

N — Maternal and newborn

14 statements · Recommended tool: CP-MOTHER Mother & Newborn Check · Validated scales: MEOWS, APGAR

N1 Pregnancy discomfort

Group: Maternal and newborn | Type: Actual problem

Definition: Physical discomfort during pregnancy such as backache, nausea, or swelling.

Possible causes: Hormones; growing uterus; weight gain; fatigue

Signs and symptoms: Backache; nausea; swelling; heartburn; sleep trouble

Scenario. A woman at 30 weeks has backache and heartburn.

S: "My back aches and I get heartburn."

O: 30 weeks pregnant; backache 5/10; heartburn after meals; ankle swelling; vital signs normal.

Tools: CP-MOTHER, CP-PAIN · MEOWS, APGAR, NRS 0–10, FLACC, PAINAD ****CarePath diagnosis:****

Pregnancy discomfort related to hormonal and physical changes of pregnancy, as evidenced by backache 5/10, heartburn after meals, and ankle swelling. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Reassure. | Reassurance that these common changes are expected in pregnancy lowers worry, and anxiety can make discomfort feel worse. | | Teach comfortable positions. | Good posture and positions, such as side-lying with pillows, reduce strain on the back and take pressure off the growing uterus. | | Suggest small meals. | Small meals leave less food in the stomach at a time, which reduces pressure and acid reflux that cause heartburn. | | Encourage rest. | Rest eases muscle fatigue and strain in the back and legs, and helps the body cope with the extra workload of late pregnancy. | | Allow warm baths if permitted. | Warm baths can relax tight muscles, but they are only used if permitted because heat is not safe in every pregnancy. | | Teach warning signs to report. | Knowing warning signs lets her tell normal discomfort from problems such as severe headache or bleeding, so she seeks help early when needed. ****Expected outcomes**** - Within 1 week: reports discomfort 3/10 or lower, uses 2 comfort methods, knows warning signs. ****Linking the data to the diagnosis**** At 30 weeks, the woman says, "My back aches and I get heartburn." She has backache 5/10, heartburn after meals and ankle swelling, and her vital signs are normal. This fits pregnancy discomfort because the symptoms are common, caused by hormones and the growing uterus, and no danger signs are present, which separates it from the high-risk pregnancy statement. The problem is already present, so it is actual. The plan aims for her, within 1 week, to report discomfort at 3/10 or lower, use 2 comfort methods and know the warning signs to report.

CarePath diagnosis: Pregnancy discomfort related to hormonal and physical changes of pregnancy, as evidenced by backache 5/10, heartburn after meals, and ankle swelling.

Intervention	Rationale
Reassure.	Reassurance that these common changes are expected in pregnancy lowers worry, and anxiety can make discomfort feel worse.
Teach comfortable positions.	Good posture and positions, such as side-lying with pillows, reduce strain on the back and take pressure off the growing uterus.
Suggest small meals.	Small meals leave less food in the stomach at a time, which reduces pressure and acid reflux that cause heartburn.
Encourage rest.	Rest eases muscle fatigue and strain in the back and legs, and helps the body cope with the extra workload of late pregnancy.
Allow warm baths if permitted.	Warm baths can relax tight muscles, but they are only used if permitted because heat is not safe in every pregnancy.
Teach warning signs to report.	Knowing warning signs lets her tell normal discomfort from problems such as severe headache or bleeding, so she seeks help early when needed.

Expected outcomes: Within 1 week: reports discomfort 3/10 or lower, uses 2 comfort methods, knows warning signs.

Linking the data: At 30 weeks, the woman says, "My back aches and I get heartburn." She has backache 5/10, heartburn after meals and ankle swelling, and her vital signs are normal. This fits pregnancy discomfort because the symptoms are common, caused by hormones and the growing uterus, and no danger signs are present, which separates it from the high-risk pregnancy statement. The problem is already present, so it is actual. The plan aims for her, within 1 week, to report discomfort at 3/10 or lower, use 2 comfort methods and know the warning signs to report.

N2 High-risk pregnancy

Group: Maternal and newborn | Type: Risk problem

Definition: Pregnancy conditions that raise the chance of harm to mother or baby.

Risk factors: Age; diabetes; high blood pressure; twins; past complications

Warning signs: Abnormal scans or tests; bleeding; severe headache; reduced baby movement

Scenario. A 36-year-old woman with twins and diabetes attends a routine antenatal visit.

S: "I am worried about my pregnancy because of my age."

O: Age 36; twin pregnancy; gestational diabetes; blood pressure 128/80; no protein in urine; no headaches.

Tools: CP-MOTHER, CP-SKIN, CP-ELIM · MEOWS, APGAR, Braden Scale, TIME wound chart, Bristol Stool Chart, bladder scan ****CarePath diagnosis:**** High-risk pregnancy related to age, twins and diabetes (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Arrange regular visits. | Regular visits allow early detection of changes in blood pressure, blood sugar or the growth of the twins before they cause harm. | | Monitor vital signs and baby movement. | Vital signs and baby movement are key indicators of her health and the babies' wellbeing, and a change can be the first sign of trouble. | | Teach warning signs. | Knowing warning signs such as bleeding, severe headache or reduced movement helps her seek help at once instead of waiting. | | Refer early. | Early referral to a specialist team means complications are handled sooner, which improves outcomes for the mother and both babies. | ****Expected outcomes**** - Blood pressure and tests stay in a safe range. - Attends visits. - Reports warning signs promptly. - No complications. ****Linking the data to the diagnosis**** The 36-year-old woman with twins and gestational diabetes says, "I am worried about my pregnancy because of my age." Her blood pressure is 128/80, there is no protein in her urine and she has no headaches, so no complication has occurred. This is a risk diagnosis because age, a twin pregnancy and diabetes raise the chance of harm, but the harm is not present yet. An actual problem would need abnormal findings. The plan aims for blood pressure and tests to stay in a safe range, for her to attend visits, to report warning signs promptly and to avoid complications.

