

N432 Postpartum Care Plan

Destiny Bell

Lakeview College of Nursing

N432: Maternal-Newborn Care

Professor Debra Kamradt

6/27/23

Demographics (3 points)

<u>Date & Time of Admission</u> 6/19/23; 1602	<u>Patient Initials</u> S.F	<u>Age</u> 24 years old	<u>Gender</u> Female
<u>Race/Ethnicity</u> Caucasian	<u>Occupation</u> Manager at JoAnn Fabrics	<u>Marital Status</u> Married	<u>Allergies</u> None
<u>Code Status</u> Full code	<u>Height</u> 170.2 cm; 5ft 7in	<u>Weight</u> 136.8kg; 301 lbs. 9.6 oz	<u>Father of Baby Involved</u> Yes

Medical History (5 Points)

Prenatal History: G1P1001

Past Medical History: Abscess of the abdominal wall (1/24/22)

Past Surgical History: Tonsillectomy (No known date), Myringotomy with tubes (no known date), Abscess drainage (no known date), C-section (6/20/23)

Family History: Paternal grandfather; diabetes mellitus

Social History (tobacco/alcohol/drugs): Denies any tobacco, alcohol, or recreational drug use

Living Situation: Lives at home with her spouse, who is also the baby's father.

Education Level: High school diploma

Admission Assessment

Chief Complaint (2 points): Scheduled induction of labor (IOL)

Presentation to Labor & Delivery (10 points): S.F. is a 24-year-old Caucasian female who presented to labor and delivery on 6/19/23 at 37 weeks 0 days gestation for a scheduled induction of labor. Patient was seen in her ob/gyn clinic prior to arriving to labor and delivery for a routine prenatal visit in which her blood pressure was elevated at 154/98, which placed her in criteria for gestational hypertension and gestational diabetes.

Diagnosis

Primary Diagnosis on Admission (2 points): Labor Induction at 37 weeks, 0 days

Secondary Diagnosis (if applicable): Gestational hypertension

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	3.80-5.30 10(6)/uL	4.47 uL	4.59 uL	3.72 uL	RBCs are within normal limits
Hgb	11.0-16.0 g/dL	13.6 g/dL	14.0 g/dL	11.5 g/dL	Hgb is within normal limits
Hct	34-47%	41.2%	39.5%	32.6%	Blood loss from c-section
Platelets	140-440 10(3)/uL	184 uL	216 uL	201 uL	Platelets are within normal limits
WBC	4.0-11.0 10(3)/uL	11.88 uL	12.87 uL	23.05 uL	Increased WBC count can be a sign of infection or a trauma response due to her recent c-section (Pagan et al., 2018).
Neutrophils	47.0-	N/A	N/A	N/A	Neutrophils were not

	73.0%				obtained.
Lymphocytes	18.0-42.0%	25.9%	N/A	7.5	Decreased lymphocyte levels could be due to trauma from her c-section (Pagana et al., 2018)
Monocytes	4.0-12.0%	4.0%	N/A	4.7%	Monocytes are within normal limits.
Eosinophils	0.0-5.0%	0.5%	N/A	0.0%	Eosinophils are within normal limits
Bands	N/A	N/A	N/A	N/A	Bands were not obtained

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	Varies between A, B, AB, O	O	N/A	N/A	The blood type is normal
Rh Factor	VARIABLES Negative or positive	Positive	N/A	N/A	Rh factor is normal.
Serology (RPR/VDRL)	Non-reactive	Non-reactive	N/A	N/A	Serology is normal.
Rubella Titer	<0.09= not immune. 0.90-0.99; equivocal >Or = 1.00; immune	1.08	N/A	N/A	Rubella titer is normal, patient is immune.
HIV	Non-reactive	Non-reactive	N/A	N/A	HIV is normal.
HbSAG	Non-reactive	Non-reactive	N/A	N/A	HbSAG is normal.
Group Beta Strep Swab	Negative	Negative	N/A	N/A	Group B strep swab is normal.
Glucose at 28 Weeks	60-99	205	99	N/A	Glucose level was elevated related to the

					patient's diagnosis of gestational diabetes (Pagana et al., 2018).
MSAFP (if Applicable)	N/A	N/A	N/A	N/A	MSAFP was not obtained.

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

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)	N/A	N/A	N/A	N/A	Urine creatinine was not obtained.

Lab Reference (1) (APA):

Pagana, K.D. & Pagana T.J. (2018) *Mosby's Diagnostic and Laboratory Test Reference* (6th ed.). Mosby.

