N305 Postpartum Care plan

Student's Name: Addison Pavlick **Time/ Date of Care:** 2/20/19, 0700-1300.

Instructions: The care plan is to be typed into a WORD document and submitted to the Postpartum Dropbox within 1 week after your clinical has ended. Be sure and compare your work with the attached rubric before submitting this to the dropbox. The care plan is worth 50 points. In order to pass you must achieve at least 38.5 points to acquire a pass. If you do not pass, you will have one opportunity to do a postpartum care plan on a different patient. You must pass the care plan in order to pass your clinical and thus your course.

Client's initials: AK. Client's Age: 18 y/o. Marital status: single.
Ht (in and cms): 64 in, 162.5 cm. Wt (lbs and kg): 163 lb, 79.3 kg.

Nursing Note

Provide a nursing note about the client's presentation to labor and delivery. (This note should include GPTAL, due date, number of weeks gestation, any significant medical or obstetrical history, reason for coming to hospital and information about their labor and birth. This note should be detailed and include any pertinent information about the client).

G-1, P-1, T-1, P-0, A-0, L-1. Patient's due date was 2/13/19 and was 40 weeks and 5 days gestation. Patient came to OSF with chief complaint of uterine contractions, denying loss of fluids. AK's PMH is anxiety and depression, but does not take medications for either. She denies knowledge of surgical history and family history. Patient also denies alcohol, drug, and tobacco consumption. She admits to formerly using an ecig/vapor w/o nicotine. Patient was assessed and noted 2 cm dilated. There was fetal movement noted. Patient considered non compliant as she did not receive care during weeks 30-36. She was positive for GBS when swabbed. Patient failed her 1 hour glucose test at 28 weeks and did not complete her 3 hour. She stated she was checking blood sugars at home. Patient progressed from 2cm to 8cm quickly. Patient had artificial rupture of membranes at 0847. Baby was vertex, LOA. She had a vaginal birth with an EBL of 200 ml delivering at 0935. She has a laceration that is 1st degree. Pitocin was administered post delivery to prevent risk of hemorrhage.

Ethnic Information

Ethnic group: white/caucasian.
Any childbirth practices of this group that differs from our traditional practices? If so, what do they include?
N/A.

Obstetric History

Include all previous pregnancies a woman has had, no matter the length or outcome. Do NOT include the current pregnancy. Add more rows to the table as necessary.

Month/Year	Gestation (weeks)	Delivery Outcome	Infant Weight	Complications
N/A	N/A	N/A	N/A	N/A

Prenatal Lab and Ultrasound Studies

Prenatal labs consist of initial lab work, genetic screening and testing (optional), and third trimester lab work. Indicate any abnormal laboratory results, follow-up labs and treatment/plan under prenatal complications below. Prenatal ultrasound can be done for a number of reasons. For each ultrasound, follow the table below.

Name of Test and Date	Why was this test ordered for THIS patient?	Patient's Results	Expected Results	Interpretation of THIS patient's results
Blood Type	to test the patient blood type.	O	A, B, AB, or O.	Patient has blood type O.
Rh Factor	to determine the patient has an Rh factor and what it is.	-	- or +.	Patients Rh factor is -.
Serology (RPR/VDRL)	to determine if the patient has syphilis.	non reactive	non reactive	normal.
Rubella titer	to see if mother if immune to rubella.	nonimmune	immune	recommend Rubella vaccine, as this could affect future pregnancies.
H & H (Hemoglobin and Hematocrit)	to monitor for values outside the norm. (early treatment/intervention)	hgb: 10.5 hct: 30.4%	hgb: 12.0-15.8 hct:36.0-47.0%	within normal limits.
HIV	to test for HIV.	not detected	not detected	normal, does not have HIV.
HbSAG	to test for Hepatitis B.	not detected	not detected	normal, does not have Hepatitis B.
GBS (Group B Strep)	to test for GBS and assess need for treatment or not.	positive	negative	GBS + requires antibiotics prior to delivery and after delivery.
Glucose (at 28 weeks gestation)	to test for gestational diabetes.	failed @ 1 hr, did not complete 3 hr	blood sugar within normal range 70-99.	noncompliant, abnormal, diet control as needed.
Urine protein	N/A	N/A	N/A	N/A
Genetic Screening and diagnostic testing (AFP,	N/A, optional	N/A	N/A	N/A

CVS, Amniocentesis)				

Vital Signs :

Prenatal (last set taken):
BP- 128/84, HR- 98, RR- 18, O2- 96%, temp- 98.4℉ (36.9℃).
Labor (set during labor):
BP- 122/61 HR- 111, RR- 16, temp- 97.9℉ (36.6℃)
Today (the VS from your assessment today):
BP- 98/54 HR- 84, RR- 18, O2- 98%, temp- 98.1℉.

