N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission	Patient Initials	Age	Gender
02/08/2023 1851	CO	32	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Black/African American	Not Employed	Married	No Known Allergies
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full	5’ 2.99”	184 lb	Yes

Medical History (5 Points)

Prenatal History: $G^2T^2P^0A^0L^2$

Past Medical History: None according to patient.

Past Surgical History: Cesarean Section 5/2018.

Family History: None.

Social History (tobacco/alcohol/drugs): None.

Living Situation: Home with spouse and daughter.

Education Level: Bachelor’s Degree.

Admission Assessment

Chief Complaint (2 points): Spontaneous rupture of membranes with contractions.

Presentation to Labor & Delivery (10 points):.

32yo, $G^2T^2L^2$ patient presented to labor and delivery with a rupture of membranes. The patient experienced lower abdomen pain. The patient was evaluated upon presentation. The patient desired a VBAC, which failed due to non-reassuring fetal heart tones. Labor progressed

quickly. Due to non-reassuring fetal heart tones, the patient was sent to the operating room for a cesarean section. The patient has a history of an emergency cesarean section in Kenya due to non-reassuring fetal status. Patient GBS negative as of 02/20/2023.

Diagnosis

Primary Diagnosis on Admission (2 points): Labor

Secondary Diagnosis (if applicable): History of previous cesarean section.

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 10^6/uL	4.39 10^6/uL	4.39 10^6/uL	3.51 10^6/uL	Result within normal limits.
Hgb	11.0-16.0 g/dL	13.3 g/dL	13.3 g/dL	11.2 g/dL	Result within normal limits.
Hct	34.0-47%	38.9%	38.9%	33.7%	Several studies have concluded that the volume of blood that is lost during delivery is the best indicator of postpartum hematocrit level (Ricci et al., 2021).
Platelets	140-400 10^3/uL	212 10^3/uL	212 10^3/uL	154 10^3/uL	Result within normal limits.
WBC	4.00-11.00 10^3/uL	13.15 10^3/uL	13.15 10^3/uL	11.68 10^3/uL	Women experience a 50% increase in their blood volume during pregnancy but only a 30% increase in the number of red blood cells (The Mothers Program, n.d.).
Neutrophils	1.60-7.70 10^3/uL	10.27 10^3/uL	10.27 10^3/uL	9.80 103/uL	Women experience a 50% increase in their blood volume during pregnancy

					but only a 30% increase in the number of red blood cells (The Mothers Program, n.d.).
Lymphocytes	20%-40%	13.9%	13.9%	10.3%	Several studies have concluded that the volume of blood that is lost during delivery is the best indicator of postpartum hematocrit level (Ricci et al., 2021).
Monocytes	2%-8%	6.5%	6.5%	5.1%	Result within normal limits.
Eosinophils	0%-5%	0.5%	0.5%	0.1%	Result within normal limits.
Bands	0% - 3%	N/A	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+-, O+-,AB +-	O+	O+	O+	Result within normal limits.
Rh Factor	Positive	Positive	Positive	Positive	Result within normal limits.
Serology (RPR/VDRL)	Non-Reactive	Non-Reactive	Non-Reactive	Non-Reactive	Result within normal limits.
Rubella Titer	Negative	In Process	In Process	In Process	N/A
HIV	Non-Reactive	Non-Reactive	Non-Reactive	Non-Reactive	Result within normal limits.
HbSAG	Negative	Negative	Negative	Negative	Result within normal limits.
Group Beta Strep Swab	Positive & Negative	Negative	Negative	Negative	Result within normal limits.
Glucose at 28 Weeks	↓ 140	136	136	136	Result within normal limits.
MSAFP (If Applicable)	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

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
Rupture of Membrane Test	Negative	N/A	Positive	Positive	Premature rupture of membranes (PROM) occurs when the amniotic sac that surrounds the baby (the membrane) breaks before the start of labor (Ricci et al., 2021).
Sickle Cell Screen	Negative	Positive	Positive	Positive	Sickle cell anemia during pregnancy is associated with more sever anemia and frequent vaso-occlusive crises with increased maternal and perinatal morbidity and mortality (Ricci et al., 2021).
Cystic Fibrosis Screen	Negative	Negative	Negative	Negative	Result within normal limits.
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)	20-275 mg/dL	N/A	N/A	N/A	N/A

Lab Reference (1) (APA):

Carle Database. (2023).

