N432 Postpartum Care Plan

Lakeview College of Nursing

Patricia East

Demographics (3 points)

Date & Time of Admission 6/3/2020 1800	**Patient Initials** RK	**Age** 19 y/o	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Food Industry (McDonald's)	**Marital Status** Single	**Allergies** No known allergies
Code Status Full	**Height** 167.5 cm	**Weight** 156.5 kg	**Father of Baby Involved** No

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Medical History (5 Points)

Prenatal History: G1T1001, Chlamydia affecting pregnancy, GBS positive, Chronic Hypertension complicating pregnancy, morning sickness.

Past Medical History: Morbid obesity with BMI of 50.0-59.9, chronic hypertension.

Past Surgical History: Tonsillectomy

Family History: Father has hypertension. Mother had thyroid cancer and had a thyroidectomy.

Social History (tobacco/alcohol/drugs): Patient does not have a history of tobacco or alcohol use. Patient states she used to occasionally have an alcoholic beverage, but not since being pregnant. She states she would have a couple of drinks, whenever she is out with friends. The patient states it was maybe four times a year.

Living Situation: Patient lives in Cisco, IL with her mother. She plans on staying at this residence while raising her daughter. Her mom is a lot of help.

Education Level: High school.

Admission Assessment

Chief Complaint (2 points): Scheduled induction due to chronic hypertension affecting pregnancy.

Presentation to Labor & Delivery (10 points): The patient is a 19-year-old Caucasian who has a scheduled induction due to chronic hypertension complicating pregnancy. The father is not present. Mom of patient is at bedside. On admission, the patient's vitals were B/P 116/61, temperature 97.0 F, HR 98 bpm, respirations were 16/min, and oxygen saturation is at 97%. Patient is on room air. This is the patient's first pregnancy and has been diligent with her prenatal care.

Diagnosis

Primary Diagnosis on Admission (2 points): schedule induction

Secondary Diagnosis (if applicable):labor and delivery

Postpartum Course (18 points)

The patient is a 19-year-old female that has experienced high blood pressure before 20 weeks of pregnancy. She states that "my blood pressure has always been high but keeps getting higher throughout my pregnancy". She was admitted on 6/3/2020 at 1800. Her vitals upon admission were B/P 116/6, temperature 97.0 F, HR 98 bpm, respirations are 16 per min, and oxygen saturation is at 97%. Patient is on room air. Patient states that she has experience vision loss, headaches, nausea, vomiting, and swell throughout her pregnancy. When experiencing vision loss, it was only one side she could not see. The patient states that she would lay down and rest when feeling nauseous to prevent vomiting. Her headaches still come and go. The patient states that she feels better when she lays down and relaxes. Sometimes a cold washcloth on her head helped with her headaches. She does not currently take anything for these symptoms. Upon admission, patient did not have contractions or pain. She was started on Cervidil at 2000.

Patient's cervix was not continuing to dilate. A foley bulb was placed at 0830 on 6/4/2020 to help encourage dilation. Membranes ruptured at 1126. The baby's heart rate dropped to 86 bpm and intolerant to labor. An emergency primary low transverse cesarean section was performed.

The patient was taken back to the OR at 1129. This procedure was quick, and baby was delivered in 2 minutes. The patient was prepped, and anesthesia was administered. The patient required general anesthesia due to the labor intolerance from baby and required an emergency cesarean (SOAP, 2018). The procedure stared at 1146, baby was born at 1148 weighing 3680 grams. Incision was closed and procedure ended at 1222. Patient was stable and was taken to recovery.

During postpartum assessment, the fundus of the uterus was firm without massage and at the umbilicus. She has a presence drain over incision. No pain with palpation of stomach. Encouraged patient to cough and deep breathe (ATI, 2019) to prevent post procedure complications with respiratory. An abdominal binder was applied to abdomen to help prevent dehiscence of wound (ATI, 2019).

