

N432 Postpartum Care Plan
Lakeview College of Nursing
Kati Davis

Demographics (3 points)

Date & Time of Admission 11.16.2022 @ 0735	Patient Initials A.J.	Age 17yo	Gender Female
Race/Ethnicity Caucasian / Non-Hispanic or Latino	Occupation Highschool student - Unemployed	Marital Status Single	Allergies NKA
Code Status Unknown	Height 5'6"	Weight 180lbs	Father of Baby Involved No

Medical History (5 Points)

Prenatal History: G1 | T1 | P0 | A0 | L1

Past Medical History: The patient has a past medical history of asthma.

Past Surgical History: No past surgical history

Family History: Mother – Hypertension | Father – Long-term cigarette smoker

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

Living Situation: The patient lives at home with her mother and father.

Education Level: Some high school

Admission Assessment

Chief Complaint (2 points): Abdominal pain

Presentation to Labor & Delivery (10 points): The patient is a 17-year-old with a prenatal *history* of G1T1P0A0L0. The patient presents to the emergency department with abdominal pain. The patient is having contractions that are becoming more frequent and somewhat stronger; she is noted to be in the latent phase of stage 1. The patient complains of abdominal pain around

0630 on 11/16/2022. At the time of admittance, the patient denies headaches, SOB, RUQ pain, visual changes, and leakage/bleeding.

Diagnosis

Primary Diagnosis on Admission (2 points): Abdominal Pain

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 (x 10⁶)	3.5-5.2	3.0	3.62	3.24	Women may become slightly anemic during pregnancy due to the increase in blood volume (Pagana et al., 2019). The patient had a slightly lower prenatal value. The decreased value today is probably due to the blood loss during childbirth and the rubra lochia following.
Hgb (g/dL)	11-16.8	11.0	9.4	9.0	The HGB is low because the RBCs are low. RBC carries the HGB which carries O ₂ throughout the body (Pagana et al., 2019).
Hct	34%-47%	35.0	30.1	28.3	HCT reflects the percentage of blood volume that makes up the RBC (Pagana et al., 2019). The patient may have been slightly anemic during pregnancy and the blood loss from childbirth decreased her levels even more.
Platelets	140,000-400,000	291	330	275	

WBC (cells/mcL)	4,000-11,000	10.53	7.78	16.02	The stress of delivery may lead to a case of leukocytosis, or increased white blood cell count (Pagana et al., 2019).
Neutrophils	40-80%	N/A	N/A	N/A	
Lymphocytes	18-40%	N/A	N/A	N/A	
Monocytes	2-10%	N/A	N/A	N/A	
Eosinophils	0-8%	N/A	N/A	N/A	
Bands	0-10%	N/A	N/A	N/A	

Other Tests **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	A, B, AB, O	O	O	O	The mother's blood type is O.
Rh Factor	(+) or (-)	(-)	(-)	(-)	The mother's Rh factor is (-).
Serology (RPR/VDRL)	Reactive or Nonreactive	Nonreactive	Nonreactive	Nonreactive	This value is within normal limits.
Rubella Titer	Immune or Nonimmune	Nonimmune	Nonimmune	Nonimmune	Very few or no antibodies were present in the sample. The mom is not immune to rubella.
HIV	Reactive or Nonreactive	Nonreactive	Nonreactive	Nonreactive	This value is within normal limits.
HbSAG	Reactive or Nonreactive	Not performed	Not performed	Not performed	There are no lab values available for HbSAG.
Group Beta Strep Swab	(+) or (-)	(+)	(+)	Not retested	The patient was (+) for GBS. GBS is caused by a bacterium that can be found in the vaginal or rectal region (Pagana

					et al., 2019)
Glucose at 28 Weeks	< 140	105	N/A	N/A	This value is within normal limits.
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
N/A	N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	N/A	

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)	45-90 (Pagana et al., 2019)	N/A	N/A	N/A	There are no lab values available for urine creatinine

Lab Reference (1) (APA):

Pagana, K. D., Pagana, T.J., & Pagana T. N. (2019). *Mosby's diagnostic and laboratory desk reference* (14 th ed.). Elsevier.