CarePath diagnosis: High-risk pregnancy related to age, twins and diabetes (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Arrange regular visits.	Regular visits allow early detection of changes in blood pressure, blood sugar or the growth of the twins before they cause harm.
Monitor vital signs and baby movement.	Vital signs and baby movement are key indicators of her health and the babies' wellbeing, and a change can be the first sign of trouble.
Teach warning signs.	Knowing warning signs such as bleeding, severe headache or reduced movement helps her seek help at once instead of waiting.
Refer early.	Early referral to a specialist team means complications are handled sooner, which improves outcomes for the mother and both babies.

Expected outcomes: Blood pressure and tests stay in a safe range. · Attends visits. · Reports warning signs promptly. · No complications.

Linking the data: The 36-year-old woman with twins and gestational diabetes says, "I am worried about my pregnancy because of my age." Her blood pressure is 128/80, there is no protein in her urine and she has no headaches, so no complication has occurred. This is a risk diagnosis because age, a twin pregnancy and diabetes raise the chance of harm, but the harm is not present yet. An actual problem would need abnormal findings. The plan aims for blood pressure and tests to stay in a safe range, for her to attend visits, to report warning signs promptly and to avoid complications.

N3 Fear of labor

Group: Maternal and newborn | Type: Actual problem

Definition: Worry or fear about childbirth, pain, or outcomes.

Possible causes: First birth; frightening stories; fear of pain; uncertainty

Signs and symptoms: Anxious; tearful; avoids classes; many questions

Scenario. A first-time mother is afraid of labor.

S: "I'm terrified of labor."

O: First pregnancy; tearful; asks many questions; avoids classes.

Tools: CP-MOTHER · MEOWS, APGAR ****CarePath diagnosis:**** Fear of labor related to first birth, as evidenced by anxious and tearful. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Explain the stages. | Knowing what happens in each stage removes much of the fear of the unknown, which is a main driver of her terror. | | Teach breathing and comfort methods. | Breathing and comfort methods give her practical tools to cope with pain, which increases her sense of control. | | Tour the labor ward. | Seeing the labor ward beforehand makes the place familiar, so it feels less frightening when she arrives in labor. | | Support her partner. | Her partner is her main support in labor, so a calm and informed partner helps her feel safe and less alone. | | Encourage questions. | Open questions allow the nurse to correct myths and frightening stories, and she is more willing to share fears when welcomed. | ****Expected outcomes**** - Attends a class. - Rates fear 3/10 or lower. - Practices breathing. - Feels prepared. ****Linking the data to the diagnosis**** The first-time mother says, "I'm terrified of labor." She is in her first pregnancy, tearful, asks many questions and avoids classes. These data fit fear of labor because the fear is directed at childbirth and comes from not knowing what to expect, and it is already causing distress and avoidance. It differs from labor pain, which is about pain that is happening now. The plan aims for her to attend a class, rate her fear at 3/10 or lower, practice breathing and feel prepared, using clear teaching, a ward tour and support for her partner.

CarePath diagnosis: Fear of labor related to first birth, as evidenced by anxious and tearful.

Intervention	Rationale
Explain the stages.	Knowing what happens in each stage removes much of the fear of the unknown, which is a main driver of her terror.
Teach breathing and comfort methods.	Breathing and comfort methods give her practical tools to cope with pain, which increases her sense of control.
Tour the labor ward.	Seeing the labor ward beforehand makes the place familiar, so it feels less frightening when she arrives in labor.
Support her partner.	Her partner is her main support in labor, so a calm and informed partner helps her feel safe and less alone.
Encourage questions.	Open questions allow the nurse to correct myths and frightening stories, and she is more willing to share fears when welcomed.

Expected outcomes: Attends a class. · Rates fear 3/10 or lower. · Practices breathing. · Feels prepared.

Linking the data: The first-time mother says, "I'm terrified of labor." She is in her first pregnancy, tearful, asks many questions and avoids classes. These data fit fear of labor because the fear is directed at childbirth and comes from not knowing what to expect, and it is already causing distress and avoidance. It differs from labor pain, which is about pain that is happening now. The plan aims for her to attend a class, rate her fear at 3/10 or lower, practice breathing and feel prepared, using clear teaching, a ward tour and support for her partner.

N4 Labor pain

Group: Maternal and newborn | Type: Actual problem

Definition: Pain during contractions and birth that needs comfort support.

Possible causes: Contractions; cervical changes; fear; position

Signs and symptoms: Moaning; sweating; tense; restless

Scenario. A woman in active labor rates her pain 9 out of 10.

S: "I can't take this pain!"

O: Pain 9/10; contractions every 2 minutes; sweating; restless.

Tools: CP-MOTHER, CP-PAIN · MEOWS, APGAR, NRS 0–10, FLACC, PAINAD ****CarePath diagnosis:**** Labor pain related to contractions, as evidenced by moaning and sweating. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Offer comfort. | A caring, calm presence lowers fear and tension, and fear makes pain worse, so comfort is the base for every other measure. | | Massage. | Massage relaxes tight muscles and distracts from contraction pain, and many women find touch from staff or a partner soothing. | | Position changes. | Changing position can ease pressure, help the baby move down and make contractions more bearable. | | Breathing support. | Guided breathing helps her relax between contractions and gives her something to focus on, which reduces panic and muscle tension. | | Water immersion if available. | Warm water can relax the body and ease pain, but it is used only when available and when it is safe for her and the baby. | | Pain relief as ordered. | Medicine for pain relief is given as ordered because pain at 9/10 may need more than comfort measures, and orders keep both mother and baby safe. | | Reassurance. | Encouraging words help her feel supported and capable, and this reduces the fear that adds to her pain. | ****Expected outcomes**** - Pain 5/10 or lower with comfort measures. - Feels supported. - Labor progresses safely. ****Linking the data to the diagnosis**** The woman in active labor says, "I can't take this pain!" She rates pain 9/10, contractions come every 2 minutes, and she is sweating and restless. This fits labor pain because the pain comes from contractions and is happening now, so it is actual, and it is stronger than the worry described in fear of labor. The plan aims for pain of 5/10 or lower with comfort measures, for her to feel supported and for labor to progress safely, using touch, position changes, breathing support, ordered pain relief and steady reassurance.