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

	Your Assessment
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<p>History of labor:</p> <p>Length of labor</p> <p>Induced /spontaneous</p> <p>Time in each stage</p>	<p>The patient had a spontaneous, induced labor that resulted in a c-section.</p> <p>The total length of labor was 19 hours and 55 minutes.</p> <p>1st stage: 10 hours 55 minutes</p> <p>2nd stage: 8 hours and 15 minutes (failure to progress)</p> <p>3rd stage: 0 hours and 45 minutes (c-section time)</p>
<p>Current stage of labor</p>	<p>Stage 4: Postpartum</p> <p>This stage begins after the placenta is expelled. The patient's fundus should be firm and at the midline of the umbilicus region (Pagana et al., 2018). It is important to assess and monitor the mother for hemorrhaging during this time. Prior to discharge the patient's vital signs should be assessed every 6 hours, or per doctor's order (Phelps, 2017).</p>

Stage of Labor References (2) (APA):

Pagana, K.D. & Pagana T.J. (2018) *Mosby's Diagnostic and Laboratory Test Reference (6th ed.)*. Mosby.

Taylor, C. M., Ralph, S. S., & Phelps, L. L. (2017). *Sparks & Taylor's Nursing Diagnosis Reference Manual*. Wolters Kluwer.

**Current Medications (7 points, 1 point per completed med)
*7 different medications must be completed***

Home Medications (2 required)

Brand/Generic	Ibuprofen	Acetaminophen			
Dose	600mg	1000mg			
Frequency	Every 6 hours	Every 6 hours			
Route	Oral	Oral			
Classification	NSAID ANALGESIC (Jones & Bartlett Learning, 2021).	Pharmacological class; Nonsalicylate, paraminophenol derivative Therapeutic class; Antipyretic, non-opioid analgesic Pregnancy class: B (Jones & Bartlett Learning, 2021).			
Mechanism of Action	Blocks activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain, swelling and vasodilation. By inhibiting prostaglandins, this NSAID reduces inflammatory symptoms and relieves pain (Jones & Bartlett Learning, 2021)	Inhibits the enzyme cyclooxygenase blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on the temperature regulating center in the hypothalamus by inhibiting synthesis of the prostaglandin E2 (Jones & Bartlett Learning, 2021).			
Reason Client Taking	To relieve pain	To manage pain			
Contraindications (2)	Angioedema, asthma,	Hypersensitivity to acetaminophen or its			

	<p>bronchospasm</p> <p>Hypersensitivity to ibuprofen, its components or other pain relievers (Jones & Bartlett Learning, 2021).</p>	<p>components, severe hepatic impairment, severe active liver disease (Jones & Bartlett Learning, 2021).</p>			
Side Effects/Adverse Reactions (2)	<p>CNS: Aseptic meningitis, Seizures</p> <p>CV: Heart failure, MI (Jones & Bartlett Learning, 2021).</p>	<p>CV: Hypotension</p> <p>EENT: Stridor (Parenteral form)</p> <p>Other: Hypokalemia, hypomagnesemia</p>			
Nursing Considerations (2)	<p>Ibuprofen should not be used in pregnant woman under 30 weeks' gestation due to the risk for premature closure of the ductus arteriosus in the fetus. Ibuprofen should be avoided in patient's whom have experienced a recent myocardial infarction due to risk of reinfarction. (Jones & Bartlett Learning, 2021).</p>	<p>Know that before and during long term therapy including parenteral therapy, liver function tests such as AST, ALT, should be monitored because acetaminophen may cause hepatotoxicity. Monitor renal function in patient's on long term therapy as blood or albumin in the urine can indicate nephritis (Jones & Bartlett Learning, 2021).</p>			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	<p>Monitor liver enzymes as elevated levels could lead to</p>	<p>During long-term therapy use the nurse should monitor liver function test results,</p>			

	hepatic failure or liver necrosis; monitor BUN, creatine, and CBC (Jones & Bartlett Learning, 2021).	including AST, ALT, bilirubin, and creatinine levels, as well as monitor renal function (Jones & Bartlett Learning, 2021).			
Client Teaching needs (2)	Take this medication with a full glass of water; take with food or after meals to avoid GI distress (Jones & Bartlett Learning, 2021).	Do not exceed more than 4,000mg per day due to risk of liver failure, tablets can be taken crushed or whole (Jones & Bartlett Learning, 2021).			