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

	Your Assessment
<p>History of labor:</p> <p>Length of labor</p> <p>Induced /spontaneous</p> <p>Time in each stage</p>	<p>The total length of labor is un-noted and unknown. From the time the patient was admitted to the time she delivered her baby boy totaled 13 hours. The patient had a spontaneous vaginal delivery.</p>
<p>Current stage of labor</p>	<p>This patient is currently in the fourth stage of labor, which we often call postpartum. The fourth stage begins when the placental ejection and membranes are finished (Ricci et al., 2021). The postpartum phase that the mother goes through begins now. The mother may feel a sense of exhilaration and tranquility. The fundus should be solid and well-constricted (Ricci et al., 2021). During the assessment, the patient’s fundus was boggy, 1 cm above the umbilicus, and deviated to the right. In this case, her bladder may be full. The mom should try to void. Also, in this stage, the lochia is red, with small clotting and moderate flow (Ricci et al., 2021). To prevent problems and risk factors related to postpartum hemorrhage, bladder distention, and venous thrombosis, monitoring the mother is the primary goal. During this stage, vital signs, the quantity and texture of the lochia, and</p>

	<p>the uterine fundus are assessed every 15 minutes for the first hour (Ricci et al., 2021).</p> <p>This patient presented to the hospital with complaints of abdominal pain. Abnormal findings upon presentation to the hospital include low HGB & HCT levels which may indicate slight anemia during pregnancy (Pagana et al., 2019). The phase at which the patient is experiencing during the assessment is the “taking-in” phase, which occurs up to 48 hours postpartum (Ricci et al., 2021). The mom may recoup her physical stamina and gather scattered ideas about her new role during the taking-in period. Postpartum complications include postpartum hemorrhage infection and postpartum mood disorders. Signs and symptoms of infection include redness, fever, and tenderness (Ricci et al., 2021). Postpartum infection may occur after a vaginal delivery because of the physiologic and iatrogenic trauma to the reproductive, genital, and urinary tracts that occur during the birthing process. Risk factors for postpartum mood disorders include a medical history of depression, anxiety, or other disorders before pregnancy (Ricci et al., 2021).</p>
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Stage of Labor References (2) (APA):

Pagana, K. D., Pagana, T.J., & Pagana T. N. (2019). *Mosby’s diagnostic and laboratory desk reference* (14 th ed.). Elsevier.

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 different medications must be completed

Home Medications (2 required) (Jones & Bartlett Learning, 2021)

Brand/Generic	Prenatal Vitamins	Albuterol inhaler/ AccuNeb
Dose	1 tablet	2 puffs
Frequency	Once daily	PRN
Route	Oral	Inhalation
Classification	<u>Pharm:</u> Vitamin <u>Therapeutic:</u> Water soluble vitamin	<u>Pharm:</u> Adrenergic <u>Therapeutic:</u> Bronchodilator
Mechanism of Action	The tablet helps the baby's growth and development as well as the prevention of neural tube abnormalities. It may also lessen the risk of anemia.	Albuterol attaches to beta 2 receptors on bronchial cell membranes, which stimulates the intracellular enzyme adenylate cyclase to convert ATP to cAMP. This reaction decreases intracellular calcium levels. It also increases intracellular levels of cAMP. Together, these effects relax bronchial smooth-muscle cells and inhibit histamine release.
Reason Client Taking	For pregnancy	The patient has a previous medical history of asthma.
Contraindications (2)	1. Stomach/intestinal issues 2. Disorders of iron metabolism	1. Hypersensitivity to albuterol or its components. 2. A patient with low amount of potassium in the blood.
Side Effects/Adverse Reactions (2)	1. Upset stomach 2. Constipation	1. Hypotension 2. Angioedema
Nursing Considerations (2)	1. Watch the patient for iron toxicity 2. Have caution with any patient that has kidney stones	1. Use cautiously in patients with cardiac disorders, diabetes mellitus, digitalis intoxication, hypertension, hyperthyroidism, or a history of seizures. 2. Monitor serum potassium level because albuterol may cause transient hypokalemia.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor vitamin b-12 lab and iron labs Assess the patient's pregnancy before, during, and after	Monitor respiratory rate, oxygen saturation, and lung sounds before and after administration.
Client Teaching needs (2)	1. Do not consume alcohol while taking vitamin	1. Warn patient to not exceed prescribed dose or frequency If doses become less

	2. Take the medication with food or at night if it causes stomach upset.	effective, tell patient to contact her prescriber. 2. Tell patient to immediately report signs and symptoms of allergic reaction, such as difficulty swallowing itching, and rash.
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Hospital Medications (5 required) (Jones & Bartlett Learning, 2021)