CarePath diagnosis: Labor pain related to contractions, as evidenced by moaning and sweating.

Intervention	Rationale
Offer comfort.	A caring, calm presence lowers fear and tension, and fear makes pain worse, so comfort is the base for every other measure.
Massage.	Massage relaxes tight muscles and distracts from contraction pain, and many women find touch from staff or a partner soothing.
Position changes.	Changing position can ease pressure, help the baby move down and make contractions more bearable.
Breathing support.	Guided breathing helps her relax between contractions and gives her something to focus on, which reduces panic and muscle tension.
Water immersion if available.	Warm water can relax the body and ease pain, but it is used only when available and when it is safe for her and the baby.
Pain relief as ordered.	Medicine for pain relief is given as ordered because pain at 9/10 may need more than comfort measures, and orders keep both mother and baby safe.
Reassurance.	Encouraging words help her feel supported and capable, and this reduces the fear that adds to her pain.

Expected outcomes: Pain 5/10 or lower with comfort measures. · Feels supported. · Labor progresses safely.

Linking the data: The woman in active labor says, "I can't take this pain!" She rates pain 9/10, contractions come every 2 minutes, and she is sweating and restless. This fits labor pain because the pain comes from contractions and is happening now, so it is actual, and it is stronger than the worry described in fear of labor. The plan aims for pain of 5/10 or lower with comfort measures, for her to feel supported and for labor to progress safely, using touch, position changes, breathing support, ordered pain relief and steady reassurance.

N5 Risk of heavy bleeding after birth ⚠ URGENT

Group: Maternal and newborn | Type: Risk problem

Definition: Blood loss after delivery may be higher than expected.

Risk factors: Uterus not contracting; tears; retained tissue; long labor

Warning signs: Heavy bleeding; soaked pads; fast pulse; dizziness

Scenario. A mother has just delivered after a long labor and has a perineal tear.

S: "I feel tired but okay."

O: Delivery 20 minutes ago; labor lasted 20 hours; perineal tear; uterus firm; pad lightly stained; pulse 82/min; blood pressure 118/74.

Tools: CP-MOTHER, CP-SKIN, CP-BREATH · MEOWS, APGAR, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG ****CarePath diagnosis:**** Risk of heavy bleeding after birth related to long labor and a perineal tear (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Check bleeding, uterus firmness and vital signs at ordered times. | Regular checks of bleeding, uterine firmness and vital signs catch early blood loss, since a soft uterus and a rising pulse are warning signs. | | Massage the uterus if it feels soft. | A soft uterus cannot clamp the blood vessels where the placenta was attached, and massage encourages it to contract and slow bleeding. | | Check pads and weigh them if bleeding seems heavy. | Checking and weighing pads gives a more accurate measure of blood loss than guessing, which is often underestimated. | | Give uterus-contracting medicine as ordered. | Medicines that make the uterus contract help it stay firm and reduce bleeding, and they are given only as ordered because dose and timing matter. | | Call for help at once if pads soak quickly, the uterus stays soft, pulse rises or the mother feels faint. | Heavy bleeding can cause shock within minutes, so calling for help at once brings extra staff and treatment before the mother becomes unstable. | ****Expected outcomes**** - Within 2 hours: uterus firm and bleeding light. - Pulse and blood pressure stay normal. - Heavy bleeding, if it occurs, is reported and treated within minutes. ****Linking the data to the diagnosis**** The mother delivered 20 minutes ago after a 20-hour labor and has a perineal tear. Her uterus is firm, the pad is lightly stained, her pulse is 82/min and her blood pressure is 118/74, and she says, "I feel tired but okay." This is a risk diagnosis because heavy bleeding has not happened; the long labor and tear raise the chance. Because bleeding can become dangerous quickly, help is called first if signs appear. The plan aims for a firm uterus with light bleeding within 2 hours, normal pulse and pressure, and fast treatment if heavy bleeding occurs.

CarePath diagnosis: Risk of heavy bleeding after birth related to long labor and a perineal tear (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Check bleeding, uterus firmness and vital signs at ordered times.	Regular checks of bleeding, uterine firmness and vital signs catch early blood loss, since a soft uterus and a rising pulse are warning signs.
Massage the uterus if it feels soft.	A soft uterus cannot clamp the blood vessels where the placenta was attached, and massage encourages it to contract and slow bleeding.
Check pads and weigh them if bleeding seems heavy.	Checking and weighing pads gives a more accurate measure of blood loss than guessing, which is often underestimated.
Give uterus-contracting medicine as ordered.	Medicines that make the uterus contract help it stay firm and reduce bleeding, and they are given only as ordered because dose and timing matter.
Call for help at once if pads soak quickly, the uterus stays soft, pulse rises or the mother feels faint.	Heavy bleeding can cause shock within minutes, so calling for help at once brings extra staff and treatment before the mother becomes unstable.

Expected outcomes: Within 2 hours: uterus firm and bleeding light. · Pulse and blood pressure stay normal. · Heavy bleeding, if it occurs, is reported and treated within minutes.

Linking the data: The mother delivered 20 minutes ago after a 20-hour labor and has a perineal tear. Her uterus is firm, the pad is lightly stained, her pulse is 82/min and her blood pressure is 118/74, and she says, "I feel tired but okay." This is a risk diagnosis because heavy bleeding has not happened; the long labor and tear raise the chance. Because bleeding can become dangerous quickly, help is called first if signs appear. The plan aims for a firm uterus with light bleeding within 2 hours, normal pulse and pressure, and fast treatment if heavy bleeding occurs.

