

N432 Postpartum Care Plan

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N432: Maternal-Newborn Care

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Demographics (3 points)

Date & Time of Admission 07/12/23 1000	Patient Initials BW	Age 27 years-old	Gender Female
Race/Ethnicity White	Occupation Unemployed	Marital Status Single	Allergies Morphine, Penicillin, Seroquel, Adhesive tape-silicone
Code Status Full code	Height 160.02 cm	Weight 90 kg	Father of Baby Involved Yes

Medical History (5 Points)

Prenatal History: G5T2P0AB3L2, postpartum hemorrhage, recreational drug use.

Past Medical History: Domestic Violence, Sexual abuse, Bipolar, Kidney disease, Eye trauma due to domestic violence, Antepartum anemia.

Past Surgical History: Myringotomy with tubes, c-section, appendectomy, lymph node biopsy.

Family History: Mother: Fibromyalgia, Brain aneurysm, DVT Maternal Grandmother: Bipolar, COPD

Social History (tobacco/alcohol/drugs): Methamphetamine Last Use 2/4, Marijuana, Cocaine, Smoker 2pks/day for 9 years.

Living Situation: Lives at home with Fiancé and four dogs.

Education Level: Until 11th grade.

Admission Assessment

Chief Complaint (2 points): C-section

Presentation to Labor & Delivery (10 points):

The patient presented to the hospital for a scheduled c-section at 1000. Accompanying the patient was her fiancée and the father of the baby. The patient had a previous c-section with her

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last pregnancy, and at this time, the baby was in a vertex position. The patient is scheduled to deliver at 37 weeks due to pregnancy complications such as substance abuse and gestational diabetes. The patient also poses a high risk for postpartum hemorrhage due to experiencing postpartum hemorrhage with her last delivery.

Diagnosis

Primary Diagnosis on Admission (2 points): Repeat C-section

Secondary Diagnosis (if applicable): Gestational Diabetes, Recreational drug abuse, History of Postpartum hemorrhage, Anxiety, Depression, and history of domestic violence.

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	2.98	2.73	The patient refused to have labs drawn.	The patient experienced antepartum anemia and was possibly not compliant with prenatal vitamins (Ricci et al., 2021).
Hgb	11-16	9.9	9.0	The patient refused to have labs drawn.	The patient experienced antepartum anemia, and which can lead to low hemoglobin and hematocrit levels (Ricci et al., 2021).
Hct	34-47%	29.7	27.7	The patient refused to have labs drawn.	The patient experienced antepartum anemia, and which can lead to low hemoglobin and hematocrit levels (Ricci et al., 2021).

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Platelets	140-400	235	262	The patient refused to have labs drawn.	N/A
WBC	4-11	20.45	19.58	The patient refused to have labs drawn.	High white blood cell counts is consistent with fighting an infection (Ricci et al., 2021).
Neutrophils	1.6-7.7	17.18	15.44	The patient refused to have labs drawn.	High neutrophil count in pregnancy can be consistent with fighting an infection (Ricci et al., 2021).
Lymphocytes	1-4.90	1.58	2.32	The patient refused to have labs drawn.	N/A
Monocytes	0-1.10	1.39	0.99	The patient refused to have labs drawn.	N/A
Eosinophils	0-5	0.06	0.10	The patient refused to have labs drawn.	N/A
Bands	0	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, AB, O	A	A	A	

