The postpartum period is a critical transition from a woman, newborn, and family on a physiologic and psychological level (Ricci et al., 2021). This particular patient is in the taking-in phase. The postpartum assessment includes vital signs and physical and psychosocial assessments (Ricci et al., 2021). Within the first 24 hours of delivery, the patient should receive assessments every four hours (Ricci et al., 2021). The mother's temperature during the first 24 hours should remain within normal limits. Some women may experience a low-grade fever. However, it should be evaluated if it exceeds 100.4 degrees (Ricci et al., 2021). In this

	patient's scenario, her temperature remained within normal limits of 97.4 degrees. The pulse rate during postpartum should be within 60-80 beats per minute (Ricci et al., 2021). Tachycardia could suggest anxiety, fatigue, pain, or excessive blood loss (Ricci et al., 2021). This patient had a normal rate of 67 beats per minute. Respirations should remain within the normal limits of 12-20 breaths per minute (Ricci et al., 2021). This patient had a standard rate of respirations, and they were unlabored. Blood pressure should remain the same as labor. Hypotension could indicate shock, whereas hypertension could suggest gestational hypertension (Ricci et al., 2021). Readings should not be higher than 140/90 or lower than 85/60 (Ricci et al., 2021). This patient's blood pressure remained within normal limits, with a reading of 129/76. Assessment of fundus and lochia are done every 4 hours along with the vitals. The fundus should be midline and firm (Barlow et al., 2019). A boggy uterus is a sign of uterine atony (Barlow et al., 2019). This patient's fundus was midline with the umbilicus. Heavy, bright red lochia with large tissue fragments and foul odor is a negative sign (Barlow et al., 2019). Excessive bleeding may indicate hemorrhage. This patient had a moderate amount of lochia present. Postpartum complications can consist of hemorrhage and

	infection (Ricci et al., 2021). Factors that increase the risk of infection include cesarean section, catheter insertion, and history of diabetes (Riccie et al., 2021). Risk for hemorrhage increases if labor induction is initiated, cesarean section, and uterine atony (Ricci et al., 2021). In this particular patient, their risks increase because of cesarean section, foley, and labor induction.

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* (11 th ed.). Assessment Technologies Institute, LLC.

Ricci, 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	Prenatal vitamins Stuart One	Acetaminophen Tylenol			

Dose	400 mcg	650 mg			
Frequency	1 tablet/twice a day	Q8 hours			
Route	Oral	Oral			
Classification	Pharm: vitamin and mineral combination Therapeutic: iron replacement	Pharm: Nonsalicylate Therapeutic: antipyretic			
Mechanism of Action	Folate and methylation pathways are critical for the early formation of the CNS, which is what this vitamin does (Drugs.com, 2022).	Blocks prostaglandin production and interfering with pain impulse.			
Reason Client Taking	Patient was pregnant.	Moderate pain			
Contraindications (2)	-If they're currently taking a blood thinner. -If they have too much iron in the body.	-Hypersensitivity to Tylenol. -Severe hepatic impairment.			
Side Effects/Adverse Reactions (2)	-Constipation -Change in color of stool	-Hypotension -Fever			
Nursing Considerations (2)	-Allergic to prenatal vitamin or any part of prenatal vitamins. -Tell the physician if patient is breast feeding.	-Use cautiously in patients with hepatic impairment. -Monitor renal function throughout drug therapy.			
Key Nursing	-Assess iron	-Assess kidney			

Assessment(s)/Lab(s) Prior to Administration	levels before administration. -Ensure appropriate dosing before administration.	function -Assess pain level			
Client Teaching needs (2)	-Take with a full glass of water. -Do not take antacids within 2 hours before or after taking prenatal vitamins.	-Tablets may be crushed or swallowed whole. -Instruct patient to read label and dose appropriately.			