Hospital Medications (5 required)

Brand/Generic	Dulcolax/ bisacodyl	Enoxaparin	Ondansetron	Prenatal Vitamin/ Vit- Sel-Iron Fumate- Folic Acid	N/ A
Dose	10mg	40mg	4mg	27mg	
Frequency	PRN daily	Daily	PRN DAILY	Once a day	
Route	Oral; By Mouth	Subcutaneous injection	IV PUSH	Oral; By mouth	
Classification	Laxative; stimulant laxative (Jones & Bartlett Learning, 2021).	Low molecular weight heparin; Anticoagulant (Jones & Bartlett Learning, 2021).	Selective serotonin receptor antagonist; Antiemetic (Jones & Bartlett Learning, 2021).	Vitamin and mineral	
Mechanism of Action	Stimulates peristalsis while altering fluid and electrolyte transportation thus producing	Potentiates the action of antithrombin III, a coagulation inhibitor. By binding the antithrombin III, enoxaparin	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the	Assists in providing the fetus with more folic acid and iron to avoid the chance of neural tube	

	fluid accumulates in the colon (Jones & Bartlett Learning, 2021).	rapidly binds with and inactivates clotting factors (Jones & Bartlett Learning, 2021).	intestine. This action reduces nausea and vomiting by preventing serotonin release (Jones & Bartlett Learning, 2021).	defects (Jones & Bartlett Learning, 2021).	
Reason Client Taking	Constipation	To prevent DVT	Nausea/vomiting	Pregnancy	
Contraindications (2)	Abdominal pain, nausea/vomiting, obstruction (Jones & Bartlett Learning, 2021).	Active major bleeding; history of heparin induced thrombocytopenia	Concomitant use of apomorphine, congenital long QT syndrome (Jones & Bartlett Learning, 2021).	Hypersensitivity to any components of the prenatal vitamin. High levels of iron throughout the body (Jones & Bartlett Learning, 2021).	
Side Effects/Adverse Reactions (2)	Abdominal cramps and hypokalemia (Jones & Bartlett Learning, 2021).	CV ; atrial fibrillation HEME : hemorrhage Other ; hyperkalemia (Jones & Bartlett Learning, 2021).	CV: chest pain GI; abdominal pain GU; hematuria (Jones & Bartlett Learning, 2021).	Anaphylaxis and fever (Jones & Bartlett Learning, 2021).	
Nursing Considerations (2)	For more rapid results take the medication on an empty stomach; can be taken either at nighttime or in the morning (Jones & Bartlett Learning, 2021)	Use with extreme caution in patients with an increased risk of hemorrhage; Know that multidose vials should be avoided if possible, in pregnant women because benzyl alcohol can cross the placenta and cause fetal harm (Jones & Bartlett Learning, 2021).	Know that if hypokalemia or hypomagnesemia are present these should be corrected prior to administration; Monitor patient closely for signs of hypersensitivity such as an allergic reaction (Jones & Bartlett Learning, 2021).	Assess for signs of an allergic reactions; assess to signs of constipation (Jones & Bartlett Learning, 2021).	
Key Nursing Assessment(s)/Lab(s) Prior to	Assess the patient for the presence of	Watch closely for bleeding; monitor platelet	Monitor patient's electrocardiogram as arrhythmias	Monitor folic acid levels as well as Iron	

Administration	bowel sounds and usual pattern of bowel function; assess color, consistency and the amount of stool produced (Jones & Bartlett Learning, 2021)	count and notify provider if platelets are under 100,000/mm ³ (Jones & Bartlett Learning, 2021).	can occur; Monitor patient for signs of an allergic reaction (Jones & Bartlett Learning, 2021).	levels (Jones & Bartlett Learning, 2021).	
Client Teaching needs (2)	Increase fluid intake to about 1500-2000 mL/day to prevent dehydration (Jones & Bartlett Learning, 2021).	Inform patient that they may bruise and/or bleed more easily and that it may take longer than usual to stop the bleeding; Caution patient not to rub the site after administering the injection to help minimize bruising (Jones & Bartlett Learning, 2021).	Advise patient to report signs of hypersensitivity immediately such as a rash; Reassure patient's with transient blindness that it will resolve within a few minutes to 48 hours (Jones & Bartlett Learning, 2021).	Start a prenatal prior to conception if actively trying to conceive and if GI upset occurs while taking the medication in the morning they can take later in the day or at bedtime (Jones & Bartlett Learning, 2021).	