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Rh Factor	Positive	Positive	Positive	Positive	
Serology (RPR/VDRL)	Nonreactive	Nonreactive	Nonreactive	Nonreactive	
Rubella Titer	Greater than 10	Non-Immune	Non-Immune	Non-Immune	Nonimmunity of rubella during pregnancy causes a risk of contracting the disease (Ricci et al., 2021).
HIV	Negative	Negative	Negative	Negative	
HbSAG	Nonreactive	Nonreactive	Nonreactive	Nonreactive	
Group Beta Strep Swab	Negative	Positive	Positive	Positive	Harmful bacteria to the baby, that can be passed during a vaginal delivery (Ricci et al., 2021).
Glucose at 28 Weeks	Less than 140	186	The patient refused to have lab drawn.	The patient refused to have lab drawn.	High results at 28 weeks leads to gestational diabetes and can develop into diabetes II later in life (Ricci et al., 2021).
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
Protein in Urine analysis	0-8	Not Drawn	Not Drawn	30	Can be a sign of preeclampsia (Marcin, 2021).
WBC in Urine analysis	0	Not Drawn	Not Drawn	34	Infection can cause a high count of infection in urine (Ricci et al., 2021).

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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)	Not Drawn	Not Drawn	Not Drawn	Not Drawn	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.

Marcin, A. (2021, January 13). *What It Means If You Have Protein in Your Urine During Pregnancy*. Healthline. <https://www.healthline.com/health/pregnancy/protein-in-urine-pregnancy#symptoms>

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

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	Your Assessment
<p>History of labor:</p> <p>Length of labor</p> <p>Induced /spontaneous</p> <p>Time in each stage</p>	<p>Repeat C-section</p> <p>Stages 1 & 2 were not experienced because the patient had a scheduled c-section.</p> <p>Stage 3: 2 minutes</p>
<p>Current stage of labor</p>	<p>The beginning of the healing process is marked by the early postpartum period, sometimes referred to as the fourth stage of labor. Depending on the mother's birthing history, the body adjusts to not having a fetus at this period.</p> <p>For the remainder of the patient's hospital stay, blood pressure, respiration, blood loss, and temperature is monitored frequently.</p> <p>A nurse may massage the patient's abdomen to encourage contractions, stop bleeding, and manage pain (Ricci et al., 2021).</p> <p>The mother's heart rate is frequently anticipated to decrease postpartum, with minimal bleeding for a few days and exhaustion after protracted labor (Racci et al., 2021). Mothers risk contracting an infection, bleeding, or developing sadness and anxiety after giving birth. During the postpartum phase, these risks are abnormal findings. It frequently happens for patients to develop postpartum problems. Because of the cesarean incision,</p>

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	<p>this client is susceptible to infection. Fever, exhaustion, and chills are some indications of an infection. The patient is at high risk for postpartum hemorrhage, and the signs and symptoms include high pulse rate, low blood pressure, and a significant amount of vaginal bleeding. This patient is also at high risk for postpartum depression. Research shows that 70 percent of women with bipolar disorder relapse during the postpartum phase (Bhat et al., 2018). The mother is currently in the taking-holding stage and is worried about bleeding while exerting too much power to urinate.</p>
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Stage of Labor References (2) (APA):

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

Bhat, A., Cerimele, J. M., & Byatt, N. (2018). Pregnant and Postpartum Women With Bipolar Disorder: Taking the Care to Where They Are. *Psychiatric services* (Washington, D.C.), 69(12), 1207–1209. <https://doi.org/10.1176/appi.ps.201800133>

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

Home Medications (2 required)

Brand/Generic	Glargine/Lantus	Ferrous Sulfate/Feosol	N/A	N/A	N/A
Dose	28 units	325 mg	N/A	N/A	N/A
Frequency	Daily	Daily	N/A N/A	N/A	N/A
Route	Subcutaneous	Oral	N/A	N/A	N/A
Classification	Pharmacological class: Antidiabetic	Pharmacological class: Hematinic	N/A N/A	N/A	N/A

