

Student Name: Katie Ventresca

N201: Nursing Diagnosis Form

List the two Nursing Diagnoses along with rationale, at least 2 goals, assessments, and nursing interventions for each patient.

Patient Problem # 1: Risk for bleeding

Rationale for selecting: Uterine atony, overdistention of uterus

Goals: 1. Fundus will be firm at midline and appropriate height in relation to my days of care.
2. Moderate lochia rubra will not exceed 1 pad per hr during 1st day postpartum.

Ongoing Assessments: Assess fundal height and location qshift, Assess fundal tone q4h, assess lochia amount, color, and consistency q2-3hr, HR & BP q4h.

- NI:
1. Perform fundal massage prn for boggy uterus.
 2. Notify physician if clots present.
 3. Encourage voiding q2-3hr.
 4. Encourage breastfeeding 8-12 times per day.
 5. Educate on S/Sx of hemorrhage before and after labor.
 6. Administer Oxytocin as ordered.

Patient Problem # 2: Risk for infection

Rationale for selecting: Separation of placenta, AROM

Goals: 1. Temperature will range from 36.5-37.5C during my time of care.
2. Lochia rubra will be scant amount with no foul odor during my time of care.

Ongoing Assessments: Assess lochia q2-3hr, assess uterine pain/tenderness q4h, assess temperature q4h, assess HR and BP q4h.

- NI:
1. Perform hand hygiene when entering/leaving room
 2. Educate on proper hand hygiene for parents and visitors prn
 3. Wipe front to back after toileting
 4. Change pad q2-3h, remove pad front to back
 5. Change linens daily
 6. Shower daily

Directions:

Initials/ Signature KV/ Katie Ventresca SNB

Chart any and all nursing interventions done for your patient during your time of care (if nursing interventions performed by others, write as an “E” note). After each intervention, document your patient’s response to the intervention (evaluation note).

Time	I or E (NI or Eval)	Notes	Specify NDx #
0800	E	Report form RN David: 28yo gravida-one, para-one. African American. Delivered @ 0530. 41 week male 9lbs 3oz. 15 hr labor with epidural. 3 hr second stage w/vacuum assist & mid-line episiotomy. Received 600mL IV bolus Oxytocin, 20unit in 1000mL of lactated ringers. EBL 250mL. delivery complicated by chorioamnionitis- received IV Abx. B- blood type. Baseline HGB 12, HCT 37%. Uses inhaler for asthma. Fundus firm @ 2 finger breadths below umbilicus & midline. T 38.7, HR 96, RR 12, BP 132/72, pain 2/10. Baby 1 min apgar was 7, 5 min apgar was 8.-----KV	1,2,3
0830	E	In bed, husband at bedside.-----KV	O
0830	I	Performed fundal massage.-----KV	1
0830	E	Fundus slightly boggy, firms with massage. 2 finger breadths below umbilicus, deviated right. Moderate lochia. HR 105, RR 18, BP 112/70, O2 Sat 98%.-----KV	1,2
0840	I	Assisted to bathroom.-----KV	1,2
0845	E	Unable to urinate.-----KV	1,2
0850	I	Obtained urine via straight catheter.-----KV	1,2
0855	E	Urine output of 600mL. 3 pads soaked in last hour. Fundus midline at umbilicus.-KV	1,2
0900	I	Notified provider of increased blood loss-----KV	1
0910	E	Labs ordered, pain 3/10.-----KV	1,2,3
0915	I	Administered Ibuprofen 600mg PO.-----KV	3
0945	E	Pain 1/10, O2 Sat 91%.-----KV	1,3
0945	I	Administer 2L O2 via NC, performed fundal massage, weighed pads.-----KV	1
1000	E	O2 Sat 96% on 2L O2 NC. 367g of blood loss in pads. Clots expressed upon palpation. No placental fragments. HCT 23%.-----KV	1,2
1010	I	Notified doctor.-----KV	1
1030	E	Carboprost ordered, has asthma.-----KV	1
1030	I	Notified doctor of asthma. Dr changed order to oxytocin.-----KV	1
1040	E	Asks “Why am I bleeding so much?”-----KV	1
1040	I	Explained that bleeding is due to the chorioamnionitis.-----KV	1,2
1130	E	Fundus remains boggy, still bleeding and passing clots. T 38.3, HR 96, RR 16, PB 96/62, O2 95% 2L NC. -----KV	1
1135	I	Nancy performed fundal massage.-----KV	1
1140	E	Continues to bleed. HCT 23%. -----KV	1
1145	I	Doctor in room advising client that a uterine curettage and balloon tamponade are necessary. -----KV	1,2
1145	E	States “Surgery? Why?”-----KV	O,1
1145	I	Doctor explained reason for surgery is to figure out cause of bleeding and get it under control.-----KV	1
1150	E	Doctor in room explaining procedure.-----KV	1
1110	I	Obtained signed consent form.-----KV	1
1230	E	Post op. 2 units of packed red blood cells ordered. -----KV	1
1235	I	Administered 2 units of packed red blood cells.-----KV	1

1330	E	States "I'm feeling much better". Has questions about breastfeeding.-----KV	O
1345	E	Lactation consultant in room.-----KV	O
1350	I	Brought baby in the room.-----KV	O
1355	E	States that she has no questions at the moment but is "anxious to hold my baby"--KV	O

Reflective Thinking: 1) Read over your notes
 2) Reflect on the patient problems you identified in your documentation
 3) Determine appropriate nursing diagnoses for your patient based on the problems you identified
 4) List your nursing diagnoses below, assigning each a number
 5) Return to your notes and write the corresponding nursing diagnosis # beside each entry

1	Risk for bleeding	
2	Risk for infection	
3	Acute pain	

* Boxes that are blue should be completed using textbook information, what you expect to find. Boxes that are orange should be data collected from your patient's chart and from your assessment.