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2022 Nurse's Drug Handbook* (Jones & Bartlett Learning, Ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:	The patient is alert and orientated x4 (person, place, time, and situation). Patient is well-groomed and appears to be in no apparent distress.
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INTEGUMENTARY (1 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Skin is warm, dry and intact. No bruises or rashes noted. Large abdominal incision noted in the lower abdomen; no drainage noted.
HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:	
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 type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:	S1 and S2 present. No murmurs or gallops noted. Patient is in a regular rate and rhythm. Peripheral pulses 3+ bilaterally, capillary refill is < 2 seconds
RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character	Lungs are clear to auscultation bilaterally, no wheezes or crackles noted.
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 is on a Regular diet at home. Patient's current diet is regular. Patient is 5 foot, 7 inches Patient weighs 301 pounds, 9.6 ounces Bowel sounds are active and heard throughout all quadrants; Normoactive. Patient's last bowel movement was 6/21/23. Patient has no mass or organomegaly upon palpation, mild pain upon palpation related to incision site. Abdomen is distended with an incision noted on the lower abdomen. No other scars, drains, or wounds noted.

GENITOURINARY (2 Points): Quantity of urine: Pain with urination: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:	Patient reports voiding x 3 times, Patient reports pain with urination. Inspection of genitals; episiotomy
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: Activity/Mobility Status: Independent (up ad lib) X Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/>	Patient is independent in ADLs.
NEUROLOGICAL (2 points): MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC: DTRs:	Unable to assess all of neuro; Patient has 5/5 strength in bilateral upper and lower extremities. Patient is alert and orientated x 4. Patient's speech is normal, no slurred speech.
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):	Active listening, decision-making, positive reinforcement, self-care, verbalization of feelings. Significant other very supportive.
Reproductive: (2 points) Fundal Height & Position: Bleeding amount: Lochia Color: Character: Episiotomy/Lacerations:	Fundus is firm and below the umbilicus. There is minimal bleeding present. Lochia color- rubra Character- similar to menstrual flow 2nd degree perineal laceration that has been repaired
DELIVERY INFO: (1 point) Rupture of Membranes: Time: Color: Amount: Odor:	Rupture of Membranes: 06/19/2023 Time: 1834 Color: clear Amount: moderate Odor: none Delivery Date: 06/20/2023

Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:	Time: 1157 Type (vaginal/cesarean): cesarean Quantitative Blood Loss: 240 mL Male or Female: Male Apgars: 9/10 Weight: 8 lb, 1.4oz Feeding Method: breast
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Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	86 bpm	132/98	18	97.8 F	99% room air
Labor/Delivery	82 bpm	116/78	18	98.4 F	99% Room air
Postpartum	75 bpm	128/74	18	98.2 F	97% room air

Vital Sign Trends: No significant changes, blood pressure in her prenatal visit was elevated but has since decreased.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numerical	Stomach	2	Achy	Acetaminophen given
1100	Numerical	N/A	0	Denies presence of pain	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:	Size of IV: 20 g Location of IV: left lower forearm Date on IV: 06/19/2023 Patency of IV: intact & patent; saline lock Signs of erythema, drainage, etc.: None IV dressing assessment: intact

Intake and Output (2 points)

Intake	Output (in mL)
Breakfast; 100% consumed	Patient reports she voided x 3

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.
Encouragement of breastfeeding. (N)	Every 1 to 2 hours	Post discharge the infant should be eating every 1 to 2 hours (Capriotti, 2020).
Assessment for postpartum depression (N)	Weekly	Postpartum blues are likely to occur due to increased hormones post birth (Capriotti, 2020).
The baby went to spend a night in the nursery (N)	One night	This allowed for the patient to obtain some rest after her c-section, once baby was returned to the room the mother appeared well rested and

		had the assistance of her spouse in caring for the newborn.
Educate the patient on the importance of taking medication as prescribed and how and when to take OTC medications such as acetaminophen and ibuprofen. Be sure to alternate between the two and not take them at the same time. (M)	Acetaminophen can be taken every 6 hours, the patient should not exceed more than 4,000mg in a day.	Acetaminophen and Ibuprofen should NOT be taken together at the same time due to increased risk of kidney damage (Capriotti, 2020).

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? Dependent Taking- in phase in the process of transitioning into the taking-hold phase.

What evidence supports this? The patient is prioritizing her recovery, the patient's spouse has assisted with caring for the newborn as well as the baby has spent a night in the nursery so the patient could get some rest.