Brand/ Generic	Oxytocin/Pitocin	Colace/Docusate calcium	Ibuprofen/Motrin	Ampi (ampicillin)	Benzocaine-menthol (dermoplast)
Dose	250 mL	100mg	800mg	2 grams	Ointment 20%, a small amount gets applied to the perineum
Frequency	250 mL Bolus and then 200mL/hour	BID	Every 8 hr	3 doses	PRN
Route	IV	Oral	Oral	IV push	Topical
Classification	<u>Pharm:</u> Oxytocic <u>Therapeutic:</u> Uterine stimulant	<u>Pharm:</u> Surfactant <u>Therapeutic:</u> Laxative, stool softener	<u>Pharm:</u> NSAID <u>Therapeutic:</u> analgesic, anti-inflammatory, antipyretic	<u>Pharm:</u> Penicillin binding proteins <u>Therapeutic:</u> Penicillins	<u>Pharm:</u> Keratolytic agent <u>Therapeutic:</u> Local anesthetic
Mechanism of Action	Oxytocin increases the sodium permeability of uterine myofibrils, indirectly stimulating contraction of the uterine smooth muscle.	Acts as a surfactant that softens stool by decreasing surface tension between oil and water in feces	By inhibiting prostaglandins, this NSAID reduces inflammatory symptoms and relieves pain.	Inhibition of cell wall peptidoglycan formation, deactivation of inhibitors to autolytic enzymes, and interference with cell wall synthesis through attachment to penicillin-binding proteins (PBPs).	It reduces the neuronal membranes' susceptibility to sodium ions, which inhibits depolarization and, as a result, blocks both the initiation and conduction of nerve impulses.
Reason Client Taking	To stimulate uterine contractions.	Moms who have just given birth may worry about their bowel movements due to the general amount	To alleviate mild-moderate pain.	For patient having a positive group B strep test	For patient's perineum discomfort

		of tenderness they experience, a stool softener will help them pass that first stool easier.			
Contraindications (2)	1. Hypersensitivity to oxytocin or its components. 2. Obstetric emergencies that favor surgery.	1. Concomitant use with mineral oil 2. Fecal impaction	1. Current or recent stomach ulcer 2. Have severe liver disease	1. Allergy to cephalosporins and carbapenems 2. Renal failure patients	1. Allergy to local anesthetics 2. Hypersensitivity to benzocaine
Side Effects/Adverse Reactions (2)	1. CV: bradycardia 2. CNS: permanent CNS damage	1. CNS: Dizziness 2. GI: Abdominal cramps	1. GI: GI bleeding 2. GU: Renal failure (acute)	1. Rash 2. Black hairy tongue	1. A rash 2. It may sting
Nursing Considerations (2)	1. Monitor for frequency, duration, and force of contractions. 2. Monitor for signs and symptoms of water intoxication, which include headache, irritability, confusion, nausea.	1. Expect excessive or long-term use of docusate to cause dependence on laxatives for bowel movements, electrolyte imbalances, osteomalacia, steatorrhea, and vitamin and mineral deficiencies. 2. Assess for laxative abuse syndrome, especially in women with anorexia nervosa, depression, or personality disorders.	1. NSAIDs like ibuprofen should be avoided in patients with a recent MI because risk of reinfarction increases with NSAID therapy. 2. Risk of heart failure increases with use of NSAIDs such as ibuprofen.	1. Give only after blood culture drawn 2. Observe for signs of adverse reactions – “Ampicillin rash” usually seen 1-2 weeks after administered.	1. Monitor for allergic reactions 2. Assess pain levels
Key Nursing Assessment(s) /Lab(s) Prior to Administration	Assess a 20-minute electronic fetal monitoring strip prior to medication administration.	Auscultate for bowel sounds, percuss for dullness, and palpate for masses.	Conduct a pain assessment. Also, assess blood pressure as some NSAIDs may increase BP in certain patients.	Blood culture should be drawn before administration	Assess for pain and itching Assess for external and internal hemorrhoids
Client Teaching needs (2)	1. Provide the patient with education about how oxytocin will affect their contractions. 2. Advise the patient to report headache,	1. Tell the patient not to use docusate when she has abdominal pain, nausea, or vomiting.	1. Instruct patients to take tablets with a full glass of water and caution them to not lie down for 15-30 minutes to prevent	1. Educate on why they need this antibiotic for GBS. 2. Educate on how many doses they will receive	1. Before using ointment, wash the afflicted area with mild soap and warm water, then completely rinse and pat

