**Nursing Care Plan Using the Nursing Process Student Name: Chasiti Falls**

 **Date: 09/12/2011**

 **Client’s Initials: ACD**

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| **Assessment** (Client Story- Reason for Admission, Course of Stay, Medical/Surgical History, Current Assessment Findings (OB or Peds)Vital Signs, Current Laboratory/Radiology Results, Current Medications, Support System, )Reason for Admission: Undelivered Pregnancy Course of Stay: 09/10/2011 – 09/13/2011PMH: HSV 🡪 no current lesions; low-lying placenta – all clear at 26 weeks ; On 04/13/11 c/o palpitations/heart pounding & syncope c SOB – Sent to ER – no results foundAllergies: AmoxicillinCurrent Assessment:  GTPAL:1,1,0,0,15’7” 230lb BMI: 36.0 – Prior pregnancy weights not listed, but have been educated on nutrition during discharge teaching. Nutritional needs similar to when pregnant. Need energy (calories), protein, calcium (emphasized greatly), iodine, zinc, the B vitamins, and vitamin C.Delivery time: 1819 on 9/10/2011Type of delivery: c/s lower uterine transverseEpidural (spinal) given at 1810Membrane of ROM: spontaneous at 0900 on 09/10/11; Fluid clearPlacenta: Manual removal at 1820 on 09/10/11Blood Loss: > 500mL 🡪 aeb low RBC, Hct, Hgb, & Plt countsPresentation: CephalicCephalic Position: Vertex Blood Type: O positiveRhoGam: positiveRubella Status: ImmuneTdap: 11-18-08Physical Assessment: Breast: soft, nipples sore, no cracking, no bleedingUterine Fundus: Firm, U/1Bowel: active \* 4 quadrants; Last BM on Friday, 09/08/11; Flatulence present; Slight tenderness on palpation of uterus. Pt. states 2/10 pain rating prior to palpation. The pain 2/10 does not hinder pt. ability to function. 2 Percocet given on request at 0850. Follow up assessment findings were that comfort function level was maintained but not reduced. Bladder Status: Voiding Freely; on I&O till 11:15 A on 09/12/11Lochia: light rubraEpisiotomy/Cesarean Incision: CDI c Steri Strips Hemorrhoids: NoneEdema: NoneBreastfeeding – Effective; however, on the night shift, mother was anxious and tried to feed the infant too often. Baby would not latch & got fussy and mother did not understand why. She was educated on the matter, sent the baby to the nursery to get some rest. No problems noted on our shift. I&O: Void- 600cc; Intake: 480mLCV: S1, S2 present. Regular rate & rhythm. Lungs: Chest wall symmetrical with equal expansion. Respiration regular, unlabored, & symmetrical. CTA. ADL’s: Able to complete all ADL’s on her own, no limitations. Showered, got dressed, and walked to gift shop. VS: Temperature: 98.6 degrees Fahrenheit BP: 104/64 Pulse: 80Respirations: 16Medications:Colace 100mg PO BID for stool softening Prenatal Multivitamin PO dailyIbuprofen (Motrin) 800mg PO Q6H for painValtrex 500mg PO daily for HSVOxycodone/APAP 5-325 mg (Percocet) Q4H PRN for severe painSupport System: Married c no other children. Husband seems eager to participate in infant care as well as that of the mother while limited. Labs:WBC (3.7-11.0) – 11.9 H because invasive procedure and incision site.RBC (4.01-4.0) – 3.31L because blood loss during delivery.Hgb (12.2 – 15) – 10.1 L because blood loss during delivery.Hct (35.8-47.9) – 29.8 L because blood loss during delivery.Plt (150-400) – 141L because of blood loss during delivery.Readiness for enhanced childbearing processReadiness for enhanced family processes Risk for constipation r/t pain medicationsRisk for Postpartum Depression r/t anxietyActivity Intolerance r/t surgical incision aeb fatigue & painRisk for Infection r/t incisionKnowledge Deficit of Postpartum Care r/t being first time mother aeb asking lots of questions & anxietyAcute Pain r/t tissue damage aeb pain rated 2/10Risk for fluid deficit d/t postpartum hemorrhage Fatigue r/t anxiety and giving birth aeb forgetfulness Impaired Tissue Integrity r/t caesarean aeb incision with Steri strips Anxiety r/t knowledge deficit along with being first time mother aeb early morning breastfeeding, separation anxiety during the night, and being unable to sleep |  |