N6 Slow recovery after birth

Group: Maternal and newborn | Type: Actual problem

Definition: Healing, energy, or comfort after birth is slower than expected.

Possible causes: Tears; surgery; poor sleep; anemia; pain

Signs and symptoms: Soreness; fatigue; slow wound healing; reduced mobility

Scenario. A mother after cesarean cannot lift her baby comfortably.

S: "I can't lift my baby."

O: Cesarean day 2; pain 6/10; low energy; slow walking.

Tools: CP-MOTHER, CP-PAIN · MEOWS, APGAR, NRS 0–10, FLACC, PAINAD ****CarePath diagnosis:**** Slow recovery after birth related to cesarean surgery, as evidenced by pain 6/10, low energy, and slow walking. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Give pain relief. | Pain relief makes it easier for her to move, breathe deeply and hold her baby, and it supports healing by lowering stress on the body. | | Encourage rest and mobility. | Rest restores energy for healing, and gentle mobility improves circulation, helps prevent blood clots and speeds recovery after surgery. | | Wound care. | Wound care keeps the incision clean and allows early detection of redness, discharge or other signs of infection. | | Nutrition. | Good nutrition provides protein, iron and energy that the body needs to repair tissue and restore strength after surgery and blood loss. | | Support. | Practical and emotional support helps her care for the baby while recovering and builds her confidence as she regains strength. | ****Expected outcomes**** - By day 3: pain 3/10 or lower, walks unaided, cares for baby comfortably, wound healing. ****Linking the data to the diagnosis**** The mother is on day 2 after cesarean and says, "I can't lift my baby." She reports pain 6/10, has low energy and walks slowly. This fits slow recovery after birth because healing, energy and comfort are all behind what is expected, and it is already affecting her care of the baby. It is an actual problem, not a risk. The plan aims for her, by day 3, to have pain of 3/10 or lower, walk unaided, care for her baby comfortably and show a healing wound, through pain relief, rest, movement, wound care, nutrition and support.

CarePath diagnosis: Slow recovery after birth related to cesarean surgery, as evidenced by pain 6/10, low energy, and slow walking.

Intervention	Rationale
Give pain relief.	Pain relief makes it easier for her to move, breathe deeply and hold her baby, and it supports healing by lowering stress on the body.
Encourage rest and mobility.	Rest restores energy for healing, and gentle mobility improves circulation, helps prevent blood clots and speeds recovery after surgery.
Wound care.	Wound care keeps the incision clean and allows early detection of redness, discharge or other signs of infection.
Nutrition.	Good nutrition provides protein, iron and energy that the body needs to repair tissue and restore strength after surgery and blood loss.
Support.	Practical and emotional support helps her care for the baby while recovering and builds her confidence as she regains strength.

Expected outcomes: By day 3: pain 3/10 or lower, walks unaided, cares for baby comfortably, wound healing.

Linking the data: The mother is on day 2 after cesarean and says, "I can't lift my baby." She reports pain 6/10, has low energy and walks slowly. This fits slow recovery after birth because healing, energy and comfort are all behind what is expected, and it is already affecting her care of the baby. It is an actual problem, not a risk. The plan aims for her, by day 3, to have pain of 3/10 or lower, walk unaided, care for her baby comfortably and show a healing wound, through pain relief, rest, movement, wound care, nutrition and support.

N7 Baby feeding poorly

Group: Maternal and newborn | Type: Actual problem

Definition: The baby has weak sucking, poor latch, or takes too little milk.

Possible causes: Poor latch; sleepiness; tongue-tie; low milk; illness

Signs and symptoms: Short feeds; poor weight gain; weak suck; fussiness

Scenario. A baby falls asleep early at feeds and loses weight.

S: "He keeps falling asleep and won't feed."

O: Baby lost 9% of birth weight; weak suck; falls asleep; 3 wet diapers daily.

Tools: CP-MOTHER, CP-SAFE, CP-FLUID · MEOWS, APGAR, Morse Fall Scale, MUST, fluid chart, glucose

****CarePath diagnosis:**** Baby feeding poorly related to poor latch, as evidenced by short feeds and poor weight gain. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Check the latch. | A poor latch is a common cause of weak feeding, so checking it finds problems that can be fixed to help the baby take more milk. | | Wake the baby. | Sleepy babies feed poorly, and waking him with gentle stimulation lets him feed long enough to take in needed milk. | | Set a feeding plan. | A clear plan with feeding times gives structure so that he is fed often enough, since weight loss shows he is not getting enough now. | | Weigh regularly. | Regular weights show whether feeding is working, and tracking them allows the plan to change if weight keeps falling. | | Get lactation help. | Lactation specialists have extra skill in fixing latch and supply problems, which can be hard to correct without expert help. | | Report problems. | Reporting problems promptly ensures that the doctor reviews him, because a loss of 9% of birth weight and few wet diapers may signal dehydration. | ****Expected outcomes**** - Feeds 8-12 times a day. - Gains weight by day 7. - At least 6 wet diapers per day. ****Linking the data to the diagnosis**** The baby falls asleep at feeds, and his mother says, "He keeps falling asleep and won't feed." He lost 9% of birth weight, has a weak suck and has only 3 wet diapers daily. This fits baby feeding poorly because intake is too low, shown by weight loss and few wet diapers, and the problem is already present, so it is actual. The plan aims for feeding 8 to 12 times a day, weight gain by day 7 and at least 6 wet diapers per day, by checking the latch, waking him, using a feeding plan and getting lactation help.

CarePath diagnosis: Baby feeding poorly related to poor latch, as evidenced by short feeds and poor weight gain.