The mother is in postpartum room resting. The patient's mom is at bedside to help the patient with baby while she rests and recovers. Mom and baby are both adjusting well to breast feeding. Mom is active in baby's care. The patient was given Toradol right after procedure and rates pain at 3/10. If pain increases, she can have hydrocodone and Tylenol. She is also prescribed Colace and Pitocin. Mother and baby have no needs currently.

Postpartum Course References (2) (APA):

ATI Nursing Education. (2019). *RN maternal newborn nursing (11th ed.)* Assessment Technologies Institute, LLC.

SOAP. (2018, May 26). *General Anesthesia for Cesarean Section.* SOAP. https://soap.org/education/information-for-mothers/questions-answered/general-anesthesia-for-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	3.5-5.20	4.28	4.13	NA	
Hgb	Male: 14-18 Female: 12-16	12.2	10.3	NA	Blood loss is common with vaginal births. With the lost of blood, it can cause anemia in mothers (Pagana, 2019).
Hct	42%-52%	37.1	31.4	NA	Hct decreases and accompanies a low Hgb in patients who are anemia. The patient lost 763 mL of blood postpartum. This is within normal range of blood loss with cesareans (ATI, 2019).
Platelets	140-400	259	245	NA	
WBC	4-11	10.8	10.8	NA	
Neutrophils	55%-70%	68.9%	70.7%	NA	Neutrophils increase with emotional and physical stress (Pagana, 2019).The patient's body went through long period of stress laboring and going through an emergency cesarean.
Lymphocytes	20-40%	20.4%	23.0%	NA	
Monocytes	2-8%	6.9%	5.3%	NA	
Eosinophils	1-4%	0.6%	0.8%	NA	Eosinophils are decreased when taking steroid

					medications (Pagana, 2019). A week before her scheduled induction, the patient had an allergic reaction to poison ivy and was prescribed prednisone.
Bands	0.5-1%%	NA	NA	NA	

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	O	NA	NA	NA	
Rh Factor	Positive	NA	NA	NA	
Serology (RPR/VDRL)	Non-reactive	NA	NA	NA	
Rubella Titer	Positive	NA	NA	NA	
HIV	Not detectable	NA	NA	NA	
HbSAG	Non-reactive	NA	NA	NA	
Group Beta Strep Swab	Neg	Positive	NA	NA	GBS is a natural occurring bacterium found in the vagina or rectum. This mom will receive an intravenous prophylactic antibiotic to prevent infection in baby (ATI, 2019).
Glucose at 28 Weeks	<140	<100	NA	NA	
MSAFP (If Applicable)	Neg	Neg	NA	NA	

Additional Admission Labs Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Chlamydia	Neg	Positive on 11/11/2019	Negative on 5/13/2020	NA	Chlamydia is a sexually transmitting infection of the genitals. The patient was infected by a partner (Pagana, 2019).
Gonorrhoeae	Neg	Negative on 11/11/2019	Negative on 5/13/2020	NA	
Alkaline phosphate	30-120 units/L	NA	148	NA	Alkaline phosphate can increase from albumin levels. (Pagana, 2019). This patient had protein present in her urine.
Albumin	3.5-5.7	NA	3.4	NA	
Lactate dehydrogenase	107-207	NA	174.3	NA	
UR protein Rand, QT	0.0-12.0	NA	22.5	NA	Proteinuria can indicate preeclampsia in women who are pregnant (Pagana, 2019).

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)	2.8.0-217.0 mg/dL	NA	161.3 mg/dL	NA	

Lab Reference (APA):

ATI Nursing Education. (2019). *RN maternal newborn nursing (11th ed)* Assessment Technologies Institute, LLC.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic and laboratory test reference*. St. Louis, MO: Elsevier.