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Mechanism of Action	Long acting insulin that helps promote the absorption of glucose from the blood stream.	Acts to normalize RBC production by binding with hemoglobin or by being oxidized and stored as hemosiderin or aggregated ferritin in reticuloendothelial cells of the bone marrow, liver, and spleen.	N/A	N/A	N/A
Reason Client Taking	Gestational diabetes	Iron deficiency	N/A	N/A	N/A
Contraindications (2)	1.Low blood sugar levels 2. Renal impairment	1.Hemochromatosis 2.Hemolytic anemias	N/A	N/A	N/AV
Side Effects/Adverse Reactions (2)	1.Headaches 2.Hypokalemia	1.Hypotension 2.Hemolysis	N/A	N/A	N/A
Nursing Considerations (2)	1.Rotate vial gently 2. Avoid vigorous shaking	1.Give tablets with a full glass of water or orange juice to help with absorption. 2.To maximize absorption, it should be given one hour before or two hours after meals.	N/A	N/A	N/A
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Metabolic panel	Monitor hemoglobin and hematocrit levels	N/A	N/A	N/A
Client Teaching needs (2)	1.Administer subcutaneous only. 2.Do not use if it contains precipitation.	1.Urge the patient to eat chicken, fish, or lean meat. 2.Avoid foods that impair iron absorption including dairy products.	N/A	N/A	N/A

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Hospital Medications (5 required)

Brand/ Generic	Oxytocin/ Pitocin	Ketorolac/ Toradol	Prenatal	Measles, Mumps, and Rubella/ MMR vaccine	Enoxaparin/ Lovenox
Dose	30u/500ml	15 mg	29 mg	0.5 ml	40 mg
Frequency	Once	Every 6 hours	Daily	Once	Daily
Route	IV	IV Push	Oral	Subcutaneous	Subcutaneous
Classification	Pharmacolo gical class: Uterine- active agent	Pharmacolo gical class: NSAID	Pharmacolo gic class: Iron product	Pharmacologi cal class: Live attenuated vaccine	Pharmacologi cal class: Low- molecular- weight heparin
Mechanism of Action	Directly stimulate smooth muscle contraction s in the uterus and cervix	Blocks cyclooxygen ase, an enzyme needed to synthesize prostaglandi ns. This NSAID reduces inflammatio n and relieves pain.	A variety of vitamins and minerals helps get babies the nutrients that are needed during development	Stimulates the immune system to produce antibodies by inducing subclinical and noncommunic able infection with attenuated virus particles.	Potentiates the action of antithrombin III, a coagulation inhibitor. By binding antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors.
Reason Client Taking	Risk of postpartum hemorrhage	Pain	Vitamin Intake	MMR nonimmune	Risk for DVT
Contraindicati ons (2)	-Hypertonic or hyperactive uterine	1.Risk of bleeding 2.Risk of renal	1.Hypersens itivity 2. Vitamin B12	1.Hepatic impairment 2.Renal impairment	1.Active major bleeding 2.Pork

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	pattern - Unfavorable fetal position or presentation that's undeliverable without conversion	impairment due to volume depletion	deficiency		products
Side Effects/Adverse Reactions (2)	1. Arrhythmias 2. Neonatal Bradycardia	1. Respiratory depression 2. Bronchospasm	1. Dry skin 2. Puritis	1. Thrombocytopenia 2. Bronchospasm	1. Hemorrhage 2. Dyspnea
Nursing Considerations (2)	1. May cause painful contractions. 2. May cause coma and seizures in mother.	1. Inject over 15 seconds. 2. Monitor site for bleeding	1. Many multivitamin products also contain minerals such as calcium, iron, magnesium, potassium and zinc. Minerals (especially taken in large doses) can cause side effect. 2. Advise client to keep a balanced diet.	1. Allergy to eggs 2. Consult provider before breastfeeding	1. Patient should consult provider before breastfeeding. 2. Use with caution with patients who have history of gastric ulcers.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Monitor mother's blood pressure.	Pain assessment	Monitor metabolic panel labs	Rubella titer	INR labs

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<p>Client Teaching needs (2)</p>	<p>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 would have begun naturally.</p>	<p>1. Advise the patient that medication may cause adverse GI reactions. 2. Instruct patient to notify patient of show of blood in urine, easy bruising, or rash.</p>	<p>1. Prenatal vitamins should be stored out of reach of children and in child resistant bottles. 2. Severe iron Toxicity may occur in overdose.</p>	<p>1. Notify doctor of an allergic reaction. 2. Notify patient of possible fever.</p>	<p>1. Advise patient to notify provider about adverse reactions such as bleeding. 2. Caution patient not to rub the site after giving the injection to minimize bruising.</p>