Intervention	Rationale
Check the latch.	A poor latch is a common cause of weak feeding, so checking it finds problems that can be fixed to help the baby take more milk.
Wake the baby.	Sleepy babies feed poorly, and waking him with gentle stimulation lets him feed long enough to take in needed milk.
Set a feeding plan.	A clear plan with feeding times gives structure so that he is fed often enough, since weight loss shows he is not getting enough now.
Weigh regularly.	Regular weights show whether feeding is working, and tracking them allows the plan to change if weight keeps falling.
Get lactation help.	Lactation specialists have extra skill in fixing latch and supply problems, which can be hard to correct without expert help.
Report problems.	Reporting problems promptly ensures that the doctor reviews him, because a loss of 9% of birth weight and few wet diapers may signal dehydration.

Expected outcomes: Feeds 8-12 times a day. · Gains weight by day 7. · At least 6 wet diapers per day.

Linking the data: The baby falls asleep at feeds, and his mother says, "He keeps falling asleep and won't feed." He lost 9% of birth weight, has a weak suck and has only 3 wet diapers daily. This fits baby feeding poorly because intake is too low, shown by weight loss and few wet diapers, and the problem is already present, so it is actual. The plan aims for feeding 8 to 12 times a day, weight gain by day 7 and at least 6 wet diapers per day, by checking the latch, waking him, using a feeding plan and getting lactation help.

N8 Baby's temperature unstable

Group: Maternal and newborn | Type: Actual problem

Definition: The newborn cannot keep a safe body temperature.

Possible causes: Prematurity; cold room; low weight; infection

Signs and symptoms: Cold or hot skin; shivering; poor feeding

Scenario. A newborn has a temperature of 35.5 degrees.

S: (Parent) "He feels cold."

O: Temperature 35.5 C; pale; poor feeding; day 1 of life.

Tools: CP-MOTHER · MEOWS, APGAR ****CarePath diagnosis:**** Baby's temperature unstable related to immature temperature control in a newborn, as evidenced by a temperature of 35.5 C, pale skin, and poor feeding. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Do skin-to-skin contact. | Skin-to-skin contact lets the mother's body warm the baby quickly and also calms him and helps feeding. | | Warm the room. | A warm room reduces heat lost to the air, since newborns lose heat fast and cannot shiver well. | | Use a hat. | A hat covers the head, which is a large part of a newborn's body surface and a major site of heat loss. | | Check temperature. | Frequent temperature checks show whether warming is working and catch a fall or rise early. | | Feed. | Feeding supplies the energy a baby needs to make heat, and low blood sugar can worsen cold stress. | | Report abnormal readings. | Abnormal readings may signal infection or another illness, so reporting lets the team assess and treat him without delay. | ****Expected outcomes**** - Within 1-2 hours: temperature 36.5-37.5 C, feeding well, skin pink and warm. ****Linking the data to the diagnosis**** The newborn is on day 1 of life with a temperature of 35.5 C, is pale and feeds poorly, and a parent says, "He feels cold." This fits baby's temperature unstable because the reading is below the safe range of 36.5 to 37.5 C and the baby cannot hold his own heat, and it is already happening, so it is actual. The plan aims for temperature of 36.5 to 37.5 C within 1 to 2 hours, good feeding and warm pink skin, using skin-to-skin contact, a warm room, a hat and close monitoring.

CarePath diagnosis: Baby's temperature unstable related to immature temperature control in a newborn, as evidenced by a temperature of 35.5 C, pale skin, and poor feeding.

Intervention	Rationale
Do skin-to-skin contact.	Skin-to-skin contact lets the mother's body warm the baby quickly and also calms him and helps feeding.
Warm the room.	A warm room reduces heat lost to the air, since newborns lose heat fast and cannot shiver well.
Use a hat.	A hat covers the head, which is a large part of a newborn's body surface and a major site of heat loss.
Check temperature.	Frequent temperature checks show whether warming is working and catch a fall or rise early.
Feed.	Feeding supplies the energy a baby needs to make heat, and low blood sugar can worsen cold stress.
Report abnormal readings.	Abnormal readings may signal infection or another illness, so reporting lets the team assess and treat him without delay.

Expected outcomes: Within 1-2 hours: temperature 36.5-37.5 C, feeding well, skin pink and warm.

Linking the data: The newborn is on day 1 of life with a temperature of 35.5 C, is pale and feeds poorly, and a parent says, "He feels cold." This fits baby's temperature unstable because the reading is below the safe range of 36.5 to 37.5 C and the baby cannot hold his own heat, and it is already happening, so it is actual. The plan aims for temperature of 36.5 to 37.5 C within 1 to 2 hours, good feeding and warm pink skin, using skin-to-skin contact, a warm room, a hat and close monitoring.

N9 Newborn jaundice

Group: Maternal and newborn | Type: Actual problem

Definition: Yellow skin or eyes in a newborn from high bilirubin.

Possible causes: Immature liver; blood group differences; prematurity

Signs and symptoms: Yellow skin and eyes; sleepy; poor feeding

Scenario. A baby on day 3 looks yellow.

S: "His skin looks yellow."

O: Yellow face and chest on day 3; sleepy; high bilirubin.

Tools: CP-MOTHER, CP-SKIN · MEOWS, APGAR, Braden Scale, TIME wound chart ****CarePath diagnosis:**** Newborn jaundice related to immature liver, as evidenced by yellow skin and eyes and sleepy.