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

The Mothers Program. (n.d.) *1st Trimester*. Retrieved February 13, 2023, from https://www.themothersprogram.ca/during-pregnancy/prenatal-tests/1st-trimester#:~:text=Complete%20Blood%20Count%20(CBC)%20and%20Anemia&text=Because%20of%20the%20normal%20changes,number%20of%20red%20blood%20cells.

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

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	**4 hours** **Spontaneous** **Stage 1: 4 hours** **Stage 2: Patient did not experience due to cesarean section.** **Stage 3: 0h 1m**
Current stage of labor	The early postpartum hours, which are also sometimes referred to

	as the fourth stage of labor, signal the beginning of recovery. Blood pressure, respirations, and blood loss are monitored for the remainder the patient's hospital stay. To encourage contractions and stop bleeding, a nurse may massage the patient's abdomen as well as monitor and manage pain. The patient may experience shivers or shakes. Research by Hutchinson et al. (2022) supports the third stage of labor commences when the fetus is delivered and concludes with the delivery of the placenta. Separation of the placenta from the uterine interface is hallmarked by three cardinal signs, including a gush of blood at the vagina, lengthening of the umbilical cord, and a globular shaped uterine fundus on palpation. Spontaneous expulsion of the placenta typically takes between 5 to 30 minutes. A delivery time of greater than 30 minutes is associated with a higher risk of postpartum hemorrhage and may be an indication for manual removal or other intervention. Management of the third stage of labor involves placing traction on the umbilical cord with simultaneous fundal pressure to effect faster placental delivery. According to Ricci et al. (2021), if the uterus becomes boggy, it is massage to keep it firm. The vaginal discharge is red, mixed with small clots and of moderate flow.

Stage of Labor References (2) (APA):

Hutchison, J., Mahdy, H., Hutchison, J. (2022). Stages of Labor. *StatPearls Publishing.*

https://www.ncbi.nlm.nih.gov/books/NBK544290/

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	Kenalog (triamcinolone)	Iron Asparto (prenatal vitamin)			
Dose	0.1%	29mg			
Frequency	2 times twice a Day	Once daily			
Route	Topical	Oral			
Classification	Pharmacologic class: Glucocorticoid Therapeutic class: Corticosteroid	Pharmacologic class: Iron product Therapeutic class: Vitamin and mineral combination			
Mechanism of Action	Inhibits histamine and kinin release, preventing the formation of scar tissue.	Prenatal vitamins give you extra amounts of these three key nutrients for pregnant women: Folic acid helps your baby's brain and spinal cord develop correctly. This nutrient reduces the risk of serious birth defects called spina bifida and anencephaly. Calcium protects your bones as your baby grows.			
Reason Client	To treat a multitude	Used to treat or			

Taking	of disorders exhibiting severe inflammation or need for immunosuppression.	prevent vitamin deficiency due to poor diet, certain illness, or during pregnancy.			
Contraindications (2)	1. Hypersensitivity to triamcinolone or its components. 2. Idiopathic thrombocytopenic purpura.	1. Hypersensitivity to soy 2. Vitamin B_{12} deficiency			
Side Effects/Adverse Reactions (2)	1. Vaginal hemorrhage. 2. Pruritus.	1. Skin dryness or peeling. 2. Easy bruising.			
Nursing Considerations (2)	1. Use with caution only if benefit to mother outweighs potential risk to fetus. 2. Patient should check with prescribers before breastfeeding because drug could interfere with endogenous corticosteroid production, suppress growth, or cause other adverse reactions.	1. Take your prenatal multivitamin with a full glass of water. 2. Many multivitamin products also contain minerals such as calcium, iron, magnesium, potassium and zinc. Minerals (especially takin in large doses) can cause side effect such as tooth staining, increased urination stomach bleeding, uneven heart rate, confusion, and muscle weakness of limp feeling.			
Key Nursing Assessment(s)/Lab(s	• Obtain and score EPDS	• Monitor BMP			

) Prior to Administration	• Monitor CBC labs • ACTH Stimulation Test	labs			
Client Teaching needs (2)	1. Inform patient that maximum benefit of triamcinolone therapy may not occur for up to two weeks. 2. Caution patient to avoid exposure to people who have chickenpox or measles, as well as other contagious infections, throughout triamcinolone therapy and for 12 months afterward.	1. Prenatal vitamins should be stored out of reach of children and in child resistant bottles. 2. Sever iron toxicity many occur in overdose.			