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). 2021 Nurse’s Drug Handbook (19 th ed.). Jones & Bartlett Learning

M-M-R II (measles, mumps, and rubella virus vaccine live) dose, indications, adverse effects, interactions. . . from PDR.net. (n.d.). <https://www.pdr.net/drug-summary/M-M-R-II-measles--mumps--and-rubella-virus-vaccine-live-363#:~:text=The%20MMR%20vaccine%20is%20classified,and%20is%20contraindicated%20in%20pregnancy.>

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Alert and responsive. Oriented to person, place, time, and situation. In no apparent stress. Overall good appearance, well-groomed.</p>
<p>INTEGUMENTARY (1 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: 20 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Skin color is usual for ethnicity. Moist and intact. Warm to the touch. Elastic turgor. No rash noted. No bruising. Cesarean incision is clean, dry, with no discharge noted.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck symmetrical, trachea midline without deviation. Bilateral auricles no visible or palpable lesions or deformities. EOMs intact. Bilateral lids without lesions, bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink. Septum is midline, no drainage or bleeding noted. Good dentation noted.</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 type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>Clear S1 and S2 sounds with no gallops or murmurs noted. Normal Sinus rhythm. 3+ Pulses bilaterally on upper extremities and lower extremities. Less than 3 seconds capillary refill bilaterally fingers and toes.</p>
<p>RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>Normal rate and pattern of respirations, symmetrical breathing with clear breath sounds bilateral.</p>
<p>GASTROINTESTINAL (2 points): Diet at Home: Current Diet: Height:</p>	<p>Regular diet at home. Current regular diet. Height is 160.02 cm. Weight is 90 kg.</p>

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<p>Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds:</p>	<p>Bowel sounds are normoactive. Last bowel movement was on 3/7/23. No pain or mass was noted when palpated. Cesarean incision is clean, dry, with no discharge noted. No scars were noted. No drains were noted. No wounds were noted.</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>Void of 300 ml. No abnormalities noted on genital.</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: 0 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>No obvious deficit. All extremities have an active range of motion. No supportive devices. 5/5 bilaterally, Active motion against full resistance. Patients need minimal assistance when getting out of bed.</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 type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC: DTRs:</p>	<p>Person, Place, Time, Location Normal Cognition Slurred speech Normal Alert 2 bilaterally-normal</p>
<p>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</p>	<p>Intimacy vs. Isolation Christianity The patient has multiple pets and owns a plot of land with her fiancé, where they raise goats, pigs, and ducks. The patient currently has a hard time being able to see her daughter because her</p>

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available family support):	mother has custody.
Reproductive: (2 points) Fundal Height & Position: Bleeding amount: Lochia Color: Character: Episiotomy/Lacerations:	At umbilicus level Moderate Rubra Normal None
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:	Due to the c-section, there wasn't a rupture of membranes. 07/12/23 1348 Cesarean 290 ml Male 8, 9 2900 g Bottle

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	83	107/59	18	97.8	Not documented
Labor/Delivery	96	96/56	20	98.3	96
Postpartum	104	97/63	18	98.6	96

Vital Sign Trends:

The patient is known to have previously low blood pressure readings. The patient was also experiencing an 8 out of 10 pain level. The high amount of pain the patient is experiencing can be the reason the patient is experiencing a high pulse rate.

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Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	0-10	Incision for spinal block	8	Sharp and throbbing	Continue monitoring and promoting a change of position and a heating pad.
1100	0-10	Incision for spinal block	6-7	Sharp and throbbing	Pain medication is given.

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:	18 gauge Left upper arm. 07/12/23 No signs were noted. Dry, clean, and intact.