****Interventions and rationale**** | Intervention | Rationale | |---|---| | Check bilirubin. | Bilirubin levels show how severe the jaundice is and whether treatment is needed, because skin color alone can be misleading. | | Feed often. | Frequent feeds make the baby pass stool and urine, which removes bilirubin from the body, and also prevent dehydration. | | Give phototherapy as ordered. | Phototherapy light changes bilirubin into a form the baby can pass out, and it is given as ordered to lower the level safely. | | Monitor. | Ongoing monitoring shows whether levels are falling and finds any rise early, since very high bilirubin can harm the brain. | ****Expected outcomes**** - Bilirubin falls below the treatment line. - Feeds well. - Yellowing fades. - No complications. ****Linking the data to the diagnosis**** The baby is on day 3 with a yellow face and chest, and a parent says, "His skin looks yellow." He is sleepy and his bilirubin is high. This fits newborn jaundice because the yellow color and raised bilirubin are present now, so it is an actual problem, and sleepiness is a sign that needs watching. The plan aims for bilirubin to fall below the treatment line, for him to feed well, for the yellowing to fade and for complications to be avoided, through testing, frequent feeds, ordered phototherapy and close monitoring.

CarePath diagnosis: Newborn jaundice related to immature liver, as evidenced by yellow skin and eyes and sleepy.

Intervention	Rationale
Check bilirubin.	Bilirubin levels show how severe the jaundice is and whether treatment is needed, because skin color alone can be misleading.
Feed often.	Frequent feeds make the baby pass stool and urine, which removes bilirubin from the body, and also prevent dehydration.
Give phototherapy as ordered.	Phototherapy light changes bilirubin into a form the baby can pass out, and it is given as ordered to lower the level safely.
Monitor.	Ongoing monitoring shows whether levels are falling and finds any rise early, since very high bilirubin can harm the brain.

Expected outcomes: Bilirubin falls below the treatment line. · Feeds well. · Yellowing fades. · No complications.

Linking the data: The baby is on day 3 with a yellow face and chest, and a parent says, "His skin looks yellow." He is sleepy and his bilirubin is high. This fits newborn jaundice because the yellow color and raised bilirubin are present now, so it is an actual problem, and sleepiness is a sign that needs watching. The plan aims for bilirubin to fall below the treatment line, for him to feed well, for the yellowing to fade and for complications to be avoided, through testing, frequent feeds, ordered phototherapy and close monitoring.

N10 Newborn breathing difficulty ⚠ URGENT

Group: Maternal and newborn | Type: Actual problem

Definition: The baby breathes fast, grunts, or struggles to get enough air.

Possible causes: Prematurity; lung fluid; infection; aspiration

Signs and symptoms: Fast breathing; grunting; chest pulling in; blue color

Scenario. A newborn breathes at 80 breaths a minute and grunts.

S: (Parent) "He's breathing fast."

O: Respiratory rate 80/min; grunting; chest indrawing; oxygen saturation 88%.

Tools: CP-MOTHER, CP-BREATH · MEOWS, APGAR, NEWS2, SpO₂, ECG ****CarePath diagnosis:**** Newborn breathing difficulty related to prematurity, as evidenced by fast breathing and grunting. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Call for help. | Calling for help first brings skilled staff and equipment quickly, because a newborn with these signs can deteriorate within minutes. | | Give oxygen. | Oxygen raises the amount in the blood, which is low at 88%, and protects the brain and organs from lack of oxygen. | | Keep warm. | Newborns lose heat fast, and cold stress raises oxygen needs and breathing effort, so keeping him warm eases the workload. | | Monitor. | Continuous monitoring of breathing rate and oxygen level shows whether treatment is working and detects worsening early. | | Position. | A neutral position with the airway open lets air flow more easily and reduces breathing effort. | | Prepare for care. | Preparing for further care, such as transfer or extra equipment, saves time if he does not improve quickly. | ****Expected outcomes**** - Respiratory rate 40-60/min. - Oxygen saturation at target. - No grunting. - Stable. ****Linking the data to the diagnosis**** The newborn breathes at 80 breaths a minute, grunts, has chest indrawing and an oxygen saturation of 88%, and a parent says, "He's breathing fast." This fits newborn breathing difficulty because the rate is far above normal and the signs show he is struggling to get enough air, so it is actual and urgent. Help is called first, before other care. The plan aims for a respiratory rate of 40 to 60/min, oxygen saturation at target, no grunting and a stable baby, using oxygen, warmth, monitoring and preparation for further care.

CarePath diagnosis: Newborn breathing difficulty related to prematurity, as evidenced by fast breathing and grunting.

Intervention	Rationale
Call for help.	Calling for help first brings skilled staff and equipment quickly, because a newborn with these signs can deteriorate within minutes.
Give oxygen.	Oxygen raises the amount in the blood, which is low at 88%, and protects the brain and organs from lack of oxygen.
Keep warm.	Newborns lose heat fast, and cold stress raises oxygen needs and breathing effort, so keeping him warm eases the workload.
Monitor.	Continuous monitoring of breathing rate and oxygen level shows whether treatment is working and detects worsening early.
Position.	A neutral position with the airway open lets air flow more easily and reduces breathing effort.
Prepare for care.	Preparing for further care, such as transfer or extra equipment, saves time if he does not improve quickly.

Expected outcomes: Respiratory rate 40-60/min. · Oxygen saturation at target. · No grunting. · Stable.

Linking the data: The newborn breathes at 80 breaths a minute, grunts, has chest indrawing and an oxygen saturation of 88%, and a parent says, "He's breathing fast." This fits newborn breathing difficulty because the rate is far above normal and the signs show he is struggling to get enough air, so it is actual and urgent. Help is called first, before other care. The plan aims for a respiratory rate of 40 to 60/min, oxygen saturation at target, no grunting and a stable baby, using oxygen, warmth, monitoring and preparation for further care.

N11 Difficulty adjusting to new parenthood

Group: Maternal and newborn | Type: Risk problem

Definition: Stress, exhaustion, or lack of support may make adjusting to a baby hard.

Risk factors: First baby; poor sleep; lack of support; stress

Warning signs: Overwhelmed; worried; crying; doubts about skills

Scenario. A new mother says she does not know what she is doing.