	dizziness, palpitations, or intense pain.	2. Advise the patient to take docusate with a full glass of milk or water.	esophageal irritation. 2. Advise patient to take drug with food or after meals to reduce GI distress.		dry. 2. Do not use large amounts of the topical.
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Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>The patient is a 17-year-old female. The patient is groomed and awake but quiet. Height 5’6”, weight 180lbs. The patient is AAOX4. Patient is calm, quiet, and appears tired. Baby in a crib next to the bed.</p>
<p>INTEGUMENTARY (1 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: 22 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>The skin is warm and dry upon palpation. The skin is elastic, intact, and without discoloration. The skin turgor is less than two seconds with normal mobility. The nails are without clubbing. There are no rashes or bruises upon inspection. The perineum is slightly bruised and swollen, small hemorrhoids are present. The patient’s capillary refill is less than 3 seconds between fingers and toes bilaterally. Braden score of 22, indicates there is no risk.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>The patient’s head and neck are symmetrical. There are non-palpable lymph nodes. There is acuity to regular voices. There is no visible abnormality of ears or palpable deformities. There is no edema or redness present. The sclera is white bilaterally. The patient’s cornea is clear b/l. Their conjunctiva is pink b/l with no mucus. There is no external drainage. The patient does not wear glasses. Their EOMs are intact b/l and PERRLA b/l. The patient’s septum is midline. The patient’s lips/oral mucosa are pink; there is good dentition, and the patient does not have dentures. The patient swallows without difficulty.</p>

<p>CARDIOVASCULAR (2 point): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema: lower extremities bilaterally.</p>	<p>Heart sounds regular with no abnormal beats, pulses strong, equal with palpation at radial/pedal/post-tibial landmarks, brisk cap refill, 1+ edema in lower extremities bilaterally</p>
<p>RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Breath sounds clear with equal aeration bilaterally ant/post, nonlabored respiratory effort</p>
<p>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:</p>	<p>Diet at home: normal Diet during inpatient stay: Regular diet Height: 5'6" Weight: 180lb</p> <p>Abdomen soft/non-distended, bowel sounds audible per auscultation in all four quadrants, positive flatus, no BM since delivery.</p>
<p>GENITOURINARY (2 Points): Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Voiding without difficulty. Denies any burning with urination. Hasn't voided yet this morning.</p>
<p>MUSCULOSKELETAL (1 points): ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: 2 Activity/Mobility Status: Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>There is no observed or reported muscle weakness and joint swelling or tenderness from the patient. All the patient's extremities are with symmetrical movement bilaterally.</p>

<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input checked="" type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC: DTRs:</p>	<p>Alert and oriented to person, place, time, and situation (x4). The patient’s speech is coherent, and their senses are intact. Upon assessment, PERRLA b/l. The patient’s strength is equal throughout. The patient follows commands, and motor responses are good. The patient’s deep tendon reflexes and within normal limits and reactive.</p>
<p>PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): Medication therapy Developmental level: Appropriate for age Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>The patient is taking ibuprofen for pain. The patient is alert and oriented x4 (person, place, time, and situation). Thought processes are coherent and memory is intact. Developmental level is appropriate for age. The patient does not practice a specific religion. The patient has support from mother and father. Mother is bedside.</p>
<p>Reproductive: (2 points) Fundal Height & Position: Bleeding amount: Lochia Color: Character: Episiotomy/Lacerations:</p>	<p>Fundus boggy 1 cm above umbilicus and deviated to the right. The patient states she has not yet changed her pad this morning, peri-pad is saturated with rubra lochia, small clots noted Perineum slightly bruised and swollen, small hemorrhoids noted.</p>
<p>DELIVERY INFO: (1 point) Rupture of Membranes: Time: Color: Amount: Odor: Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: 200 mL Male or Female Apgars: Weight: Feeding Method:</p>	<p>Membranes ruptured: Spontaneous Time: 1945 Color: Clear Amount: Moderate Odor: None Delivery Date: 11/16/2022 Time: 2032 Type: Vaginal QBL: 200mL Gender: Male Apgar: 8 at 1 minute and 9 at 5 minutes. Weight 7lb 0 oz Feeding Method: Breastfeeding</p>

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
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Prenatal	65	110/60	18	98.6	100% room air
Labor/Delivery	N/A	N/A	N/A	N/A	N/A
Postpartum	74	124/78	18	98.6	98% room air

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numerical	Perineum	3 on a 0-10 scale	“Sore”	Ice pack being applied
0920	Numerical	Abdomen	5 on a 0-10 scale	Cramping	Ibuprofen given.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: <i>Information not available</i> Location of IV: <i>Information not available</i> Date on IV: <i>Information not available</i> Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	Peripheral IV – Infusing medications. The dressing appeared clean, dry, and intact.

