Christie Benoit

Concept Map

Nursing Diagnosis Baby

Deficient knowledge of Hyperbilirubinemia related to absence exposure of information as evidenced by the mother state “I don’t know what hyperbilirubinemia is"

Expected Outcome

The Mother will verbalize 3 sign/symptoms of hyperbilirubinemia that require immediate attention to healthcare provider.

Nursing Interventions

1.Educate parent about the importance of frequent breast feedings every 2-3 hours
2.assess the mother level of understanding throughout the shift
3.provide information about the different type of jaundice and implication throughout the shift
4.provide educated regarding expected normal finding such as I/O, feeding, temperature.
5. Encourage patient to ask question about hyperbilirubinemia and enforce information as needed.

Evaluation

Goal met; the mother verbalizes 3 sign/symptoms of hyperbilirubinemia within 8 hours of nursing intervention.

Assessment MOM

Past medication History (Mother): AAO x4, Vitals: within normal range, no pain, soft breast, 2+ pedal pulse bilaterally, patient bonding with baby Rubria lochia, earthy odor, fundus firm 1finger width below, 2+ pedal pulses bilaterally, taking-in phase

Assessment BABY

Vitals within normal range, breasted, weight, length and head size AGA 10-90th percentile, new Ballard score 39, al reflexes positive, symmetrical, received erythromycin and vitamin k

Medication/ treatment

For Mom

Ferrous sulphate 350mg BD
Acetaminophen 250mgPRN
Motrin 100md PRN
Docusate sodium 100mg BD
Prenatal vitamins800 mg
Ursodiol 300mg /2x day

For Baby

Erythromycin 5mg/g eyes
Vitamins 1mg/0.5ml oral

Nursing Diagnosis

Constipation related to low fiber diet as evidence by patient states” I haven’t poop in 3 days ago.”

Expected outcome

The patient will have a bowel movement within 12-24 hours of nursing interventions .2/24/2023

Nursing Interventions

1.Educate the patient on the importance of increasing fluid intake, 2L daily.
2. Educate patient to increase fiber of at least 20 to 30G daily.
3.Assess the patient's bowel movements, including the frequency, consistency, and amount.
4.Administer any prescribed medications, including laxatives or stool softeners, as ordered by the healthcare provider.
5.Provide a comfortable and private environment for the patient to promote elimination

Evaluation

Goal met, Patient last bowel movement was 2/24/2023, within 2 hours after medication

Nursing Diagnosis

Risk for infection related to 2nd degree perineum laceration.

Expected outcome

The patient will show no signs of infection during postpartum period.

Nursing intervention

1. Educate patient to Keep the area clean and dry
2.Monitor Vital every 4 hours
3.Educate patient about sign and symptoms of infection to report
4.Educate patient to avoid sexual activity until the area is fully healed for 6 weeks.

Evaluation

Goal met, Patient perinium display healing without signs of redness, warmth and drainage

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