Hospital Medications (5 required)

Brand/Generic	Flagyl Metronidazole	Acetaminophen Tylenol	Roxicodone Oxycodone	Simethicone Mylicon	Docusate Colace
Dose	500 mg	650 mg	5 mg	80 mg	100 mg
Frequency	1 tablet/2 times a day	Q4 hours	Q6 hours	4 times a day, after meals and nightly	As needed Q12 hours
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pharm: nitroimidazole Therapeutic: antiprotozoal	Pharm: non salicylate Therapeutic: antipyretic	Pharm: opioid Therapeutic: opioid analgesic	Pharm: GI agents Therapeutic: gas relief	Pharm: surfactant Therapeutic: laxative
Mechanism of Action	It damages DNA structure and breaks its strands which causes cell death (Jones &	Blocks prostaglandin production and interferes with pain impulse in the peripheral	Alters perception of and emotional response to pain at spinal (Jones &	Changes the surface tension of gas bubbles and causes collapse of	Softens stool by decreasing surface tension between oil and water in

	Bartlett Learning, 2021).	nervous system (Jones & Bartlett Learning, 2021).	Bartlett Learning, 2021).	bubbles, allowing easier passage of gas (Multum, 2020).	feces (Jones & Bartlett Learning, 2021).
Reason Client Taking	Bacterial infection	Pain	Pain	Relieve pain pressure caused by excess gas	Constipation due to opioid administratio n.
Contraindications (2)	Drug is present in breast milk. A decision should be made to discontinue breastfeeding or the drug to avoid potential adverse reactions in the infant.	Hypersensitivity to Tylenol or severe hepatic impairment.	Significant respiratory depression, paralytic ileus.	-Hypersensiti vity to Mylicon. -Ask provider before patient breastfeeds.	Undiagnosed abdominal pain and concomitant use with mineral oil.
Side Effects/Adverse Reactions (2)	Dysuria, urinary frequency, dyspnea.	-Use of drug during pregnancy may increase risk of ADHD after birth. -Drug is present in breast milk.	Hypotension, bradycardia.	-Diarrhea -Nausea and vomiting	Dizziness and abdominal cramps.
Nursing Considerations (2)	-Monitor neurologic status throughout therapy. -Don't give IV administration.	-Use cautiously in patients with hepatic impairment. -Ensure the dose is based on patient's weight.	-Prolonged use of drug during pregnancy can result in neonatal opioid withdrawal syndrome. -Use with caution only if the benefit to mother outweighs potential risk	-Ask physician before breast feeding. -Assess for any allergies.	-Expect excessive or long-term use to cause dependence on laxatives for bowel movements. -Electrolyte imbalances may occur.

			to fetus.		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-Ask about allergies. - Ensure it's an appropriate antibiotic treatment for this particular patient.	Assess pain level and liver function before administration.	Assess pain level and vital signs before administration .	-Assess gastric pain -Assess when the last time a bowel movement was done	-Assess the last time patient had a bowel movement. - Ensure she doesn't have any abdominal pain before administratio n.
Client Teaching needs (2)	-Take with food to minimize GI discomfort. - Urge patient to finish entire course of drug therapy.	-Tell patient that tablets may be crushed or swallowed whole. -Teach patient to recognize signs of hepatotoxicity.	-Strongly warn patient not to break, chew, or crush oxycodone tablets because taking them broken will increase absorption. - Do not take more often than prescribed.	-Works best if taken after meals and at bedtime. -Tablet must be chewed before swallowing.	-Advise patient to take with a full glass of milk or water. - Encourage increase in fiber intake.

Medications Reference (1) (APA):

Drugs.com. (2022). *Prenatal vitamin.* Drugs.com. https://www.drugs.com/cdi/prenatal-vitamin.html#before-taking

Jones & Bartlett Learning. (2021). *2021 Nurse's drug handbook* (20 th ed.). Jones & Bartlett Learning.

