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# Emotional distress affecting participation in care Hyperemesis gravidarum

Midwifery & O.G. Nursing | Focused diagnosis-based template

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

## Clinical assessment

Subjective: Cannot retain usual food or drinks and feels dizzy.

Objective findings and required checks: Reduced intake, weight loss and dehydration require maternity assessment.

Physical examination and investigations: Review weight, hydration, electrolytes, renal function and alternative causes as clinically indicated.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

## Clinical focus and pathophysiology

Hyperemesis gravidarum: Severe pregnancy-related nausea and vomiting can disturb nutrition, fluid and electrolyte balance.

## Medical / surgical management

Follow the maternity hydration, antiemetic and nutrition plan; monitor response and complications.

## Illustrative drug and treatment study



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| Medicine / treatment | Purpose | Nursing checks |
| --- | --- | --- |
| Prescribed pregnancy-appropriate antiemetic | Control nausea/vomiting | Verify product suitability and adverse effects |
| prescribed thiamine and fluids when indicated | Prevent deficiency harm and correct losses | Follow specialist timing and monitoring. |

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.



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# Focused nursing-problem template

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

| Assessment: subjective / objective | Nursing diagnosis: original problem wording | Short- and longer-term goals | Nursing interventions with rationale | Evaluation |
|---|---|---|---|---|
| Ask: Ask what worries the patient most and how they prefer to receive information. Assess: Observe distress, attention and ability to engage without making assumptions. | Emotional distress affecting participation in care. Possible factors: uncertainty, symptoms or unfamiliar treatment. Validate against the patient's assessment. | Short-term: At the next patient-specific reassessment: Identifies one immediate concern and participates in an agreed next step. Longer-term: Before the clinically approved transition or agreed follow-up: Describes helpful support and coping strategies before transition of care. | 1. Listen without judgment and acknowledge specific concerns. Rationale: Feeling heard supports trust and therapeutic engagement. 2. Explain one step at a time and use teach-back with permission. Rationale: Manageable information reduces uncertainty and checks understanding. 3. Offer culturally appropriate support and refer when distress persists or safety concerns arise. Rationale: Additional support may be needed beyond bedside reassurance. 4. Follow the maternity hydration, antiemetic and nutrition plan; monitor response and complications. Rationale: Severe pregnancy-related nausea and vomiting can disturb nutrition, fluid and electrolyte balance. The condition-specific plan addresses the underlying problem while response is monitored. | Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement. |



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## Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____



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## Health education and continuing care

Discuss tolerated intake, medicine instructions and early review for recurrent dehydration.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

## Urgent warning signs

**Fainting, very low urine, hematemesis, confusion or inability to maintain hydration requires urgent care.**

## Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

## Quick Revision

- Severe pregnancy-related nausea and vomiting can disturb nutrition, fluid and electrolyte balance.
- Priority concerns: Emotional distress affecting participation in care.
- Fainting, very low urine, hematemesis, confusion or inability to maintain hydration requires urgent care.
- Discuss tolerated intake, medicine instructions and early review for recurrent dehydration.

**Exam / viva: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?**

## References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Maternal-Newborn Nursing: external further reading - OpenStax / Rice University
https://openstax.org/books/maternal-newborn-nursing/pages/preface



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