Stage of Labor Write Up, APA format (15 points):

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	The patient G1T1P0A0L1. The patient had to undergo an emergency cesarean. The patient came into the hospital on 6/3/2020 at 1800 for a schedule induction. She was started on Cervidil to help dilate the cervix. This medication begun at 2000 and was given until 0830. There was no progress with the Cervidil. A foley bulb was inserted at 0830 until 1040 to help encourage cervix dilation. The baby's heart rate dropped to 86 bpm around 1120. The baby was intolerant to labor and HR was not returning to normal and an emergency primary low transverse cesarean section was performed. Patient went to the OR at 1129. The patient was intubated and draped and sterilized. The procedure began at 1146. The surgeon started to cut at 1146. The baby was born at 1148. The incision was closed at 1222 and the procedure was over.
Current stage of labor	The mother's vital signs are stable. B/P will increase with

	activity. When B/P increase, care is stopped, and patient is to relax. Perineal care, pad was changed, and the patient was transferred into a new room to recover. This is the fourth stage of labor, postpartum. Monitoring blood pressure Q4 hours for the next 8 hours (ATI, 2019). Fundus and lochia are assessed. Fundus is firm and at the umbilicus. Pitocin is being administered to help maintain uterine tone and hemorrhage (ATI, 2019). Mother is skin to skin with baby and breastfeeding every 2 to 3 hours. Mother had a total of 113 mL of blood loss 4 hours postpartum. Mom has blood loss total is 763 mL. Mother has a foley catheter in place. She reports no pain with urination or in general. Mom has good output. Urine is clear and yellow. No odor.

Stage of Labor References (2) (APA):

ATI Nursing Education. (2019). ***RN maternal newborn nursing (11th ed)*** **Assessment Technologies Institute, LLC.**

Ricci, S.S., Kyle, T., & Carman, S. (2017). ***Maternity and pediatric nursing (3rd ed.)*** **Wolters Kluwer.**

Current Medications (7 points, 1 point per completed med)
7 <u>different</u> medications must be completed

Home Medications (2 required)

Brand/Generic	**Prenatal multivitamins/ Zenate**	**Aspirin/ acetylsalicylic acid**	**Prednisone/ Apo-Prednisone**	**N/A (patient did not**	**N/A (patient did no**

				have any more home meds)	**have any more home meds)**
Dose	1 mg	81 mg	20 mg		
Frequency	Daily	Daily	BID		
Route	Oral	Oral	Oral		
Classification	vitamin	Non-steroidal anti-inflammatory drug	Anti-inflammatory, immunosuppressant		
Mechanism of Action	Provide additional vitamins during pregnancy	Relives pain and aches	Suppresses inflammatory and immune response		
Reason Client Taking	Pregnancy and breastfeeding	Headaches	To treat poison ivy		
Contraindications (2)	Diuretics Heart or blood pressure medication	Allergy to tartrazine dye Asthma	Systemic fungal infection Hypersensitivity to prednisone		
Side Effects/Adverse Reactions (2)	Upset stomach Unusual or unpleasant taste in mouth	Decreased blood iron levels Bronchospasm	Edema Hypertension		
Nursing Considerations (2)	Do not give milk with this medication, the calcium can make it difficult to absorb into the body Encourage mothers to continue	Do not crush time-release or controlled-release aspirin tablets. Identify if patient has an allergy to tetrazine dye before	Administer once daily in the morning to match body's normal cortisol secretion schedule Assess for adverse reactions		

	taking prenatal vitamin while breastfeeding.	administering medication.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Make sure there is at least 2 hours between administering a prenatal vitamin with another vitamin.	Identify if patient has a tetrazine dye allergy	Blood glucose levels Cortisol levels		
Client Teaching needs (2)	Never take more than the recommended dose Take prenatal multivitamin with a full glass of water.	Instruct patients to take medication with food to help prevent GI upset. Educate patient to not take aspirin if it has a strong vinegar-like odor.	Avoid people with contagious infections Take with food to decrease GI distress		

Hospital Medications (5 required)

Brand/Generic	**Colace/ docusate sodium**	**Lovenox/ Enoxaparin sodium**	**Norco/ Hydrocodone and acetaminophen**	**Pitocin/ Oxytocin**	**Tums/ Calcium carbonate**