Intake and Output (2 points)

Intake	Output (in mL)
PO: 600mL (Water)	600mL

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
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nursing interventions with “N” after you list them, identify medical treatments with “M” after you list them.)		short rationale.
Pain medications (N)	Q8 hours	This intervention will help treat and reduce the symptom of pain that the patient is experiencing.
Ice Pack (N)	PRN	This will help alleviate perineal pain.
Administer Rubella Vaccine before discharge (M)(N)	Once	The patient’s rubella titer was nonimmune
Ambulate (N)	Q2 – as often as possible	This intervention helps reduce the risk of blood clots.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? Taking-in phase

What evidence supports this? The mother is in her first 48 hours of giving birth.

Discharge Planning (3 points)

Discharge location: The patient will discharge back home with her mom and dad.

Equipment needs (if applicable): Breast pump.

Follow up plan (include plan for mother AND newborn): The mother had an uncomplicated vaginal delivery. She will follow up with her provider for a complete checkup 6 weeks after giving birth.

Education needs: Newborn education | Breastfeeding education | Infection prevention

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)	Rational (1 pt each)	Intervention/Rational (2 per dx) (1 pt each)	Evaluation (2 pt each) How did the
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<p>Identify problems that are specific to this patient. Include full nursing diagnosis with “related to” and “as evidenced by” components</p>	<p>Explain why the nursing diagnosis was chosen</p>	<p>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.</p>	<p>patient/family respond to the nurse’s actions?</p> <ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications to plan.
<p>1. Acute pain related to related to hemorrhoids as evidence by patient verbally stating she had perineum pain rated at a 5/10 during time of assessment</p>	<p>The patient was having mild pain</p>	<p>1. Assess the patient's signs and symptoms of pain Q2 Rationale: Assessing the patient's pain allows for modifications to pain management methods (Phelps, 2020). 2. Return to patient to check intervention effectiveness 30 minutes after. Rationale: Build nurse patient trust (Phelps, 2020).</p>	<p>The patient finds the most effective pain relief measures The patient becomes comfortable and trust her nurse.</p>
<p>2. Risk for constipation as evidence by use of Colace and perineum pain related to hemorrhoids and episiotomy.</p>	<p>The patient was on medication to soften her stool</p>	<p>1. Monitor and record the patient’s stools Rationale: Monitoring will help form a treatment plan (Phelps, 2020). 2. Monitor and record input and output accurately Rationale: Monitoring intake will ensure the patient is getting enough fluids and promote elimination (Phelps, 2020).</p>	<p>The patient has a regular bowel elimination schedule She drinks 2,500 mL of fluid daily unless contraindicated by the physician.</p>
<p>3. Knowledge deficient related to breastfeeding as evidenced by first time breastfeeding.</p>	<p>It is important to provide education on breastfeeding as we do not want new moms to give up if it becomes difficult.</p>	<p>1. Educate the new mother with techniques for breastfeeding Rationale: Educating with techniques can enhance proper nutrition for the newborn (Phelps, 2020). 2. Offer information about the importance of breastfeeding and adequate nutrition. Rationale: Information will</p>	<p>The new mom understands the nutritional benefits from breastfeeding. The mother has been successful with breastfeeding so far and plans to continue with it.</p>

		help the mother meet the newborn’s demands for breast milk and adequate nutrition (Phelps, 2020).	
4. Knowledge deficient related to “newborn cues” as evidenced by first-time mother.	It is crucial for the new mother to learn for their newborn’s needs. This promotes a healthy neonate.	<p>1. Assist new parents in exploring coping methods for stress and ways to improve the health of their child. Rationale: this promotes healthy coping skills for the new parent(s) (Phelps, 2020).</p> <p>2. Have a discussion with the new parent(s) about how their actions can help improve their child’s health and behavior. Rationale: This can help decrease the pressure that the new parent(s) put on themselves and answer any questions that concern them (Phelps, 2020).</p>	The new parents understand and can spot the “newborn cues” and how to respond to these cues with ease and less stress.

Other References (APA)

Phelps, L.L. (2020). *Sparks and Taylor’s Nursing Diagnosis Reference Manual* (11th ed.).
 Wolters Kluwer.

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