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Maternal-Infant Nursing Care Plans

Karla Luxner, R.N.C., M.S.N.

MATERNAL-INFANT NURSING CARE PLANS

Karla L. Luxner RNC, MSN

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INTRODUCTION

Pregnancy, childbirth, the puerperium, and the newborn transition to extrauterine life are natural physiologic processes. The healthy mother and her infant usually require little in the way of medical intervention during these life events; they may however, benefit greatly from comprehensive nursing care. Maternal-Infant nursing is provided in diverse settings from homes and schools to Third-World clinics, hospitals, and OB Intensive Care Units. Perinatal health promotion and wellness teaching form the foundation of this care and lay the groundwork for healthy families of the future. For the families experiencing a complicated pregnancy or birth, skilled nursing care based on sound scientific knowledge is provided—not instead of, but in addition to health promotion and wellness teaching. Knowledge and respect for cultural variations is essential to modern nursing practice. Perhaps in no other specialty are there so many culturally defined prescriptions and proscriptions as those accompanying pregnancy, birth, and infant care.

The nursing process serves as a learning tool for students and as a practice and documentation format for clinicians. Based on a thorough assessment, the nurse formulates a specific plan of care for each individual client. The care plans in this book are provided to facilitate that process, not supplant it. To that end, each care plan solicits specific client data and prompts the nurse to individualize the interventions, consider cultural relevance, and to evaluate the client's individual response. The book provides basic nursing care plans for healthy clients during the prenatal, intrapartum, postpartum, and newborn periods. Common perinatal and neonatal complications for each section are then presented with associated care plans. Home visit care plans are included for the prenatal, postpartum, and newborn clients, reflecting current practice.

I am grateful to my family, students, nurse colleagues, and the many mothers, fathers, grandmas, and babies who have enriched my understanding and shaped my practice. This book is dedicated to my own mother, Elizabeth Hobart Romaine, who taught me that it could be done.

Karla L. Luxner

MATERNAL-INFANT NURSING CARE PLANS

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Using the Maternal-Infant Nursing Care Plans

These plans have been developed to reflect comprehensive perinatal nursing care for mothers and their infants. The book is divided into four units: Pregnancy, Intrapartum, Postpartum, and Newborn. Each unit begins with an overview of the general physiologic and psychological changes associated with the period. Additional pertinent information is presented in flowchart format. A Care Path for each unit provides an overview of common health care practices during each period.

The basic nursing care plans in each unit provide comprehensive care for healthy clients. These should serve as the basic plan for most clients with changes made to address individual situations. For example, designing a client-specific plan of care may include combining nursing diagnoses from the basic care plan and one or more complications. The practitioner should add, delete, and combine diagnoses as dictated by assessment of the individual client.

Perinatal and neonatal complications are briefly described, including risk factors and common medical care if indicated. Important relationships are presented in flowcharts to facilitate understanding of the basis for care. Nursing diagnoses relevant to the complication are cross-referenced when applicable and followed by specific diagnoses common for the condition.

Nursing care begins with a comprehensive review and assessment of each individual client. The data is then analyzed and a specific plan of care developed. The format for each nursing care plan in this book is summarized below.

- Nursing diagnoses as approved by the North American Nursing Diagnosis Association (NANDA) taxonomy.
- Related factors (etiology) for each diagnosis are suggested and the user is prompted to choose the most appropriate for the specific client.
- Defining characteristics for each actual diagnosis are listed with prompts to the user to include specific client data from the nursing assessment.
- Goals are related to the nursing diagnosis and include a time frame for evaluation to be specified by the user.
- Appropriate outcome criteria specific for the client are suggested for each goal.
- Nursing interventions and rationales are comprehensive. They include pertinent continuous assessments and observations. Common therapeutic actions originating from nursing and those resulting from collaboration with the primary caregiver are suggested with prompts for creativity and individualization. Client and family teaching and psychosocial support are provided with respect for cultural variation and individual needs. Consultation and referral to other caregivers is suggested when indicated.
- Evaluation of the client's goal and presentation of data related to the outcome criteria is followed by consideration of the next step for the client.

It is hoped that the user will individualize these care plans not only by inserting pertinent client data when prompted, but also find stimulation to include creative interventions not listed here.