Hospital Medications (5 required)

Brand/Generic	Toradol (ketorolac tromethamine)	Prochlorperazine (compro)	Black Draught (senna)	Tylenol (Acetaminophen)	Pitocin (oxytocin)
Dose	15mg	10mg	15mg	650mg	1 to 2 mU/min
Frequency	Every 6 hours	Every 6 hours	PRN	Every 8 hours	Every 30 to 60 minutes as needed
Route	IV Push	Oral	Oral	Oral	IV
Classification	Pharmacologic class: NSAID Therapeutic class: Analgesic	Pharmacologic class: Piperazephenothiazine Therapeutic	Pharmacologic class: Laxative Therapeutic class: Laxative	Pharmacologic class: Nonsalicylate, para-aminophenol derivative	Pharmacologic class: Uterotonic agent Therapeutic class:

		class: Antiemetic		Therapeutic class: Antipyretic, nonopioid analgesic	Oxytocic Agent
Mechanism of Action	Blocks cyclooxygenase, an enzyme needed to synthesize prostaglandins.	Alleviates nausea and vomiting by centrally black dopamine receptors in the medullary chemoreceptor trigger zone and by peripherally blocking the vagus nerve in the GI tract.	Works by irritating luminal sensory nerve endings, thereby stimulating colonic motility and reducing colonic water absorption.	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin $E_{2.}$	Increases intracellular calcium in uterine smooth muscle, which causes uterine muscle contraction.
Reason Client Taking	To treat moderate to severe pain that requires analgesia at the opioid level.	To control nausea and vomiting related to surgery.	To help relieve constipation	To relieve mild to moderate pain	To initiate or improve uterine contractions in situations where there are fetal or maternal concerns, so as to achieve a vaginal delivery
Contraindications (2)	1. High risk of bleeding	1. Hypersensiti	1. Fecal impaction	1. Use of drug at any	1. Fetal presentation,

	2. Labor and delivery	vity to prochlorperazine 2. Severe CNS depression	2. Acute surgical abdomen	time during pregnancy may increase risk attention deficit hyperactivity disorder (ADHD) after birth 2. Drug may reduce fertility in females and males.	unfavorable. 2. Inadequate labor progress with adequate contractions.
Side Effects/Adverse Reactions (2)	1. Urine retention 2. Coma	1. Hypotension 2. Tachycardia	1. Stomach pain 2. Black, tarry stools	1. Hypertension 2. Headache	1. Nausea 2. Stomach pain
Nursing Considerations (2)	1. Know that the risk of heart failure increases with ketorolac use because drug is a NSAID. 2. Notify prescriber if pain relief is inadequate or if breakthrough pain occurs between doses because supplemental doses of an opioid analgesic may be required.	1. Patient should check with provider before breastfeeding. 2. Drug may cause fetal harm.	1. Although small amounts of senna cross into breast milk, it doesn't seem to be a problem for nursing babies. As long as the mother uses senna in recommended amounts, senna does not cause changes in the frequency or consistency of babies' stools.	1. Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment. 2. Calculate total daily intake of acetaminophen including other products that may contain acetaminophen so maximum	1. May cause painful contractions. 2. May cause coma and seizures in mother.

			2. Electrolyte disturbance and potassium deficiency can make conditions worse with Senna overuse.	daily dosage is not exceeded.	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	• AST • ALT	• CBC • CMP	• Urine culture • Hg B	• CBC • CMP	• Monitor fetal heart rate pattern • Monitor blood pressure • Assess pulse • Assess respiratory Rate
Client Teaching needs (2)	1. Drug may affect fetal circulation and inhibit uterine contractions. 2. Use of drug is contraindicated during labor and delivery.	1. Drug may cause fetal harm. 2. Use with caution only if benefit to mother outweighs potential risk to fetus.	1. Stop Senna if you experience rectal bleeding, no bowel movement within 12 hours of using Senna or if you experience constipation. 2. Get	1. Tell patient that tablets may be crushed or swallowed whole but that extended-release forms should not be broken, chewed, crushed, or split. 2. Teach patient to recognize	1. Advise patient to report headache, dizziness, palpitations, or intense pain. 2. Advise patient that Pitocin can cause her contractions to start off stronger and faster than those that

			emergency help is signs of allergic reaction are experience to include hives and difficulty breathing.	signs of hepatoxicity, such as bleeding, easy bruising, and malaise, which commonly occurs with chronic overdose.	would have begun naturally.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2022). *2022 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Osmosis from Elsevier. (n.d.). *Neonatal eye prophylaxis: Nursing pharmacology*. Retrieved February 13, 2023, from https://www.osmosis.org/learn/Oxytocin:_Nursing_Pharmacology