Discharge Planning (3 points)

Discharge location: Home with her husband.

Equipment needs (if applicable): The mother needs a breast pump; the hospital supplied her with one.

Follow up plan (include plan for mother AND newborn): Baby's first appointment has been scheduled for 2 days post discharge from the hospital. The mother will be receiving a phone call from her OB office just to check in on her and to assess for any depression. The mother's postpartum visit is at six weeks post-discharge from the hospital. The mother was informed about taking it easy, no sexual intercourse or

anything in the vagina for six weeks, and resting when needed. Parents should take the newborn to all scheduled visits and keep vaccinations current.

Education needs: Safe sleeping techniques for newborns, the importance of vaccinations and compliance to the vaccination schedule, any breastfeeding refreshers she needs after meeting with the lactation specialist.

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? <ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications to plan.
1. Risk for infection related to recent c-section as evidenced by lower abdominal incision	The patient is at risk for infection due to the abdominal incision.	1. Identify risk factors Rationale; Gestational diabetes, preeclampsia/eclampsia, and prolonged labor increase the incidence of infection (Phelps, 2020). 2. Assess signs and symptoms Rationale; Fever and pain, erythema, and purulent drainage without approximation of the wound borders (Phelps, 2020).	Patient will not develop an infection during the postpartum period Patient will display surgical site healing following c-section with no signs of redness, warmth, or drainage.
2. Risk for impaired	The patient was	1. Assist the mother with breastfeeding	Patient and family members will

<p>parent/infant attachment related to c-section as evidenced by increased tiredness and limited mobility immediately following c-section</p>	<p>exhausted post c-section and missed on some initial bonding with the newborn</p>	<p>Rationale; this enables the bonding process and fetal nutrition (Swearingen, 2018). 2. When possible have baby return back into the room with mom opposed to staying in the nursery Rationale; This will allow for bonding through skin to skin contact with mom and breastfeeding as she care for the infant.</p>	<p>verbalize the understanding and importance of the parental bonding process and participate in care of both the patient and the infant (Swearingen, 2018).</p>
<p>3. Impaired thought processes related to sleep deprivation as evidenced by a newborn baby.</p>	<p>The patient was exhausted due to not obtaining enough sleep since she was up with the bay providing feedings and around the clock care.</p>	<p>1. Assess family support Rationale; Assess if the baby's father is involved in parenting. Assess if the patient has support at home from other family members (Phelps, 2020). 2. Observe attachment between the infant and both parents Rationale; Observe how each parent interacts with the infant during feeds, changing diapers and if they display any reluctance or indifference in their parenting (Phelps, 2020).</p>	<p>Patient will verbalize risk factors that increase the risk of impaired parenting; Parent will identify their personal strengths to help overcome any barriers in their parenting (Phelps, 2020).</p>
<p>4. Ineffective breastfeeding related to interruptions in feedings as evidenced by difficulty getting infant to latch</p>	<p>The patient was having difficulty getting the infant to latch onto to breast</p>	<p>1. Provide 1:1 support with the use of a lactation specialist Rationale; The lactation specialist can help assist the patient with positioning of the infant during feeds and comfort of nursing, can help with inverted or flat nipples, milk supply problems, sore nipples, and infant sucking problems</p>	<p>The patient (mother) will implement new techniques taught to her by the lactation specialist to improve breastfeeding. The Mother will obtain adequate rest and maintain her caloric intake and oral hydration. The infant will display</p>

		<p>(Swearingen, 2018). 2. Teach the patient the importance of adequate hydration, nutrition, and rest Rationale; It is important for the patient to maintain an adequate caloric intake, oral hydration, and rest as this helps to meet the periods of increased demand for breast milk during infant's growth spurts and help maintain a consistent supply of breast milk for the infant (Swearingen, 2018).</p>	<p>effective breastfeeding as evidenced by appropriate weight gain.</p>
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Other References (APA)

Capriotti, Theresa M. "Davis Advantage for Pathophysiology: Introductory Concepts and

Clinical Perspectives" 2nd ed. (2020). *F.A Davis Company*.

Phelps, L.L. (2020). *In Spark's & Taylor's Nursing Diagnosis Reference Manual 11th ed. Essay*. Wolters Kluwer.

Swearingen, P.L., & Wright, J. (2018). *All-in-One Nursing Care Planning Resource:*

Medical-Surgical, Pediatric, Maternity, and Psychiatric-Mental Health (5th ed.).

Mosby.