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UNIT I: PREGNANCY

Healthy Pregnancy

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- Pregnancy Induced Hypertension (PIH)
- Placenta Previa
- Preterm Labor
- Preterm Rupture of Membranes
- At-Risk Fetus

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Healthy Pregnancy

Pregnancy is a normal physiologic process. The goal of health care during pregnancy is to promote and maintain the health of the mother and fetus. Risk assessment, problem identification and intervention, and health teaching are important aspects of prenatal care.

Physical Changes

The placental hormones influence changes in maternal physiology during pregnancy. These hormones maintain pregnancy and promote an optimal environment for the growing fetus.

- Physiologic changes include a 50% increase in blood volume, an increased sensitivity to CO_2, and a need for higher insulin production.
- Mechanical changes result from the growing uterus and include pressure on the bladder during the first and third trimesters, a shifting center of gravity, and stretching of uterine ligaments.

Lab Value Changes

	Non-pregnant	Pregnant
Hgb (g/dL)	12-16	11-13
Hct (%)	36-48	33-39
BUN (mg/dL)	10-16	7-10
Albumin (g/dL)	4.3	3.5
WBC (mm^3)	4000-11000	5000-15000

Psychological Changes

Developmental issues and possibly hormone levels influence changes in maternal emotions and outlook. Maternal psychological tasks of pregnancy may include:

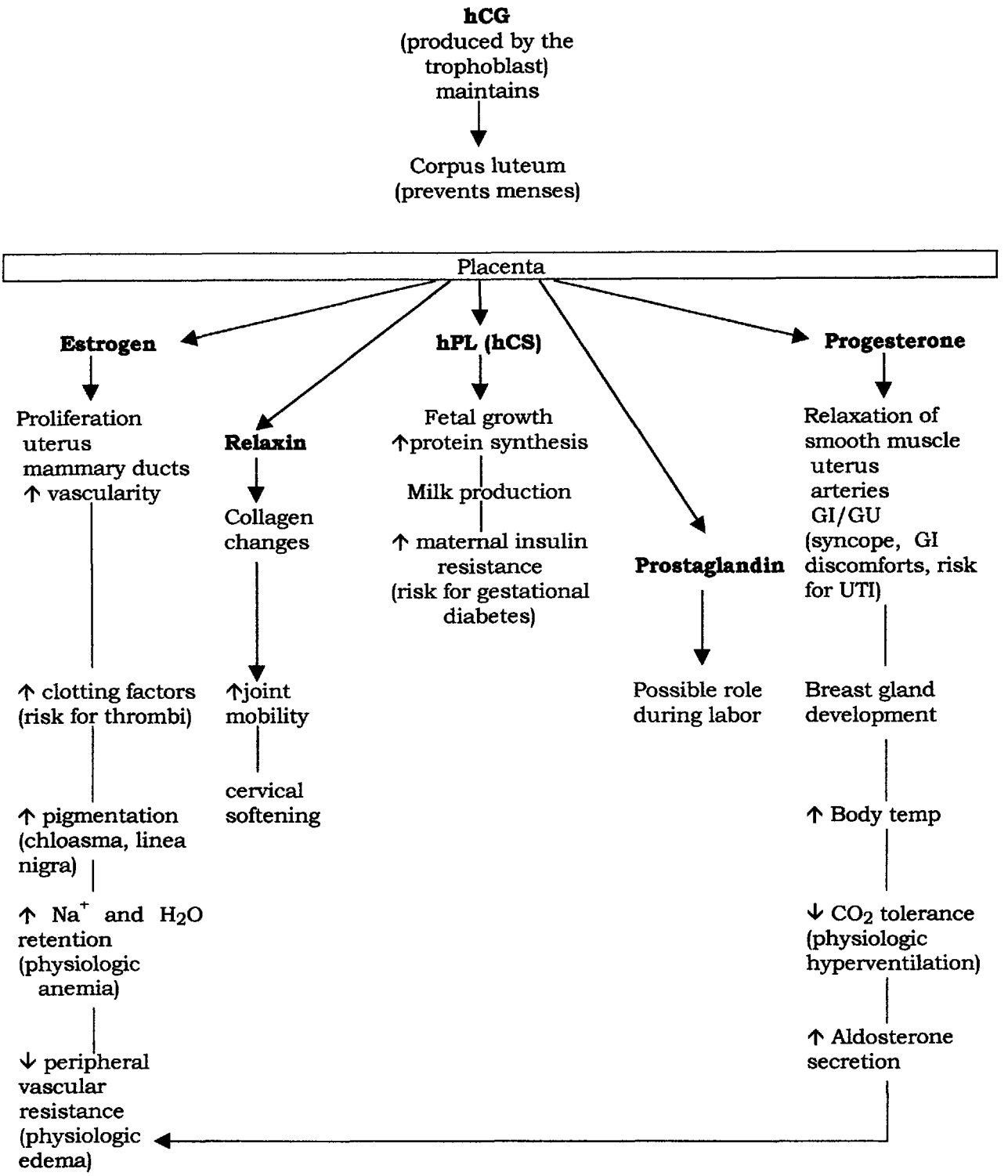
- Acceptance of the fact of pregnancy (first trimester)
- Acknowledgement of the fetus as a seperate being (second trimester)
- Preparation for birth and motherhood (third trimester)