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| **Nursing Diagnoses/Analysis**(List 2 Nursing Diagnoses in Order of Priority; 3-part statement for actual diagnoses) | **Planning**(Expected Client Outcomes) | **Implementation**(Nursing Activities with NIC InterventionLabel & Page # Tailored to Your Client) | **Evaluation**(Evaluate Each Expected Client Outcome-If Not Met Discuss Reason and Proposed Changes in Client Care) |
| **Anxiety r/t change in role function to a first time mom aeb over feeding the baby, and pt. stated that she was unable to sleep because she didn’t want to send infant to nursery** | **Will identify and verbalize symptoms of anxiety while on my shift.****Will identify, verbalize, and demonstrate at least 2 techniques to control anxiety while on my shift.****Will verbalize absence or decrease in subjective distress while in my shift.****Will appear relaxed through having appropriate posture, facial expressions, gestures, and activity levels that reflect decreased distress while on my shift.**  | **Anxiety Reduction p. 144****Educate pt. on how to care for herself and the baby.****Educate pt. on SIDS, and to put the baby down when getting distraught.** **Educated pt. on the importance of limiting visitors and getting lots of rest.** **Assess for signs of distress and its interference c ADLs q2h.** **Educate pt. on both pharmological and nonpharmological methods to use to decrease and/or control anxiety such as massage, music, and medication.** | **Goal met aeb anxiety level appeared to decrease after discharge teaching. Pt. verbalized that she felt more comfortable after becoming knowledgeable of anxiety and soothing techniques.**  |
| **Activity Intolerance r/t cesarean aeb fatigue and pain** | **Will be able to increase activity gradually while on my shift. i.e. Getting out a bed, showering, dressing, walking in halls.** **Incision site will remain CDI while on my shift****Will get enough rest to function both physically, mentally, and emotionally.****Will state symptoms of adverse effects of excessive activity and report onset of symptoms immediately while on my shift.**  | **Energy Management p. 119-121** **Educate pt. on the adverse effects of too much activity.** **Educate pt. on what she should and should not do, and to gradually increase activity. (i.e. do not lift heavy objects, do not drive for two weeks, do rest when baby allows, etc.)****Educate pt. and show how to care for incision site with soap & water.****Infant will be taken to the nursery in order for the mother to get rest.****Assess client’s ability to tolerate activities.** | **Goal met aeb discharge teaching performed and questions answered about activity tolerance. Pt. got out of bed, showered, got dressed, and walked to the gift shop after getting some rest. Incision site remains CDI. Pt. notifies staff of pain rating 2/10 after activity, no increase.**  |