Dose	100 mg	40 mg	10-325 mg	0.06-0.3 u/min	1000 mg
Frequency	BID	Daily	Q4 PRN	continuous	TID
Route	Oral	SUBQ injection	Oral	IV	Oral
Classification	Laxative/ stool softener	Antithrombotic	Opioid/ narcotic analgesic combination	Uterine active agent	Antacid
Mechanism of Action	Softens stool by decreasing surface tension between oil and water in feces	Inactivates clotting factors and prevents fibrinogen to convert to fibrin and prevents clots formation	Activates opioid receptors and relief pain	Initiate or improve uterine contraction to achieve vaginal delivery.	Neutralize or buffer stomach acid to relieve discomfort caused by hyperacidity.
Reason Client Taking	To prevent constipation	To prevent clot formation	Pain relievers	To start labor and to control bleeding after delivery	Heartburn
Contraindications (2)	Fecal impaction Undiagnosed abdominal pain	A history of heparin induced thrombocytopenia thrombocytopenia	Taking MAO inhibitors Serotonin syndrome	Fetal distress Placenta previa	Hypercalcemia Renal calculi
Side Effects/Adverse Reactions (2)	Abdominal cramps Diarrhea	Hematuria Ecchymosis	Dizziness Tachycardia	Dizziness Headache	GI upset Constipation
Nursing Considerations (2)	Educate that long-term use of laxatives can cause the bowels to be dependent on medication	Implement bleeding precautions Do not give this drug by I.M injection.	Administer exactly as this medication is prescribed Monitor for signs and symptoms for allergic	Assess for allergies with this medication Monitor infant for side	Have patient drink a full glass of water with administration of this medication Administer tablets 1 to

	Educate patient that excessive use can lead to an electrolyte imbalance		reaction	effects for side effects and adequate milk intake	2 hours after meals
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Before administering, assess for laxative abuse syndrome	PT and aPTT labs should be assess before and monitored throughout heparin therapy	Asses if patient is allergic to acetaminophen	Assess if patient is allergic to Pitocin	Monitor calcium levels Assess Chvostek's and Trousseau's signs
Client Teaching needs (2)	Take with a full glass of water or milk Encourage patient to increase fiber intake, exercise regularly, and drink 240 mL of water a day.	Educate patient no take NSAIDS or aspiring because it can increase risk for bleeding To use an electric razor to shave.	Educate patient that this medication is habit-forming and to only take it when it is absolutely needed. Educate patient to stand slowly from laying to sitting and sitting to standing to prevent falls.	Educate patient that Pitocin will start contraction of the uterus to promote labor. Teach patient how to deep breath and work through painful contractions	Chew medication thoroughly before swallowing Instruct patient to avoid taking calcium within 2 hours of oral drugs to prevent interaction.

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook*.

Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and orient x3. Appears to be in no distress. Patient appears to be comfortable with no pain.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☒ N ☐** **Type:Presence**	Skin is pink, warm, and dry. There are no rashes, bruising. Bilateral low transverse abdominal wound from cesarean. Presences drain applied with light suction. Dressing is dry and intact. Braden score is 22. Skin turgor <3 seconds. Patient's temperature is 96.5 F.
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Normocephalic, trachea is midline. No swollen or tender lymph nodes noted. PERRLA. Patient has had pervious blurred and vision changes, but not experience them now. Membranes are pink and moist. There is no nasal deviation noted or nasal drainage. Good dentation, no missing teeth.
CARDIOVASCULAR (1 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 and S2 noted. No presences of an S3, murmur, or gallops. Normal sinus rhythm. All pluses 2+ bilaterally. Capillary refill is less than 3 seconds. Edema noted bilaterally around ankles. Pt states that it is normal for her to look swollen.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Clear lung sounds bilaterally. No crackles, wheezes, or rubs. Patient has had a little tickle/cough in throat from intubation. Patient is practicing deep breathing and coughing to help prevent pneumonia and other complications.