Fetal Growth and Development

Fetal growth and development are monitored at each prenatal visit. The gestational age of the fetus is calculated from the mother's last normal menstrual period. A full-term pregnancy is 40 weeks (plus or minus 2 weeks) from the LNMP.

- During the first trimester all organ systems develop and the fetus is most vulnerable to teratogens.
- The fetal heart rate (FHT) can be heard with a doppler from 8-12 weeks. Normal FHT's are from 120-160 beats per minutes.
- Fetal movement ("quickening") is usually noticed by the mother from 16-20 weeks.
- Lanugo is fine hair, which covers the fetus from about 20 weeks until the third trimester when it thins and disappears.
- Vernix caseosa is a thick cheesy secretion that covers and protects the fetal skin from about 26 weeks. This disappears by term except in body creases.
- Viability depends on maturation of the respiratory and neurological systems. A fetus born as early as 24 weeks may survive but will require intensive care.

Placental Hormones



Prenatal Care Path

Week	Interview	Physical Exam	Tests	Teaching	Referral	Other
1st visit	Chief c/o Med/OB hx Psychosocial Religious Cultural Concerns & resources Risk assessment	Ht., Wt., B/P, TPR, reflexes Physical exam Fundal ht. & FHT if indicated Pelvic exam, adequacy, size/dates	CBC, ABO, Rh, VDRL, Rubella titer, Antibody titer, (HBsAg) (HIV), U/A, Pap, GC, chlamydia (u/s)	Normal pregnancy, Nutrition, Substance abuse, Fetal growth & development, Danger signs	Social Services, WIC	PNV, iron
12	Client concerns	Wt., vital signs, FHT, fundal ht.	Urine dip for protein & glucose	As needed	As needed	
16			MSAFP			
20	Quickening?		Urine dip (ultrasound)			
24	Client concerns & discomforts			Home visit		
28			Hgb. 1hr. GTT, Rh/antibody titer if Rh neg	S/S PTL		RhoGAM prn
32			Urine dip		Childbirth Education VBAC prn	
34				Home visit Breast prep childbirth ed.		
36			cultures: β-strep, GC, chlamydia			Chart to L&D
38 to del.		Pelvic exam if contractions				

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Basic Care Plan: Healthy Pregnancy

The nursing care plan is based on a thorough nursing history, assessment, and review of medical and laboratory findings. Specific client-related data should be inserted wherever possible and within parentheses.

Nursing Care Plans

Health Seeking Behaviors: Prenatal Care

Related to: Client's desire for a healthy pregnancy and newborn.

Defining Characteristics: Client makes and keeps prenatal care appointment (date). Client states (specify: e.g.; "I think that I am pregnant; I want to have a healthy baby"). List appropriate subjective/objective data.

Outcome Criteria

Client will keep all prenatal appointments.

Client will call the health care provider for any concerns related to pregnancy.