**Nursing Care Plan Using the Nursing Process Student Name: Chasiti Falls**

 **Date: 09/12/2011**

 **Client’s Initials: ACD NBF**

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| **Assessment** (Client Story- Reason for Admission, Course of Stay, Medical/Surgical History, Current Assessment Findings (OB or Peds), Vital Signs, Current Laboratory/Radiology Results, Current Medications, Support System, )Reason for Admission: NBF Course of Stay: 09/10/2011 – 09/13/2011PMH: Delivery time: 1819 on 9/10/2011Type of delivery: c/s lower uterine transverseMembrane of ROM: spontaneous at 0900 on 09/10/11; Fluid clearPresentation: CephalicCephalic Position: Vertex Resuscitation: Tactile Stim, Bulb SuctionLive bornTerm 38.5 weeksStableAPGAR: 1 minute – 9; 5 minutes – 99lb 15oz Head 36”Length: 22”LGA: YesMother’s Blood Type: O positiveMother’s RhoGam: positiveMother’s Rubella Status: ImmuneMother’s PMH: HSV 🡪 no current lesions; low-lying placenta – all clear at 26 weeks ; On 04/13/11 c/o palpitations/heart pounding & syncope c SOB – Sent to ER – no results foundAllergies: NKA; NKDACurrent Assessment: Identification band present/security tag active: yesBreastfeeding: Not cooperative early AM; 1015 left breast – 5 minutes; 1050 right breast – time unknown (Parents were unable to remember, we provided them a breastfeeding tracking sheet) Scalp PetechiaeMldgORS Erythema on nape & eyesGeneralized NBRRed dot c possible bruising to back of left thighScratch inside left earCracking ankle – lotion appliedVaginal DischargeCV: Regular rate & rhythm. No murmurs heard. GI: BS active \*4 quadrants.Lungs: CTA. Chest wall symmetrical with equal expansion. Respiration regular, unlabored, & symmetrical. VS: Temperature: 98.3 degrees Fahrenheit Pulse: 138Respirations: 40Support System: Married Mother & Father c no siblings. Parents both seem to have formed a loving bond with the infant and eager to provide satisfactory care.Risk for Jaundice r/t jaundice surfacing around 3rd or 4th dayRisk for Ineffective Thermoregulation r/t immaturityRisk for Ineffective Airway Clearance r/t excessive oropharyngeal mucous Risk for Infection r/t inadequate acquired immunityEffective Breastfeeding r/t infant gestational age >34 weeks aeb sucking, latching, and appears to be fullReadiness for Enhanced Organized Infant Behavior aeb |  |

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| **Nursing Diagnoses/Analysis**(List 2 Nursing Diagnoses in Order of Priority; 3-part statement for actual diagnoses) | **Planning**(Expected Client Outcomes) | **Implementation**(Nursing Activities with NIC InterventionLabel & Page # Tailored to Your Client) | **Evaluation**(Evaluate Each Expected Client Outcome-If Not Met Discuss Reason and Proposed Changes in Client Care) |
| **Risk for Ineffective Airway Clearance r/t excessive oropharyngeal mucous**  | **Infant will maintain a patent airway at all times while on my shift.** **Parents will demonstrate how to use bulb syringe while on my shift.** **Parents will identify factors that can inhibit effective airway clearance while on my shift.**  | **Teach parents taught how to use bulb syringe immediately.** **Assess infant for patent airway q2h.****Educate parents on factors that inhibit effective airway clearance such as smoking during discharge teaching.**  | **Goal met aeb infant maintained patent airway, demonstrated how to use bulb syringe, and able to identify factors that can inhibit effective airway.** |
| **Effective Breastfeeding r/t infant gestational age > 34 weeks aeb latching, sucking, and appears to be full.** **(I chose this not as a priority diagnosis, but because I had not completed a care plan on it yet.)** | **Infant will maintain effective breastfeeding during my shift.****Infant will maintain normal growth patterns while on my shift.****Mother will verbalize satisfaction with breastfeeding process while on my shift.** | **Encourage skin-to-skin contact.** **Encourage breastfeeding on demand.****Provide mother with written record to monitor breastfeeding sessions.****Assess nipples for pain, soreness, and irritation.****Provide Lanolin prn.** **Assess infant weight daily.** | **Goal partially met aeb infant breastfeeding well, and mother satisfied. Weight taken on night shift, but I did not get to retrieve that information from computer thus, I cannot confirm that the infant maintained normal growth patterns.**  |

**Reflection and Critical Thinking Questions Based on QSEN Competencies (**[**http://www.qsen.org**](http://www.qsen.org)**):**

1. What are your personal views on today’s clinical experience? What would you do differently to be more successful with your client? What **quality improvement** methods could be instituted to improve the client’s quality of care and **safety**?