Prenatal Medications

Physician's Order (medication, dosage, route, frequency)	Why was this medication ordered for THIS patient?	Common Side Effects
prenatal vitamin (Fe Fumarate (FA)), PO, 1x/daily.	Prenatal vitamins consist of a variety of vitamins and minerals that help your baby get the nutrients that are essential for healthy development. Prenatal vitamins with folic acid can help drastically reduce the incidence of neural tube defects like spina bifida and anencephaly.	Constipation, diarrhea, or upset stomach
Penicillin G, 5 million units IV bolus followed by 2.5 million units intermittent IV bolus q4 hr.	Pt was + for GBS. Penicillin G treats GBS.	urticaria, flushed skin, delayed skin rashes, fever, malaise, pruritus, vomiting, diarrhea.
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A

Intrapartum (Labor)

Membranes ruptured: **artificial** or spontaneous Date/Time: 2/18 @ 0847.
Characteristics – color, odor, etc: clear, no odor.
Augmentation? ___Yes **_X_No** Induction? __Yes **_X_No**
If yes for augmentation or induction, why? N/A.

Medication used? (Cervidil, pitocin, Cytotec): Pitocin postpartum 500ml (1 bag), 1x. (reduces risk of hemorrhage.)

Delivery Date: 2/18. Time: 0935 Type (vaginal/cesarean): vaginal.
Episiotomy/Lacerations: laceration, perineal 1st degree.

EBL (estimated blood loss): 200ccs/mls

Intrapartal (During Labor) Labs and Diagnostic Tests

Name of Test and Date	Why was this test ordered for THIS patient?	Patient's Results	Expected Results	Interpretation of THIS patient's results
CBC	to determine if there were any concerns or signs of infection with mom.	WBC:13.00 Platelet: 217	WBC: 4-12 Platelet:140-440	WBC is slightly elevated this is most often times normal. This could also be due to + GBS or stress though.
Blood Type & Screen	Confirm patient's blood type and Rh factor, preventative measure.	O-	A, B, AB, or O blood type with + or - Rh factor.	Patient has type O blood and a negative Rh factor.
Others?	N/A	N/A	N/A	N/A

Postpartum Period (After delivery)

Today's Assessment

System	Your Assessment
Vital Signs	BP- 98/54, HR- 84, RR- 18, temp- 98.1℉, O2- 98%.
Presence of HA (headache)	denies presence of headache.
Skin	Pt is caucasian. skin appears warm and dry pink, no cuts or bruises, rashes or lesions. Skin turgor is elastic. Capillary refill is less than 2 seconds.

	Braden score 23.
Breath Sounds	No accessory muscle use when breathing. Anterior and posterior lung sounds auscultated. Lung sounds clear bilaterally. Patient currently breathing room air.
Bowel Sounds	Bowel sounds present and active in all four quadrants.
Incision (if C/S)	No incision as patient delivered vaginally and did not have a CS.
Breasts	soft with no cracks in the nipples. No masses, redness, or feeling of warmth. Mother is breastfeeding.
Fundus	firm w/o massage, 2 cm umbilicus.
Bladder	uterus is midline. nondistended. patient is voiding appropriately.
Lochia	rubra color (bright red), light, less than 10 cm on pad in one hour, no odor.
Perineum	Slight redness and swelling due to 1st degree laceration (perineal skin and vaginal mucous membrane).
Homan's Sign	negative homan's sign assessed.
IV Site	peripheral IV, single lumen, metacarpal vein (top of hand), 18g, dated 2/18/19 0745. IV removed 2/19 1030.
Emotions/bonding	Patient is happy and accepting of the baby. She is breastfeeding and interested in the education provided for regarding taking home a new baby. Mom and significant other have been at bedside frequently supporting her and baby.
Pain	patient denies pain, if she had to rate it, 1/10.

