CESAREAN BIRTH NURSING CARE PLANS

Assessment	Nursing Diagnosis	Goal/Expected Outcome	Intervention/Planning	Rationale	Evaluation	Notes
Patient exhibits signs of fever, slight incision redness, and an elevated white blood cell count.	**Risk for Infection**	Patient remains free of surgical site infection within 48 hours post-op.	Maintain strict aseptic techniques during dressing changes, monitor the incision site, and reinforce proper hand hygiene.	Prevents microbial contamination and allows early detection of infection.	No signs of infection on regular assessments.	Continue routine monitoring throughout the hospital stay.
Patient reports moderate to severe pain (6/10) around the incision site.	**Acute Pain**	Pain reduced to 3/10 within 24 hours with multimodal analgesia.	Administer prescribed analgesics, reposition the patient, and use non-pharmacological methods (e.g., relaxation techniques).	Effective pain control enhances comfort and supports early mobilization.	Patient reports pain reduced to 3/10 after interventions.	Reassess pain every 4 hours and adjust interventions as needed.
Patient demonstrates difficulty moving and limited ambulation post-surgery.	**Impaired Physical Mobility**	Patient ambulating with assistance within 48 hours post-op.	Collaborate with physical therapy, encourage gradual mobilization, and assist with ambulation exercises.	Early mobilization reduces complications (e.g., DVT) and promotes faster recovery.	Patient shows improved mobility with assisted ambulation.	Monitor progress and adjust exercise regimen based on tolerance.
Patient exhibits leg swelling and reduced activity level post-op.	**Risk for Deep Vein Thrombosis (DVT)**	Patient shows no signs of DVT and maintains adequate circulation.	Encourage in-bed leg exercises, administer prophylactic anticoagulants per orders, and monitor for DVT signs.	Promotes blood flow and prevents clot formation.	No DVT signs; leg swelling is reduced.	Educate patient on the importance of leg exercises and report changes promptly.

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Patient appears anxious and expresses feelings of isolation due to the recovery process.	**Ineffective Coping**	Patient verbalizes decreased anxiety and demonstrates effective coping strategies within 48 hours.	Provide emotional support, counseling, and involve family in care discussions.	Emotional support enhances coping skills and overall recovery.	Patient reports feeling more supported with improved mood.	Schedule follow-up counseling sessions as needed.
Patient's incision shows delayed healing with minor dehiscence observed.	**Impaired Wound Healing**	Incision heals appropriately within the expected postoperative period.	Implement wound care protocols, closely monitor the incision site, and ensure the patient receives proper nutrition.	Effective wound care promotes tissue repair and prevents secondary infections.	Wound healing observed with resolution of dehiscence.	Educate patient on proper wound care and signs of complications.
Patient demonstrates signs of dehydration with imbalanced fluid intake/output.	**Risk for Fluid Imbalance**	Patient maintains balanced fluid status, with stable vital signs and normal input/output records.	Monitor fluid intake/output, adjust IV fluids as needed, and encourage oral hydration.	Proper fluid management is critical to prevent complications from dehydration or fluid overload.	Fluid balance maintained; vital signs are stable.	Regularly review daily weights and input/output charts.
Patient expresses uncertainty regarding post-operative self-care practices.	**Deficient Knowledge**	Patient demonstrates understanding of post-cesarean care, including wound care and activity restrictions, before discharge.	Provide comprehensive education on self-care practices, infection prevention, and warning signs; use written materials and visual aids.	Empowering patients with knowledge promotes adherence to the care plan.	Patient verbalizes key self-care strategies accurately.	Provide take-home materials for reinforcement.
Patient reports negative feelings about body changes post-	**Altered Body Image**	Patient expresses improved self-perception and acceptance of	Encourage discussion of feelings, provide access to counseling resources, and	Addressing emotional well-being is essential for overall	Patient shows improved self-image in	Monitor for signs of depression;

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surgery and expresses dissatisfaction with appearance.		post-surgical body changes within one week.	offer support group information.	recovery and quality of life.	follow-up assessments.	adjust support accordingly.
Patient exhibits signs of anxiety, such as restlessness and insomnia, following surgery.	**Anxiety**	Patient reports reduced anxiety levels and improved sleep patterns within 24 hours.	Implement relaxation techniques, consider anti-anxiety medication per orders, and create a calm recovery environment.	Reducing anxiety supports a better recovery and improves overall comfort.	Patient reports decreased anxiety and improved sleep quality.	Reassess emotional status regularly.
Patient shows evidence of increased vaginal bleeding and unstable hemodynamics post-surgery.	**Risk for Postpartum Hemorrhage**	Patient maintains stable hemodynamic status with controlled bleeding throughout the post-operative period.	Monitor vital signs and bleeding closely, administer uterotonics as prescribed, and prepare for emergency interventions if necessary.	Early intervention prevents severe hemorrhagic complications.	Bleeding is controlled; vital signs remain within normal limits.	Continuous monitoring is critical in the early post-operative period

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