INTERVENTIONS	RATIONALES
Establish rapport: ensure privacy, listen attentively, and allow adequate time to address client's concerns.	Client will feel comfortable in the care setting and be willing to share concerns.
Assess reason for seeking care, remain nonjudgmental, use open-ended questions, and observe nonverbal clues.	Client concerns are the basis of nursing care. Therapeutic techniques help the nurse obtain the most information.
Assess knowledge level of pregnancy and prenatal care (previous OB hx).	Assessment provides data for development of an individualized teaching plan.
Assess client concerns related to pregnancy/prenatal care: e.g., cultural expectations; emotional, family, financial concerns.	Socioeconomic concerns may interfere with the ability to obtain care. Issues may interfere with compliance.
Observe interaction with significant other, if present.	Observation provides information about social support.
Describe the components of care with rationales (schedule of care, fetal assessments, lab tests, etc.).	Understanding what to expect allays fear and promotes compliance.
Provide emotional support during invasive or painful procedures.	Most women dislike pelvic exams. Nursing support can decrease discomfort by promoting relaxation.
Modify plan of care based on client requests/needs (e.g., female physician, teaching session rather than literature for illiterate clients).	Individualizing the routines of prenatal care shows respect for the client's unique needs and concerns.
Provide the name and phone number (specify) for client to call with any questions.	Often questions will arise outside of appointments. Client will feel comfortable with a person to contact.
Provide written information about pregnancy.	Written information is available to the client in her home.
Refer client as needed (WIC, social services, etc.).	Ensures client will obtain needed assistance.

Evaluation

(Date/time of evaluation of goal)

(Has goal been met?not met? partially met?)

(Has client kept all prenatal appointments? Give data.)

(Has client called with concerns? Give data.)

(Revisions to care plan? D/C care plan? Continue care plan?)

Nutrition, Altered: Less Than Body Requirements

Related to: Increased demands of pregnancy, inability to obtain/ingest/utilize adequate nutrients.

Defining Characteristics: Specify: (Client's reported daily intake v. requirements for this pregnancy, reported nausea and vomiting, pica), (EGA, Ht, Wt, Hgb and Hct, serum albumin, blood glucose, condition of skin, hair, nails, teeth); list appropriate subjective and objective data.

Goal: Client will ingest adequate nutrients during pregnancy for maternal and fetal needs (date/time to evaluate).

Outcome Criteria

Client reports eating a balanced diet based on the Food Guide Pyramid modified for pregnancy (or prescribed diet).

Client takes prenatal vitamins and iron as prescribed.

Client gains 25 to 35 pounds during pregnancy (2-5 pounds first 12 weeks, 1 pound/week thereafter), (↑ for multiple gestation).

INTERVENTIONS	RATIONALES
Assess current food intake; 24 hour diet recall; pica; and appetite changes (at each prenatal visit).	Assessment provides baseline data. Pica is the ingestion of non-food substances (dirt, starch, ice, etc).
Assess for nausea and vomiting (amount, times).	Assessment provides information about the client's ability to ingest and absorb nutrients.
Assess skin (texture, turgor), hair, eyes, mouth, nails for signs of adequate nutrition.	Assessment provides information about general nutrition status. Skin should be smooth and elastic, hair shiny, nails smooth, pink, and not brittle.
Assess weight at each visit and compare with previous weight and expected gains. Remain nonjudgmental about weight gain.	Assessment provides information about weight gain and the pattern of gain. Shows respect for client and helps allay fears related to weight gain.
Assist client to compare her usual diet with the Food Guide Pyramid recommendations for pregnancy.	Involving the client in assessment and planning encourages compliance.
Praise positive eating habits and discuss the relationship with optimal fetal growth and development.	Praise reinforces healthy eating. Understanding the fetal needs provides incentive for obtaining optimum nutrition.
Assist client to plan a nutritious diet using the Food Guide Pyramid modified for pregnancy taking into account personal and cultural preferences and financial ability (specify: diabetic, vegetarian, kosher, etc.).	Promotes compliance by recognizing individual variations and includes client in planning.
Teach client to avoid highly processed foods or those with many artificial additives (clients with PKU need to avoid phenylalanine).	Unprocessed, natural foods contain the most nutrients. Additives may adversely affect the fetus (high phenylalanine levels may cause mental retardation in the fetus of PKU moms).
Reinforce need for prenatal vitamins and iron if prescribed.	Provides additional nutrients that may be difficult to obtain by diet alone.

INTERVENTIONS	RATIONALES
Reinforce positive nutrition habits at each prenatal visit.	Reinforcement motivates the client to maintain a healthy diet during pregnancy.
Refer to dietitian, as needed (e.g., diabetes mellitus, strict vegetarian).	Referral provides additional information and support for clients with special dietary needs.

Evaluation

(Date/time of evaluation of goal)

(Has goal been met? not met? partially met?)

(Does client report eating a balanced diet based on the Food Guide Pyramid modified for pregnancy?)

(Does client take prenatal vitamins and iron as prescribed?)

(What is client weight gain?)

(Revisions to care plan? D/C? Continue?)