S: "I don't know what I'm doing."

O: New mother; tearful; sleeping 3 hours; baby crying.

Tools: CP-MOTHER · MEOWS, APGAR ****CarePath diagnosis:**** Difficulty adjusting to new parenthood related to first baby and poor sleep (risk factors); no signs of the problem are present yet.

****Interventions and rationale**** | Intervention | Rationale | |---|---| | Teach baby care. | Showing her how to feed, handle and settle the baby builds skill, and skill builds the confidence she says she lacks. | | Encourage rest. | Sleep loss increases stress and weakens coping, so rest helps her think clearly and manage the baby's demands. | | Involve the partner. | Her partner can share care and give emotional support, which reduces her load and strengthens the family. | | Praise efforts. | Praise for what she does well builds confidence, and people who feel capable cope better with new tasks. | | Link to support. | Links to groups, health visitors or family give ongoing help after discharge, when many parents feel most alone. | ****Expected outcomes**** - Within 1 week: cares for baby with confidence, sleeps in blocks, uses support, says she feels more capable. ****Linking the data to the diagnosis**** The new mother says, "I don't know what I'm doing." She is tearful, sleeping 3 hours and the baby is crying. This is a risk diagnosis because she has not yet failed to adjust; first baby, poor sleep and stress raise the chance that she will struggle. Her tears are a warning, not a clear sign of a problem, so it differs from sadness after childbirth. The plan aims for her, within 1 week, to care for the baby with confidence, sleep in blocks, use support and say she feels more capable.

CarePath diagnosis: Difficulty adjusting to new parenthood related to first baby and poor sleep (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Teach baby care.	Showing her how to feed, handle and settle the baby builds skill, and skill builds the confidence she says she lacks.
Encourage rest.	Sleep loss increases stress and weakens coping, so rest helps her think clearly and manage the baby's demands.
Involve the partner.	Her partner can share care and give emotional support, which reduces her load and strengthens the family.
Praise efforts.	Praise for what she does well builds confidence, and people who feel capable cope better with new tasks.
Link to support.	Links to groups, health visitors or family give ongoing help after discharge, when many parents feel most alone.

Expected outcomes: Within 1 week: cares for baby with confidence, sleeps in blocks, uses support, says she feels more capable.

Linking the data: The new mother says, "I don't know what I'm doing." She is tearful, sleeping 3 hours and the baby is crying. This is a risk diagnosis because she has not yet failed to adjust; first baby, poor sleep and stress raise the chance that she will struggle. Her tears are a warning, not a clear sign of a problem, so it differs from sadness after childbirth. The plan aims for her, within 1 week, to care for the baby with confidence, sleep in blocks, use support and say she feels more capable.

N12 Sadness after childbirth

Group: Maternal and newborn | Type: Actual problem

Definition: Low mood, tearfulness, or anxiety in the weeks after delivery.

Possible causes: Hormones; stress; lack of sleep; previous mood illness

Signs and symptoms: Tearfulness; irritability; anxiety; low mood; disinterest in the baby

Scenario. A mother cries daily two weeks after birth.

S: "I cry every day and don't feel like myself."

O: Two weeks after birth; tearful; low mood; anxious.

Tools: CP-MOTHER, CP-MIND · MEOWS, APGAR, PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Sadness after childbirth related to hormones, as evidenced by tearfulness and irritability. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Listen. | Listening lets her describe feelings without judgment, and being understood eases shame and isolation that often come with low mood after birth. | | Screen mood. | Mood screening finds out how severe her symptoms are and whether she may have postpartum depression that needs treatment. | | Encourage support and rest. | Support and rest lower stress and tiredness, which both worsen mood, and help her cope with the demands of a baby. | | Refer if it lasts or is severe. | Referral for lasting or severe symptoms makes sure she gets proper treatment, since untreated depression can harm both mother and baby. | | Watch safety. | Watching safety checks for thoughts of self-harm or of harming the baby, so help can be given at once if either appears. | ****Expected outcomes**** - Within 2 weeks: mood improves, accepts help, uses support. - Urgent review if symptoms worsen. ****Linking the data to the diagnosis**** Two weeks after birth, the mother says, "I cry every day and don't feel like myself." She is tearful, low in mood and anxious. This fits sadness after childbirth because the symptoms are present now and match the time after delivery, so it is actual. Because it has lasted two weeks, mood screening is needed to tell ordinary baby blues from a more serious illness. The plan aims for mood to improve within 2 weeks, for her to accept help and use support, with urgent review if symptoms get worse.

CarePath diagnosis: Sadness after childbirth related to hormones, as evidenced by tearfulness and irritability.

Intervention	Rationale
Listen.	Listening lets her describe feelings without judgment, and being understood eases shame and isolation that often come with low mood after birth.
Screen mood.	Mood screening finds out how severe her symptoms are and whether she may have postpartum depression that needs treatment.
Encourage support and rest.	Support and rest lower stress and tiredness, which both worsen mood, and help her cope with the demands of a baby.
Refer if it lasts or is severe.	Referral for lasting or severe symptoms makes sure she gets proper treatment, since untreated depression can harm both mother and baby.
Watch safety.	Watching safety checks for thoughts of self-harm or of harming the baby, so help can be given at once if either appears.

Expected outcomes: Within 2 weeks: mood improves, accepts help, uses support. · Urgent review if symptoms worsen.

Linking the data: Two weeks after birth, the mother says, "I cry every day and don't feel like myself." She is tearful, low in mood and anxious. This fits sadness after childbirth because the symptoms are present now and match the time after delivery, so it is actual. Because it has lasted two weeks, mood screening is needed to tell ordinary baby blues from a more serious illness. The plan aims for mood to improve within 2 weeks, for her to accept help and use support, with urgent review if symptoms get worse.