Multum, C. (2020). *Mylicon*. Drugs.com. https://www.drugs.com/mtm/mylicon.html#side-effects

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented time person, place, and time. Patient doesn't appear to be using accessory muscles when breathing. She doesn't appear to be in any acute distress.
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** Abdominal incision from cesarean section. **Braden Score:** 20 **Drains present: Y☐ N ☒** **Type:**	Skin color is brown, dry, and cool upon palpation. There are lesions, rashes, or wounds upon inspection. Skin turgor is normal, less than 3 seconds. Patient has an abdominal incision from her cesarean section. Patient's braden score is 20.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck are symmetrical upon inspection and the trachea is midline. There are no noted nodules and the thyroid is nonpalpable. Bilateral carotid pulses 2+ upon palpation. Bilateral auricles have no visible deformities or drainage noted. Both eyes appear to have no lesions upon inspection. PERRLA. EOMs are intact on both eyes. Septum is midline with no notable drainage.

	Oral mucosa is pink and moist with no noted lesions. Patient has clean and intact dentition.
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:**	Normal heart sounds with no murmurs or gallops present. Rhythm is normal, rate is normal. Presents with a 2+ pulse upon palpation of all pulse sites. Capillary refill is less than 3 seconds bilaterally. No edema or neck vein distension is present.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Normal breath sounds noted in all lung fields. Respirations and patterns are non-labored with a normal respiratory rate. Patient is not using accessory muscles when breathing.
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:**	Patient was on a regular diet while at home. She was NPO for her cesarean section. Patient's height is 5'1" and 150 pounds. Normoactive bowel sounds are present in all quadrants among auscultation. Last bowel movement is unknown. Upon inspection there were no distension, scars, drains, or wounds present. There was an incision site along her abdomen from the cesarean section.
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** 16 Fr **Size:**	Patient's urine was yellow with no odor. The quantity of urine is 1,000 mL. There was no pain with urination and she is not on dialysis. Patient had a 16 Fr foley catheter in place. Upon inspection of genitals, no tears or lacerations were present.
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** 25 **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment X** **Needs support to stand and walk☐**	There was no noted weakness on any extremity. She had not been ambulated since her cesarean section, therefore she needed assistance with activities of daily living for the first time. She does not use a walker to ambulate. Two people were used for the first time ambulating her. Patient is a fall risk with a score of 25.

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 moves all extremities well. No noted weakness throughout limbs and strength is equal throughout. Patient is alert and oriented to person, place, and time. Patient is well spoken and answers questions appropriately. PERRLA. DTRs are 2+ throughout.
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 resides in a home with her boyfriend and three other children. Patient appears to have a good family structure. Baby's father is present at the bedside helping with care of the newborn. Patient's developmental level is appropriate for her age and she has appropriate coping methods. Patient didn't state any religious practices.
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	Fundus was at the level of umbilicus, midline. There was rubra lochia present. Light bleeding was noted with no odor. No episiotomies or lacerations.
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:**	Patient had an emergency cesarean section on October 26th at 2315. She gave birth to a 5 pound male. The newborn is receiving donor milk while the mother's milk comes in. She began pumping during this student's shift. Artificial rupture of membranes at 1824 on October 26, 2022. The color, amount, and odor are unknown. Apgars were 8 and 8.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

Prenatal	75 beats per minute	129/74	18 breaths per minute	97.9 degrees orally	100% room air
Labor/Delivery	96 beats per minute	129/82	20 breaths per minute	98.0 degrees orally	93% on room air
Postpartum	67 beats per minute	129/76	18 breaths per minute	97.4 degrees orally	99% room air

Vital Sign Trends: Vital signs remained stable throughout the labor and delivery process.

During labor the heart rate was slightly higher and the oxygen saturation was on the lower side.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0930	0-10	Incision site	6	Throbbing	Tylenol
1115	0-10	Incision site	3	Pain is tolerable	No interventions performed at this time

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:**	Patient had a 18 gauge in her left posterior hand. There was no date noted on the IV site. The site was dry and intact with no notable drainage or erythema.

Intake and Output (2 points)

Intake	Output (in mL)

Orders were still in as NPO, waiting for the doctor to change to a regular diet. Therefore, the patient did not eat anything during this student's shift.	1,000 mL of urine

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.
Fundal and lochia assessment (N)	Q4 hours	Ensuring proper placement and muscle tone of the fundus ensures the patient is not hemorrhaging and it is descending appropriately (Ricci et al., 2021).
Pain medication (M)	Q4 hours	Pain medications are given every four hours to ensure pain is managed following the cesarean section.
Sequential compression device (SCDs) (N)	Continuous	SCDs ensure proper blood flow is present in the limbs, thus preventing blood clots from occurring.
Abdominal binder (N)	Continuous	Wearing an abdominal binder may decrease postoperative pain and discomfort (McDermott, 2017).