Injury, Risk for: Maternal/Fetal

Related to: Exposure to teratogens, complications of pregnancy.

Defining Characteristics: None, since this is a potential diagnosis.

Goal: Client and her fetus will not experience any injury during pregnancy.

Outcome Criteria

Client denies any exposure to teratogens.

Client denies experiencing any danger signs of pregnancy.

Client's B/P remains < 140/90, reflexes same as baseline (specify), urine negative for protein.

FHT's remain between 120-160; growth is appropriate for EGA.

INTERVENTIONS	RATIONALES
Assess maternal risk for exposure to teratogens (at first prenatal visit): environmental toxins, medications/drugs, employment, or pets.	Assessment provides information about client risk factors. The fetus is at highest risk from teratogens during the first 12 weeks when organogenesis takes place.
Assess wt gain, B/P, reflexes, edema; dip urine for protein and glucose (at each visit) and compare to baseline data. Assess immunity to rubella (history, immunization).	Signs & symptoms of PIH include an increase in B/P of 30/15mmHg or more, sudden ↑ in wt, edema, and proteinuria. Gestational diabetes may cause consistent glycosuria; rubella is a known teratogen.
Assess fetal well-being at each visit. Ask about fetal movement, listen to FHT for a full minute, measure fundal height, and compare to EGA.	Complications of pregnancy may affect the fetus by interfering with placental function. The stressed fetus may have ↓ movements or ↓ fundal height. Size-dates discrepancies may indicate IUGR.
Perform, or assist with, other fetal assessments as indicated or ordered (specify: CVS, amniocentesis, NST, ultrasound, CST, biophysical profile, etc.).	Testing provides information about fetus. The fetus may exhibit signs of distress such as decreased FHR variability or late decelerations.
Teach client to avoid exposure to teratogens during pregnancy: medications/drugs not prescribed by the physician, including OTC meds; radiation (including x-rays); cat litter or raw meat; viral infections	Client may be unaware of risks associated with commonplace exposures. Provides needed information to help prevent harm to the fetus.

INTERVENTIONS	RATIONALES
(rubella); prolonged exposure to heat (hot tubs, saunas); alcohol.	
Teach good body mechanics and appropriate exercise: not to lie flat on back; wear sensible shoes; keep back straight and feet apart when bending/lifting; usually may engage in nonweight-bearing exercises (e.g., swimming, cycling, walking); avoid over-heating.	Avoids maternal or fetal injury while allowing the client to continue to participate in appropriate exercise during pregnancy.
Teach client to wear both lap and shoulder seat belts; lap belt should be worn low.	The mother and fetus are at highest risk of injury from being thrown from the car in an accident.
Discuss safe sex practices with client and significant other if available (e.g., risks of STD/HIV, proper use of condoms); address any concerns the couple may have about sex during pregnancy.	Client may not know how to protect herself and the fetus. Client and significant other may have concerns about sexuality during pregnancy.
Teach good hygiene practices: hand washing, wiping front to back after using the toilet, daily bathing.	Good hygiene prevents the spread of microorganisms, prevents fecal contamination of vagina/urethra.
Teach warning signs that client should report: severe nausea and vomiting, s/s of infection, vaginal bleeding/watery discharge, severe headache, visual disturbances, epigastric pain, severe abdominal pain, s/s of preterm labor, marked changes in fetal movement.	These are s/s of serious complications of pregnancy: hyperemesis gravidarum, placenta previa, placental abruption, pregnancy-induced hypertension, PROM, preterm labor, fetal distress. Early identification ensures prompt treatment.
Provide written reinforcement of teaching topics and verify understanding.	Written reinforcement enables client to review teaching at home. Verification allows for clarification and ensures understanding.

Evaluation

(Date/time of evaluation of goal)

(Has goal been met? not met? partially met?)

(Does client deny any warning signs?)

(What is B/P? reflexes? urine protein?)

(What are FHT's? Is fetal growth appropriate for EGA?)

(Revisions to Care Plan? D/C? Continue?)

Pain (discomfort)

Related to: Physiologic changes of pregnancy.

Defining Characteristics: Specify: (client's report of nausea & vomiting, backache, leg cramps etc. Client should rate on a scale of 1 to 10. Appropriate objective data: grimacing, etc.).

Goal: Client will experience less discomfort related to pregnancy (date/time goal to be evaluated).