I thoroughly enjoy clinical. I love the MB unit! It is a lot faster pace than Illness & Disease Practicum. I have always wanted to work in this department and still do, but I have heard that you do not learn as much as a new graduate because everything is so repetitive. I have become more comfortable with the assessments, though not as comfortable as I would like. With practice, I am sure I will become more competent and confident. . A quality improvement would include having us invest in pediatric sized stethoscopes and having a designated person to fill in for sitters for breaks. It was somewhat chaotic when the sitter needed to take a break. As for safety, the HUG alarms and bracelets are effective. One thing I have noticed is that the electric doors especially at the nursery stay open for a long time. This could allow time for an unauthorized individual to get in there.

1. Discuss your client’s disease pathophysiology and relate it to the assessment findings (including vital signs, laboratory results, and medications). Please support your answers using appropriate nursing literature- including nursing research and **evidence based practice** literature. Based on your client’s current pathophysiology or personal/family disease history, describe the genetic or genomic education, screening, or referral that you could perform with your client/family during your nursing care.

Acute Pain is “usually of recent onset and commonly associated with a specific injury, acute pain indicates that damage or injury has occurred (Brunner & Suddarth p.231).” The pulmonary, cardiovascular, gastrointestinal, endocrine, and immune systems can be affected by unalleviated pain. While a young, healthy person could probably bear these effects, an elderly or immune-compromised individual are at a disadvantage for successful recovery. The pain needs to be handled effectively, thus making the recovery process quicker and more successful (Brunner p. 232). As healing occurs, the acute pain should be reduced (Brunner p. 231). Aggravating & both pharmacological and non-pharmacologic alleviating factors need to be determined in order to provide effective care. “A first-degree laceration extends through the skin and structures superficial to muscles (Lowdermilk p.470).” Our skin is a primary defense mechanism making the patient more susceptible to infection. If the patient were to have another child, then she may want to have a caesarean birth to avoid reinjury. Substantial bleeding is expected due to the vascularity of this area. An injury like this usually heals without lasting damage.

1. What were your client/family’s educational needs and what strategies did you use to meet the needs? How did you utilize **informatics** to educate your client/family? What did you document about your education success or difficulties today?

My family was first time parents. Kassie & I completed discharge teaching. Strategies we used were providing them a book to follow along as we talked demonstration of bulb syringe use, and making the teaching more of a conversation rather than lecture. We also had to provide them the Purple Cry DVD thus we incorporated informatics such as a TV & DVD player. Today was the first day I actually did the teaching myself. I need to be more knowledgeable of the discharge notebook; thus, I am going to obtain a copy and highlight the most important bullet points that need to be taught.

1. Discuss 3 **patient-centered care** actions that you performed today that demonstrated caring towards your client/family. Were they based on the client/family’s preferences, values, and needs?

Though it is our job to tidy the patient’s room already, I helped her pick up the bathroom after she showered including her own personal belongings. I provided her with extra linens even though she said it was not necessary because her husband had already showered with them. After teaching her on anxiety and the importance of her obtaining some rest, I took the baby to the nursery. I checked on the couplet frequently and provided care and/or support as needed. When doing my assessment I made sure to inform the patient of what I was doing and to maintain privacy. Talking to my patient was a diversion activity that calmed her down. These actions were value and need based.

1. Discuss how inter-professional **teamwork & collaboration** was used to care for your client or discuss how your client might have benefitted from better inter-professional teamwork & collaboration practices.

Student nurses are great to have on any floor. Not only is it educational for the students, another hand for the nurses, but a great emotional support for the patient. As students, we have a lot more time to spend with our patients providing them with just a little something special. I enjoyed working with Kassie. When doing assessments we would do them synchronized to avoid having the patient undergo two assessments. We would compare allowing me to determine my competence. Kassie speaking me through procedures & being in the room probably calmed the patients down knowing that I am a student with little experience. I did what Kassie asked such as gathering equipment, taking VS, and simply being eager to work, and then in return, Kassie provided me with an educational experience.