GASTROINTESTINAL (5 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Fundal Height & Position:**	Patient is on a low carb diet to help with healthy weight throughout her pregnancy. She is currently on a regular diet. She is 5'6 and weighs 345 lbs. Normal active bowels in all four quadrants. No organomegaly or pain with palpation. No distention. Abdominal wound from cesarean. Fundal height and position is firm without massage at umbilicus. Last bowel movement was 6/4/2020. Presences drain dressed over abdominal wound with light suction.
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:** **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Episiotomy/Lacerations:**	Light bleeding. No pain with urination. Urine is a clear yellow without an odor. No blood in urine. Urine output 825 mL. Genitals are clean, no open or healing sores. Indwelling single lumen size 16 catheter is in place. Rupture of membranes 6/4/2020 at 1126. Rubra, light, no odor. No episiotomy or lacerations.
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☒**	Patient is up with assistance post operation. She is experiencing generalized weakness. She is independent with personal care and baby care. Patient is a fall risk. Fall score is 8. Call light is in reach and patient is educated to call for assistance to get up.
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:**	Alert and oriented X3. Awake and receives education appropriately. Speech is clear and appropriate. DTRs are present.

Mental Status: **Speech:** **Sensory:** **LOC:** **DTRs:**	
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient is active in her and her babies care. This is her first child but has a good support from her mother. The child's father is not going to be involved. She is sad but knows that she is strong and will get through it by the support of her family. She is attentive to staff and to baby's need. She hasn't gone to college but shows that she is at an appropriate development stage to learn and adapt to her new role as a mom. Patient is a Christian and may go to church. She is not active in religious practices.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	Baby was delivered at 1148 on 6/4/2020. Emergency cesarean. 763 mL Female Apgar at 1 min was 3 Apgar at 5 min was 8 Baby weighs 3680 grams Mom is breastfeeding.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal 6/3/2020 at 1800	98	116/61	16	97F	97% on room air
Labor/ Delivery 6/4/2020 at 0730	90	110/56	20	97.8F	99% on room air
Postpartum 6/4/2020 at	84	141/75	18	96.5F	99% on room air

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Vital Sign Trends: The patient's vital signs were stable. Her blood pressure was elevated during postpartum care and moving from delivery room to postpartum room.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1530	0-10	NA	0	None	None
1715	0-10	Abdomen	3	Pressure	Abdominal binder was applied

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV:** left hand **Date on IV:** 6/4/2020 **Patency of IV:** flushes without difficulty **Signs of erythema, drainage, etc.:** None **IV dressing assessment:** dressing is dry and intact	

Intake and Output (2 points)

Intake	Output (in mL)
100% of dinner **360 mL = Oral** **1250 = IV**	**825 mL of urine** **763 mL of blood loss.**

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.

"N" after you list them, identify medical treatments with "T" after you list them.)		
Prevention of blood clots/ DVTS and PE's. (T)	continuous	This is a treatment to prevent the blood from clotting. The patient is receiving enoxaparin daily. Encourage ambulation and reposition in the bed. Patient has a high BMI and has had a major surgery which puts her risk for blood clots. Having a cesarean delivery doubles the risk of development of a DVT (ATI, 2019). SCD pumps are in use when patient is laying in the bed.
Prevention of wound dehiscence (N)	continuous	This intervention helps support abdomen, maintain the abdominal pressure, promote deep breathing, and helps with post-op pain. This allows the patient to be able to cough and to move around better.
Monitor for signs and symptoms of infection (N)	continuous	Monitoring for chills, sweats, fever, shortness of breath, vital changes, redness, and drainage around abdominal wound. Providing education on how to properly take care of cesarean wound after leaving the hospital is important.
Monitor taking-hold phase (N)	continuous	Monitoring how the patient interacts with her baby and focus on newborn care. Mom will start to take care of baby without reminders from nurse. Watching how the mom interacts in her new role can identify if mom is at risk for postpartum depression.

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? Taking hold phase

What evidence supports this? The mom is actively participating in baby's care. She immediately began breastfeeding after delivery. She is attentive to baby's cries and needs. The patient's mom is at bedside and has helped with the cares. Towards the end of the day, the mother of the baby was insisting that she handle the care. Mom is also communicating and actively listening to the doctors and nursing staff in how to take care of baby and is learning quickly. This is her first baby, but she seems to be comfortable and ready to be in this role.