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? This mother is in the taking-in phase (Ricci et al., 2021).

What evidence supports this? The taking-in phase occurs immediately after birth when the client needs sleep, depends on others, and relives the events surrounding the birth (Ricci et al.,

2021). This client relied on her partner to assist with feeding the infant, cleaning the breast pump supplies, and ensuring she received adequate rest.

Discharge Planning (3 points)

Discharge location: Discharge to home

Equipment needs (if applicable): Breast pump and abdominal binder

Follow up plan (include plan for mother AND newborn): 1-week post discharge from hospital.

Education needs: The patient will need education on breast pump technique and frequency.

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. Pain related to cesarean section as evidenced by pain rating 6 out of 10 on pain scale.	This patient recently had a cesarean section.	**1.** Administer Tylenol Q4 hours. **Rationale** It is effective in managing mild to moderate pain. To ensure the client does not build a dependence on opioids, Tylenol should be preferred (Wayne, 2022). **2.** Apply abdominal binder. **Rationale** An abdominal binder can assist with pain relief and post operative discomfort (Wayne, 2022).	The patient responded well to these nursing interventions. Patient described satisfactory pain control at level 3. Will continue to administer Tylenol Q4 hours to manage pain appropriately.
2. Risk for	This patient	**1.** Apply SCDs and assess	The patient responded

blood clot related to reduced ambulation as evidenced by increased pain and poor mobility.	just had a cesarean section, thus increasing the amount of time spent in bed.	for signs of deep vein thrombosis (DVT). **Rationale** SCDs are used to ensure appropriate blood flow through lower extremities. Signs that may indicate a DVT include swelling, pain or tenderness, and warmth (Martin, 2022). **2.** Ensure early ambulation. **Rationale** Early ambulation ensures the blood flow in extremities isn't stasis, thus decreasing risk for acquiring a blood clot (Martin, 2022).	well to these interventions. There were no signs of DVT present. Patient continued to wear SCDs and began ambulating to the bathroom. Will continue use of SCDs and encourage ambulation to bathroom Q2 hours.
3. Deficient knowledge related to first cesarean section as evidenced by asking questions regarding the abdominal binder.	This patient had their first cesarean section.	**1.** Encourage the patient to ask questions. **Rationale** By doing this it will provide the patient with more confidence and it facilitates open communication (Wayne, 2022). **2.** Provide clear and thorough explanations regarding care. **Rationale:** The patient and spouse may be more comfortable in asking questions when they have a basic understanding of information (Wayne, 2022).	The patient responded well to these interventions. Patient voiced understanding of the use of abdominal binder and asked questions appropriately.
4. Deficient knowledge related to milk pumping as evidenced by asking for help with pumping.	The patient had never pumped before, therefore they were unsure of the process.	**1.** Use the teach back technique to determine the understanding of what was taught. **Rationale** This technique allows for a repetitive order, thus increasing the familiarity of pumping (Wayne, 2022). **2.** Provide immediate feedback on performance. **Rationale** It allows the patient to make corrections rather than practicing the	The patient responded well to these interventions. The client received teaching about the proper use of the breast pump and showed competence when she accomplished this task independently. Will continue to assess pumping Q2 hours and answer any questions.

		skill wrong (Wayne, 2022).	

Other References (APA)

Martin, P. (2022). *Five deep vein thrombosis nursing care plans*. Nurseslabs. https://nurseslabs.com/5-deep-vein-thrombosis-nursing-care-plans/2/

McDermott, A. (2017). *What you should know about abdominal binders*. Healthline. https://www.healthline.com/health/abdominal-binder

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

Wayne, G. (2022). *Knowledge deficit nursing care plan.* Nurseslabs. https://www.drugs.com/mtm/mylicon.html#side-effects