Outcome Criteria

Client reports a decrease in discomfort to less than (specify on a scale of 1 to 10).

Client does not show objective signs of discomfort (grimacing, etc; specify what client had been indicating).

INTERVENTIONS	RATIONALES
Assess client for discomfort at each prenatal visit. Observe for nonverbal signs such as grimacing, guarding, etc. Ask client if she has any discomfort.	Client may think discomfort is normal during pregnancy, or may not wish to complain. Some cultures do not approve of showing discomfort.
Ask client to rate the discomfort on a scale of 1 to 10 with 1 being the least and 10 the most.	A rating scale helps the nurse to measure the effectiveness of interventions.
Assess what the client usually does to alleviate the discomfort and how effective that has been.	Provides information about the methods already tried by the client to alleviate discomfort.
Explain the physiologic basis for each discomfort the client identifies and suggest possible interventions for each discomfort. Specify:	Understanding the physiologic basis helps to allay fear, an emotion that may increase the discomfort.
(Nausea and vomiting: Eat frequent small meals, dry carbohydrates or hard candy before rising in the morning.)	Keeping the stomach neither empty nor too full and avoiding greasy or highly spiced foods may help. N&V may be related to high hCG levels in early pregnancy; this usually improves by the second trimester.
(Fatigue/fainting: Teach client to obtain 7-8 hours of sleep at night and plan for a rest or nap during the day. Teach to rise slowly when changing position and if she feels faint to sit and lower her head.)	Fatigue may be due to hormone changes in first trimester and ↑ demands during last trimester. Postural hypotension may be related to venous pooling in the lower extremities from general vascular relaxation.
(Urinary frequency: Teach client to void frequently, not to "hold it." Teach Kegel exercises and signs/symptoms of UTI to report: pain, burning, and urgency in addition to frequency.)	May be caused by pressure on the bladder from the enlarging uterus - more common during first and last trimesters. UTI's may cause preterm labor and need to be identified and treated early.
(Vaginal discharge (leukorrhea): Assess for infection, STD's; teach client to wear cotton underwear and bathe daily. May wear peri pad if changed frequently.)	Hyperplasia and ↑ vaginal and cervical secretions are the result of hormone changes. Good hygiene may prevent infection.
(Leg cramps: Assess calcium intake. Teach client to extend her leg and dorsiflex the foot of the affected leg to relieve cramp.)	Cramps may be related to possible calcium imbalance or uterine pressure.
(Heart burn (gastroesophageal reflux): Teach client to eat small frequent meals, avoid fatty foods and flat positioning. Instruct to take antacids as prescribed [specify: e.g., Maalox].)	Progesterone causes ↓ motility and relaxes the cardiac sphincter. Increased uterine pressure causes gastroesophageal reflux. Antacids neutralize gastric acid.
(Varicose veins: Teach client to change positions frequently, rest with legs elevated, engage in regular exercise and wear support hose without garters.)	Decreased peripheral vascular resistance, ↑ blood volume, and uterine pressure may cause venous stasis leading to ↑ varicose veins and risk for thrombus formation.
(Backache: Needs to be differentiated from preterm labor. Assess for contractions; teach good body mechanics and pelvic rock exercise. Teach client to wear low sturdy shoes and rest with feet elevated.)	Preterm labor is often felt as lower back pain. In the third trimester the center of gravity shifts which puts added stress on lower back muscles.
(Braxton-Hicks contractions: Teach client to differentiate from labor: usu-	The uterus contracts throughout pregnancy. Labor contractions usually

INTERVENTIONS	RATIONALES
ally painless, don't ↑ in intensity over time, may decrease if activity changes (walking or resting). Suggest client practice breathing techniques with B-H contractions.	↑ over time, becoming more uncomfortable no matter what the client does. Client may feel reassured about labor if she practices with Braxton-Hicks contractions.
Notify caregiver for unusual symptoms or severe discomfort.	Unusual or severe discomfort may indicate a complication.

Evaluation

(Date/time of evaluation of goal)

(Has goal been met? not met? partially met?)

(What does client report the intensity of discomfort to be on a scale of 1 to 10?)

(Describe objective signs of discomfort or change in them [e.g., client is smiling and no longer grimacing?])

(Revisions to care plan? D/C care plan? Continue care plan?)

Basic Care Plan: Prenatal Home Visit

Prenatal home visits provide information about the client's home environment and family support system. Additional benefits are client convenience and comfort, which facilitate learning.