Discharge Planning (2 points)

Discharge location: Home in Cisco, IL

Equipment needs (if applicable): Presence drain

Follow up plan (include plan for mother AND newborn): Mom will need to follow up with OB/GYN and baby will have well baby and initial appointment with pediatrician.

Education needs: Mom was provided with monitoring blood pressure, signs and symptoms of infection, and wound dehiscence education. She was always was provided education on fever, bathing, skin color, urine/bowel movements, spit up/vomiting, breastfeeding, car seat safety, and co-sleeping.

Nursing Diagnosis (30 points)
Must be NANDA approved nursing diagnosis and listed in order of priority
Two of them must be education related i.e. the interventions must be education for the client."

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	**Evaluation (1 pt each)** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.

		APA format, cite the source for your rationale.	
1. **ONE: Wound dehiscence related to cesarean as evidence by morbid obesity with BMI of 50-59.9%**	**This diagnosis was chosen because patient's who have a high BMI are at risk for wound dehiscence because that fatty tissue has less blood flow which slows the healing process down.**	**1.Provide an abdominal binder** **Rationale:** The abdominal binder helps support abdominal muscles and helps the wound heal. **2.Presence drain applied with light suctioning** **Rationale:** This drain helps remove pus, blood, and other fluid from the wound which promotes healing.	**Patient understands the purpose of each intervention. She understands that the drain will be on even after discharge. She has a positive attitude towards the drain and that it will help prevent infection.**
2. **TWO: Need for health teaching related to cesarean abdominal wound as evidence by unfamiliarity with wound healing**	**This diagnosis was chosen because the patient has not had any prior surgeries and has no knowledge with wound care.**	**1. Demonstrate and have patient demonstrate proper hand washing, cleansing of wound, maintaining a clean field, and applying new dressing** **Rationale:** This allows the patient to ask questions and gain knowledge on ways to prevent transferring microorganisms to wound to prevent infection and help with proper healing. **2. Encourage patient to eat a well-balanced diet that includes protein, carbohydrates, fruits, vegetables, and good fluid intake.** **Rationale:** A diet that is well balanced will promote wound	**The patient understands the importance of wound healing. She knows that to take care of her child, she needs to take care of herself. The patient wants to eat healthier to promote healing of her wound, but to also have a healthier lifestyle.**

		healing.	
3. **THREE: Deficient fluid volume related to cesarean childbirth as evidence by 763 mL of blood loss.**	**The patient had a lot of blood loss after delivery of baby. This can cause mom to become vascular, cellular, and intracellular dehydrated.**	**1. Insertion of indwelling foley catheter** **Rationale:** This will help accurately measure fluid loss. **2. Administer Oxytocin** **Rationale:** This medication will contract the uterus and close off venous sinuses and stop bleeding	**The patient is responding to the foley catheter in place. She reports no pain or discomfort. She is aware that she is at risk for fluid deficiency.**
4. **FOUR: Need for teaching related to breastfeeding as evidence by lack of exposure to information.**	**This is the patient's first baby. She has never breastfed before. She wants to be successful with feeding her baby by breast.**	**1. Assist and teach patient comfortable positions** **Rationale:** Understand the different positions to hold baby while breastfeeding will help mom and baby to be successful. **2. Teach the patient that the newborn should take part of the areola and nipple in while feeding. This will help prevent nipple soreness.** **Rationale:** Preventing nipple soreness is important. This will help prevent painful feeding for mom which will help her enjoy breastfeeding. Nipple soreness can prevent moms from wanting to continue feeding.	**The patient was grateful to learn the different positions. She finds that the football hold was most comfortable for her and her baby. She is very comfortable with feeding and baby is latching on well.**

Other References (APA)

ATI Nursing Education. (2019). ***RN maternal newborn nursing (11th ed)*** **Assessment Technologies Institute, LLC.**

Swearingen, P.L., & Wright, J. D. (2019). ***All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health.*** **St.Louis, MO: Elsevier.**