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Alert Person, Place, Time, Location Pain around cesarean incision Clean, well groomed.
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** 20 **Drains present: Y☐ N ☒** **Type:**	 Brown Clean and dry Warm to touch Elastic No rashes upon assessment Slight bruising around cesarean section bandage Incision covered with clean and dry bandage
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Symmetrical with skull and face Ears not assessed Eyes not assessed Nose not assessed Teeth not assessed
CARDIOVASCULAR (2 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	 S1, S2 Cardiac rhythm not assessed Pulses 3+ bilaterally Capillary refill less than 3 seconds bilaterally
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	 Clear without wheezing or crackles
GASTROINTESTINAL (2 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:**	 Regular Diet Regular Diet 5’ 2.99” 184 lb Hypoactive Two days ago None

Inspection: **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	 None Left Transverse Cesarean Incision Scar None Cesarean incision wound
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	 Patient has not had urine output since delivery. Normal post delivery appearance.
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** 0 **Activity/Mobility Status:** **Independent (up ad lib)** X **Needs assistance with equipment** ☐ **Needs support to stand and walk** X	 Activity as tolerated Cesarean Section-Ambulation Assistance
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:**	 Person, Place, Time, Location Normal Cognition Clear, slight language barrier Normal Alert 2 bilaterally-normal
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):**	 Social Support, Religious Coping Intimacy vs. Isolation Catholic Family supportive, home environment safe.
Reproductive: (2 points)	

Fundal Height & Position:	1 Below, Midline
Bleeding amount:	Moderate
Lochia Color:	Red
Character:	Normal
Episiotomy/Lacerations:	Left Transverse Incision
DELIVERY INFO: (1 point)	
Rupture of Membranes:	Spontaneous
Time:	2122
Color:	Clear
Amount:	Not Documented
Odor:	None
Delivery Date:	02/08/2023
Time:	2322
Type (vaginal/cesarean):	Cesarean
Quantitative Blood Loss:	320 mL
Male or Female	Female
Apgars:	8/9
Weight:	6 lbs. 5.6oz. (2880 g)
Feeding Method:	Breastfeeding

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	N/A	102/62	N/A	N/A	N/A
Labor/Delivery	84 bpm	126/57	Not Documented	98.6 °F	100-room air
Postpartum	73 bpm	97/56	20 breaths/min	98.3 °F	98-room air

Vital Sign Trends: The patient's pulse trended down by eleven points. Labor and delivery are stressful times that can cause heart rate elevation. The patient's blood pressure trended down. A cesarean can provoke anxiety which can increase blood pressure. The patient's temperature and oxygen levels also trended down. The patient is no longer under the stress of labor, so her temperature has decreased, and her breathing has returned to a more normal value.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1030	5	Lower Abdomen	Moderate	Sharp	Tylenol/Changing Positions
1155	4	Lower Abdomen	Moderate	Sharp	Tylenol/Changing Positions

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	18 gauge
Location of IV:	Anterior; Lower; Proximal; Right Forearm
Date on IV:	02/08/2023
Patency of IV:	Patent/Saline Lock
Signs of erythema, drainage, etc.:	None
IV dressing assessment:	Clean, dry

Intake and Output (2 points)

Intake	Output (in mL)
Eating a regular diet, up and moving around as tolerated.	Patient has not voided since cesarean section was performed.