Nursing Care Plans

Basic Care Plan: Healthy Pregnancy (7)

Additional Diagnoses and Care Plans

Home Maintenance Management: Impaired

Related to: (Specify: inadequate finances, lack of understanding, insufficient support systems, etc.)

Defining Characteristics: Specify: (Client states she can't maintain the home – home is dirty, infested, overcrowded, etc. Home has no plumbing, heat, window screens, etc. Client states she can't afford basic hygiene needs; has inadequate support systems to help with finances and maintenance, etc.).

Goal: Client will maintain a safe, clean, and growth-promoting home environment by (date/time to evaluate).

Outcome Criteria

Client will identify hygienic needs in the home (specify).

Client will obtain financial assistance to maintain home (specify).

Client will develop a plan to improve home maintenance support system (specify).

INTERVENTIONS	RATIONALES
Assess client's understanding of the need for a clean, safe, growth-promoting environment for herself and her family.	Assessment provides information about the client's understanding of basic home maintenance needs.
Assess home environment for water supply, plumbing, air quality, heating, screens, cleanliness, food preparation area, and bathing facilities.	Assessment provides information about the safety and cleanliness of the home environment for the client and family.
Assess client's plans for newborn care area (separate room, area of other room, crib, bassinet, etc.).	Assessment provides information about the client's knowledge of infant needs and her plans to meet them.
Assist client to identify needed changes in the home (specify: safety issues, cleanliness, basic services, etc.).	Process involves the client in the plan to improve home maintenance.
Provide teaching about factors the client doesn't identify (specify).	Provides information about basic home maintenance needs.
Inform client of community services and agencies that may offer support in meeting basic home maintenance needs (specify).	Teaching provides information about available resources.
Assist the client to develop a plan to improve and maintain a clean, safe, and growth-promoting home (specify).	Assistance promotes self-esteem and encourages the client to maintain a healthy environment.
Make referrals as needed to help client implement plan (specify: Social services, WIC, community agencies, etc.).	Referrals provide additional financial or resource assistance to client.

Evaluation

(Date/time of evaluation of goal)

(Has goal been met? not met? partially met?)

(Has client identified hygienic needs? Specify.)

(Has client obtained financial assistance? Specify.)

(Has client developed a plan to improve support systems? Specify.)

(Revisions to care plan? D/C care plan? Continue care plan?)

Family Coping: Potential for Growth

Related to: Family adaptation and preparation for birth of new member of family.

Defining Characteristics: Family members describe impact of pregnancy in enhancing growth (specify: e.g., sibling states "I'm going to be a big brother and help take care of the baby!" etc.). Family members are involved in prenatal visits and preparations for baby (specify: e.g., husband attends childbirth classes, Grandma plans to babysit, etc.).

Goal: Family will continue to cope effectively during pregnancy by (date/time to evaluate).

Outcome Criteria

Family will express positive feelings about the pregnancy.

Family will be involved in prenatal care and preparations for the new baby (other specifics as appropriate).

INTERVENTIONS	RATIONALES
Assess family structure and encourage participation in home visit as appropriate (specify according to ages of children).	Client may be part of a nontraditional family. Participation during the prenatal period helps the family to bond with the new baby.
Assess family members' responses to the pregnancy: verbal and nonverbal.	Family members may need assistance to identify feelings and thoughts about the new baby.
Provide information about changes the family may experience due to the pregnancy and birth (specify for each family member).	Information provides anticipatory guidance to help the family adjust to changes they will experience.
Provide age-appropriate (specify) information to siblings of new baby: pictures, books, stories, etc.	Enhances the child's self-esteem to be included in the home visit with age-appropriate methods.
Identify and praise effective coping mechanisms used by the family (specify).	Identification and praise provides positive reinforcement to the family and helps identify skills they already possess.
Refer family members to appropriate childbirth education classes (specify: sibling, grandparent, and VBAC classes, etc.).	Childbirth education provides additional information about the childbearing process for different age groups.

Evaluation

(Date/time of evaluation of goal)

(Has goal been met? not met? partially met?)

(Does family express positive feelings about the pregnancy?)

(Is family involved in prenatal care and preparations for the new baby?)

(Revisions to care plan? D/C care plan? Continue care plan?)

Knowledge Deficit: Preparation for Labor and Birth of Newborn

Related to: (Specify: first pregnancy, first VBAC, etc.)