Medical Diagnosis: Postpartum hemorrhage

NCLEX IV (8): **Physiological Integrity/Physiological Adaptation**

NCLEX IV (7): **Reduction of Risk**

<p><u>Anatomy and Physiology</u> <u>Normal Structures</u> The uterus is a thick-walled muscular organ capable of expansion to accommodate a growing fetus. It is connected distally to the vagina, and laterally to the uterine tubes. It consists of 3 parts: the fundus, which is the top of the uterus above the entry point of uterine tubes, the body, which is the usual site for implantation of the blastocyst, and the cervix, which is the lower part of the uterus linking it with the vagina. The uterus should lie immediately posterosuperior to the bladder, and anterior to the rectum. The fundus and body of the uterus are composed of three tissue layers: peritoneum, myometrium, and endometrium. The myometrium undergoes hypertrophy and hyperplasia during pregnancy in preparation to expel the fetus at birth. Immediately after delivery of the placenta, the uterus begins the process of involution. The uterus contracts the uterine vessels and</p>	<p><u>Pathophysiology of Diseases</u> The most common cause of postpartum hemorrhage is uterine atony (failure of the uterus to contract). Primary postpartum hemorrhage due to uterine atony occurs when the relaxed myometrium fails to constrict the blood vessels that traverse its fibers, thereby allowing hemorrhage. Other causes of postpartum hemorrhage are: placental abruption, placenta previa, overdistended uterus, multiple pregnancies, gestational diabetes, preeclampsia, prolonged labor, and infections.</p>	<p><u>Actual Labs/ Diagnostics</u> -HCT 23% -HGB 10.8g/dL -platelets 135,000 mm3 -blood type – B-</p>
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impedes blood flow. Large vessels at the site of placental attachment thrombose to control bleeding.		
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NCLEX II (3): Health Promotion and Maintenance

Contributing Risk Factors
 -chorioamnionitis
 -vacuum assist
 -episiotomy
 -LGA

Signs and Symptoms
 -boggy fundus
 -blood clots
 -3 soaked pads in 1hr
 -increased HR
 -decreased BP

NCLEX IV (7): Reduction of Risk

Therapeutic Procedures
Non-surgical
 -Fundal massage
 -blood transfusion (2L)

Surgical
 -uterine curettage
 -balloon tamponade

Prevention of Complications
 (Any complications associated with the client's disease process? If not what are some complications you anticipate)
 -infection
 -continued bleeding

NCLEX IV (6): Pharmacological and Parenteral Therapies

Medication Management
 -Oxytocin 10units in 1000mL lactate ringers solution IV bolus
 -Ampicillin 2g IV bolus q4h

NCLEX IV (5): Basic Care and Comfort

Non-Pharmacologic Care Measures
 -fundal massage
 -lochia assessment
 -VS assessment

NCLEX III (4): Psychosocial/Holistic Care Needs

Stressors the client experienced?
 -fear
 -anxiety

Client/Family Education

Document 3 teaching topics specific for this client.

- how to monitor/assess lochia
- pre-op teaching
- breastfeeding education

NCLEX I (1): Safe and Effective Care Environment

Multidisciplinary Team Involvement
 (Which other disciplines were involved in caring for this client?)

- RN
- Physician
- Surgeon
- CNA
- Lactation consultant

Reflection Paper

Directions: Write a 1-page reflection paper for each patient using Times New Roman, 12 pt. font and double-spaced. Include the following:

1. Describe an "Aha" moment you experienced during this learning experience.

2. What were the most important aspects of this simulation and what did you learn?
3. How will this simulation experience impact your nursing practice?

An “Aha” moment for me during this experience was kind of continuous during the entire simulation. When I think of postpartum hemorrhage, I think that it’s a fast process and picture everyone running around trying to stop the bleeding but during this experience it was a slow process. There were many assessments, and it was hours before the decision to do surgery was made.

The most important aspects of this simulation were the consistent and prompt assessments. The RN performed the assessments in a timely manner and she caught all of the signs and symptoms of bleeding and performed intervention right away. When the interventions were not working, she promptly notified the doctor.

This simulation will impact my nursing process because it has shown me that postpartum hemorrhage is not always a blood gushing, all hands on deck kind of situation. It has shown me that thorough and prompt assessments are so important and essential to catching the signs and symptoms of a hemorrhage. It also showed how important it is to double check the physicians orders. Luckily the nurse was though and caught that the patient had asthma and was able to get the order changed from carboprost to Oxytocin.