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.
Ambulating	As early as six to eight hours post-	Early ambulation is advantageous for patients because it lowers the risk of

	surgery.	deep vein thrombosis, boosts the rate of breastfeeding, encourages better food and nutrition, and raises patient satisfaction.
Abdominal Binder	Early postpartum, wear the abdominal binder 4-6 hours per day, and as the binder becomes more comfortable, increase the wear time to 8-12 hours per day.	After your procedure, a binder will offer some comfort, light compression, and perhaps even some pain relief, all of which may aid in the healing process.
Sleeping on your back/changing positions	When sleeping or napping.	A great alternative for patients recovering from abdominal surgery because it makes getting in and out of bed simpler and doesn't place additional strain on your incision.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? Fourth Stage

What evidence supports this? The patient has completed the expulsion of the placenta and membranes. The patient has begun the attachment process and is breastfeeding and cuddling her newborn. The patient's fundus is midline and one below.

Discharge Planning (3 points)

Discharge location: Home with spouse and daughter.

Equipment needs (if applicable): Breast pump.

Follow up plan (include plan for mother AND newborn): The patient is to increase daily activities gradually—no lifting over ten pounds or strenuous activity for four weeks. Drink plenty of water. Eat high-fiber foods to maintain regular bowel movements—shower instead of bathing. Clean the perineal area with soap and water only. Change peri pads regularly-bleeding may continue for up to six weeks—abstain from sexual intercourse for the first six weeks after delivery. The patient is to follow up two weeks after the post-cesarean section for a post-partum exam with your OB physician to inspect the incision. The patient is to follow up with the OB physician again at six weeks post-partum to be released to resume normal activities and discuss birth control options.

The newborn baby girl is to follow up within twenty-four hours with a pediatrician to discuss infant health.

Education needs: Co-sleeping, SIDS, post birth warning signs, wound care, infection prevention, heaving bleeding-soaking on large peri pad within an hour, and oral temperature monitoring.

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	**Rational (1 pt each)** Explain why the nursing diagnosis was	**Intervention/Rational (2 per dx) (1 pt each)** Interventions should be specific and individualized for his patient. Be sure to	**Evaluation (2 pt each)** How did the patient/family respond to the nurse's actions? • Client response,

full nursing diagnosis with "related to" and "as evidenced by" components	chosen	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.	status of goals and outcomes, modifications to plan.
1. Risk for infection related to cesarean section incision as evidenced by alteration to skin integrity.	Patients cesarean section is a risk factor identified which predisposes patient to infection.	1. Instruct patient to clean perineum area with peri bottle after each void to help control the possibility of infection (Phelps, 2020). 2. Maintain standard precautions. Wear gloves if you might come in contact with the patient's blood and body secretions (Phelps, 2020).	The patient responded with a nod of understanding. The patient performed hand hygiene after she attempted to void.
2. Risk for sudden infant death syndrome related to incorrect sleeping health as evidenced by infant place in side-lying position to sleep	The patient was adding a blanket to the hospital infant sleeper as well as covering the infant with a blanket to assist in sleep.	1. Educate family about the risk factors of sudden infant death syndrome (SIDS) so that they'll be aware of the current practices to reduce risk and prevent its occurrence (Phelps, 2020). 2. Teach parents to avoid having loose blankets, toys, or other articles in the crib to decrease the risk of accidental suffocation (Phelps, 2020).	Patient expressed understanding of evidenced based practice with a nod and a smile.
3. Knowledge deficit related to safe sleep education as evidenced by patient sleeping with infant in hospital bed.	The patient was co-sleeping with the infant after the infant breastfed. The patient was asleep, and the infant was sleeping under the breast.	1. Communication open and honestly with patient (Phelps, 2020). 2. Don't place unrealistic demands on patient to avoid exacerbating feelings of inadequacy and anxiety (Phelps, 2020).	The patient expressed motivation to learn. The patient inquired about how the infant should sleep, side laying or on the back. Informed on the back and demonstrated with the infant.
4. Knowledge	The patient felt	1.	The patient stated

deficit related to ambulation as evidenced by patients' resistance to ambulating to urinate though patient's bladder felt full.	pain when changing positions in bed; though her bladder was full, she didn't want to ambulate to use the restroom.	Have patient practice ambulating. Provide positive reinforcement each time the patient ambulates (Phelps, 2020). 2. Provide written materials explaining skills patient is trying to develop and facts patient must remember (Phelps, 2020).	understanding of the need to urinate to prevent damage to the bladder muscles. The patient said she would attempt ambulation when she felt the urge and press her call light if she needed assistance.

Other References (APA)

Phelps, L.L. (2020*). Sparks and Taylor's nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.