

NURSING CARE PLAN

Student's Name: Kayla Davis

Date 2/9/23

Nursing Diagnosis: ~~Constipation~~

Admitting Diagnosis: Pre-eclampsia

Patient's Initials: KR

P: Risk for infection

E: R/t to open episiotomy

Expected Outcomes	Nursing Interventions	Rationales	Evaluations
<p>Patient will be able to verbalize understanding of teaching and demonstrate perineal care by the end of shift.</p>	<ol style="list-style-type: none"> 1. Teach patient to practice hand hygiene often. <u>Before and after bathroom use and before eating</u> 2. Educate patient on Peri bottle use and demonstrate how to use it. 3. Teach patient to use ice during the first 24 hours after birth. <u>To the perineum</u> 4. Educate on sitz bath after 24 hours of birth and demonstrate how to use. 5. Educate patient to pat the area dry and always dry front to back. 6. Educate patient on signs and symptoms of infection and to report them immediately. 	<ol style="list-style-type: none"> 1. Hand hygiene is one of the best ways to prevent infection so proper hand hygiene must be performed often especially before any kind of wound care near the perineum. 2. Peri bottle will help to soothe the area with warm water and ensure the area stays clean and irrigated. Proper teaching will ensure patient knows how and when to use after voiding. 3. Using ice within the first 24 hours of birth will reduce inflammation, swelling and pain to the area. 4. The sitz bath will also soothe the area with warm, salt water and helping to keep the wound clean which will help the healing process. 5. Patting the area dry will reduce any kind of friction and tearing on the wound. 6. Educating the patient on signs of infection will ensure that the patient reports signs and symptoms early for treatment. 	<p>Patient goal was met and patient was able to demonstrate perineal care, practiced keeping the area clean and dry and verbalized the steps for after care at home by the end of shift.</p>