Intake and Output (2 points)

Intake	Output (in mL)
240 mL	300 mL

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 (N)	As tolerated	To help the patient get up and move as early as possible to prevent blood clots.
Nutrition Intake (N)	During mealtimes	Ensure the patient gets adequate

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		nutrition while she is resting and healing.
Peri-bottle use (N)	Every occurrence of using the restroom	To ensure the patient knows how to keep the perineal area clean and alleviate soreness.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? Taking-in phase of maternal adaptation to parenthood.

What evidence supports this? The patient delivered the baby and ultimately expelled the placenta. The patient's fundus height at examination is aligned with the umbilicus. The patient begins the attachment process, cuddling the baby and feeding.

Discharge Planning (3 points)

Discharge location: Home

Equipment needs (if applicable): N/A

Follow up plan (include plan for mother AND newborn): The mother is to follow up with the patient's physician in two weeks to meet check the incision sight. Then six weeks following the cesarean the patient is to see their physician for a regular postpartum checkup. No heavy lifting for four weeks; maintain a high-fiber diet to help with bowel movements. The baby must see their pediatrician 24 hours after discharge to discuss the infant's health.

Education needs: The patient needs education on co-sleeping, SIDS, heaving bleeding, wound care, and infection signs and symptoms.

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

<p>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</p>	<p>Rational (1 pt each) Explain why the nursing diagnosis was chosen</p>	<p>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.</p>	<p>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. </p>
<p>1. Acute pain related to cesarean surgery, as evidenced by lower abdomen incision.</p>	<p>The patient was experiencing level 7-8 pain after the cesarean.</p>	<p>1.Preform comfort measures to promote relaxation such as repositioning, heating pad, or massages. Rationale: Help in muscle relaxation and distribute pressure on body parts (Phelps, 2020). 2.Collaborate with patients when administering prescribed analgesics when alternative methods are inadequate. Rationale: Gaining patient’s trust and involvement helps ensure compliance and can reduce medication intake (Phelps, 2020).</p>	<ul style="list-style-type: none"> The patient’s pain level lowered to an 6 out of 10. The patient was cooperative to other methods to relieve pain such as repositioning.
<p>2. Knowledge deficit related to substance abuse, as evidenced by amphetamine use during pregnancy.</p>	<p>The patient last used amphetamines on February 4th.</p>	<p>1. Establish an environment of mutual trust and respect to enhance learning. Rationale: Help creates consistency between actions and words to create trust (Phelps, 2020). 2.Don’t place unrealistic demands on patients. Rationale: To avoid exacerbating feelings of</p>	<ul style="list-style-type: none"> The patient was more open to suggestions and information. The patient displayed minimal signs of anxiety.

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		anxiety (Phelps, 2020).	
3. Knowledge deficit related to uncontrolled blood sugar levels, as evidenced by having high blood sugar levels of 100 or more.	The patient being diagnosed with gestational diabetes and stating, “I forget to check my blood sugar sometimes”.	1. Assess the patient’s level of knowledge. Rationale: Determine whether the patient needs the basic information or reinforcement (Phelps, 2020). 2. Limit the length of each teaching session. Rationale: Avoid information overload and feelings of anxiety (Phelps, 2020).	<ul style="list-style-type: none"> • The patient refused to have blood sugar levels drawn. • The patient was more comfortable receiving information in small sessions.
4. Impaired mood regulation related to untreated mental health disorder, as evidenced by not being compliant with bipolar disorder medications.	The patient gets overstimulated when asked or given too much information.	1. Use short, simple phrases to convey instructions or questions. Rationale: Impaired concentration and psychomotor agitation may inhibit the processing of information (Phelps, 2020). 2. Convey a nonjudgmental, supportive attitude and do not take irritable statements personally. Use therapeutic communication to prevent power struggles. Rationale: Maintenance of a therapeutic nurse-patient relationship is key (Phelps, 2020).	<ul style="list-style-type: none"> • The patient was more cooperative when short and straightforward phrases were used. • The patient communicated calmly and received information or instructions effectively.

Other References (APA)

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