N13 Grief after pregnancy loss

Group: Maternal and newborn | Type: Actual problem

Definition: Sorrow after miscarriage, stillbirth, or loss of a newborn.

Possible causes: Miscarriage; stillbirth; death of a newborn

Signs and symptoms: Crying; numbness; guilt; withdrawal

Scenario. A couple grieves after a stillbirth.

S: "I wanted her so much."

O: Stillbirth; crying; numb; partner distressed; no support yet.

Tools: CP-MOTHER · MEOWS, APGAR ****CarePath diagnosis:**** Grief after pregnancy loss related to miscarriage, as evidenced by crying and numbness. ****Interventions and rationale**** | Intervention | Rationale | | Show compassion. | Compassion tells the couple that their loss is real and their feelings are valid, which opens the way for grieving. | | Allow time with the baby. | Spending time with their baby lets parents say goodbye and make memories, and many find this helps them grieve in a healthy way. | | Offer keepsakes. | Keepsakes such as photos, footprints or a blanket give lasting memories of their daughter and help with later grieving. | | Refer to counseling. | Counseling gives specialized help for grief, which can be long and complicated, especially when support is lacking. | | Follow up. | Follow-up lets the team check on their coping and physical recovery, since grief can last long after discharge. | ****Expected outcomes**** - Grieves openly. - Spends time with the baby if wished. - Support in place. - Follow-up arranged. ****Linking the data to the diagnosis**** The couple grieves after a stillbirth, and the mother says, "I wanted her so much." They are crying and numb, the partner is distressed and they have no support yet. This fits grief after pregnancy loss because their sorrow is a direct response to losing the baby, and it is already present, so it is actual. It is specific to pregnancy loss rather than general grief. The plan aims for them to grieve openly, spend time with the baby if they wish, have support in place and have follow-up arranged, through compassion, keepsakes and counseling.

CarePath diagnosis: Grief after pregnancy loss related to miscarriage, as evidenced by crying and numbness.

Intervention	Rationale
Show compassion.	Compassion tells the couple that their loss is real and their feelings are valid, which opens the way for grieving.
Allow time with the baby.	Spending time with their baby lets parents say goodbye and make memories, and many find this helps them grieve in a healthy way.
Offer keepsakes.	Keepsakes such as photos, footprints or a blanket give lasting memories of their daughter and help with later grieving.
Refer to counseling.	Counseling gives specialized help for grief, which can be long and complicated, especially when support is lacking.
Follow up.	Follow-up lets the team check on their coping and physical recovery, since grief can last long after discharge.

Expected outcomes: Grieves openly. · Spends time with the baby if wished. · Support in place. · Follow-up arranged.

Linking the data: The couple grieves after a stillbirth, and the mother says, "I wanted her so much." They are crying and numb, the partner is distressed and they have no support yet. This fits grief after pregnancy loss because their sorrow is a direct response to losing the baby, and it is already present, so it is actual. It is specific to pregnancy loss rather than general grief. The plan aims for them to grieve openly, spend time with the baby if they wish, have support in place and have follow-up arranged, through compassion, keepsakes and counseling.

N14 Family planning questions

Group: Maternal and newborn | Type: Actual problem

Definition: The person wants information on contraception or spacing pregnancies.

Possible causes: Wish to space births; health reasons; lack of information

Signs and symptoms: Asks about contraception; unplanned pregnancy; confusion

Scenario. A mother asks which method is safe while breastfeeding.

S: "Which method is safe while I'm breastfeeding?"

O: Asks about contraception; unsure; motivated; recent delivery.

Tools: CP-MOTHER · MEOWS, APGAR **CarePath diagnosis:** Family planning questions related to wish to space births, as evidenced by asks about contraception and unplanned pregnancy. **Interventions and rationale** | Intervention | Rationale | | Give balanced information. | Balanced information about benefits and drawbacks lets her choose a method that fits her health and wishes instead of being steered. | | Respect choices. | Respecting her choices supports her right to decide about her own body, and she is more likely to use a method she chose. | | Explain options. | Explaining options, including which are safe while breastfeeding, answers her question and helps her avoid methods that may affect milk or health. | | Refer. | Referral to a family planning clinic or clinician gives access to methods needing a prescription or procedure, and to follow-up. **Expected outcomes** - Chooses a method suitable for her. - Understands its use. - Attends follow-up. **Linking the data to the diagnosis** The mother, who recently delivered, asks, "Which method is safe while I'm breastfeeding?" She asks about contraception, is unsure and is motivated. This fits family planning questions because she wants information to space her births and lacks the knowledge to choose, and she is ready to learn. The need is present now, so it is an actual diagnosis, but it is a request for teaching rather than a health problem. The plan aims for her to choose a method suitable for her, understand its use and attend follow-up, by giving balanced information and respecting her choices.

CarePath diagnosis: Family planning questions related to wish to space births, as evidenced by asks about contraception and unplanned pregnancy.

Intervention	Rationale
Give balanced information.	Balanced information about benefits and drawbacks lets her choose a method that fits her health and wishes instead of being steered.
Respect choices.	Respecting her choices supports her right to decide about her own body, and she is more likely to use a method she chose.
Explain options.	Explaining options, including which are safe while breastfeeding, answers her question and helps her avoid methods that may affect milk or health.
Refer.	Referral to a family planning clinic or clinician gives access to methods needing a prescription or procedure, and to follow-up.

Expected outcomes: Chooses a method suitable for her. · Understands its use. · Attends follow-up.

Linking the data: The mother, who recently delivered, asks, "Which method is safe while I'm breastfeeding?" She asks about contraception, is unsure and is motivated. This fits family planning questions because she wants information to space her births and lacks the knowledge to choose, and she is ready to learn. The need is present now, so it is an actual diagnosis, but it is a request for teaching rather than a health problem. The plan aims for her to choose a method suitable for her, understand its use and attend follow-up, by giving balanced information and respecting her choices.