Postpartum Labs and Diagnostic Tests (if any)

Name of Test and Date	Why was this test ordered for THIS patient?	Patient's Results	Expected Results	Interpretation of THIS patient's results

CBC 2/19 0531	to check for concerns and/or signs of infection.	WBC: 13 RBC: 3.54 Hct: 30.4 Hgb:10.5	WBC: 4-12 RBC:3.8-5.3 hct: 36-47% hgb: 12-15.8	WBC is slightly elevated this is most often times normal. This could also be due to + GBS or stress though. Hgb is slightly decreased as a result of loss of blood during delivery (200cc).
Blood glucose 2/19 0602	to determine patient blood glucose. (check for hypoglycemia, hyperglycemia)	73	70-110	Blood glucose within normal limits.

Postpartum Medication

Include all medications you administer or observe the nurse administer

Physician's Order (medication, dosage, route, frequency)	**Why was this medication ordered for THIS patient?**	**Common Side Effects**	**Nursing Interventions for THIS Patient**
Acetaminophen, 650mg, PO, Q4h, PRN. (OR Acetaminophen, 650mg, rectal, Q4h, PRN). (Jones & Bartlett, 2018)	mild/severe pain, fever.	hypoglycemic coma, neutropenia, hepatotoxicity in alcoholics, pancytopenia, dizziness, N/V/D.	1. Educate pt not to take other medications containing acetaminophen without medical advice. 2. Monitor renal function in patient. 3. Do not breast feed while taking this drug without consulting physician.
Rhogam, 300mcg, IM, 1x. (Jones & Bartlett, 2018)	Mother has a negative Rh factor. Rhogam will suppress antibody response in case future pregnancies have an opposite Rh factor than mother.	Injection site irritation, slight fever, myalgia, lethargy.	1. Make sure that lot numbers of drug used for the cross-match and the drug to be administered are the same. 2. Administer Rho(D) immune globulin via IM to the mother only, not to the infant. 3. Use the deltoid muscle. Give in divided doses at different sites, all at once or at intervals, as long as the

			entire dose is given within 72 h after delivery or termination of pregnancy.
Ibuprofen, 800mg, PO, Q8h, PRN. (Jones & Bartlett, 2018)	mild or more severe pain.	heartburn, nausea, occult blood loss, anaphylaxis, aplastic anemia, leukopenia, decreased H&H.	1. Monitor for therapeutic effectiveness. 2. Lab baselines and periodic evaluations of Hgb, renal and hepatic function. 3. Monitor for GI distress and S&S of GI bleeding.
Pitocin, 500ml (1 bag), IV, 1x post delivery. (Jones & Bartlett, 2018)	reduce the risk of hemorrhage following delivery.	maternal nausea, vomiting, fetal intracranial hemorrhage, anxiety, fetal bradycardia and arrhythmias, maternal cardiac arrhythmias.	1. Start flow charts to record maternal BP and other vital signs, I&O ratio, weight, strength, duration, and frequency of contractions, as well as fetal heart tone and rate, before instituting treatment. 2. Monitor fetal heart rate and maternal BP and pulse at least q15min during infusion period. Report change in rate and rhythm immediately. 3. Check fundus frequently during the first few postpartum hours and several times daily.

Reference:

2018 Nurses drug handbook (17th ed.). (2018). Burlington, MA: Jones & Bartlett Learning.

Priority Postpartum Nursing Diagnoses

Identified Problem or potential problem	Expected Outcomes/Goals	Interventions	Goals/Outcomes Met/Not Met

Identify problems that are specific to this patient. Write 2 nursing diagnosis. In order of priority.	**Include an expected outcome for each intervention. What do you expect to happen when you implement each intervention? Expected outcomes should be specific and individualized for THIS patient. Make them measurable.**	**Include 3-5 interventions for each problem. Interventions should be specific and individualized for THIS patient. Be sure to include a time interval when appropriate, such as "Assess vitals q 12 hours". Interventions could include assessment, client teaching, procedures and prn medications.. List rationales for each intervention and using APA format, list the source.**	**Include whether the goal/outcome has been met or not met and why.**
Diagnosis 1. Deficient Knowledge related to unfamiliarity of effects of postpartum wound infection risk on self and the importance of following treatment evidenced by 1st degree laceration. (Swearingen, 2016, p. 643)	1. Patient and family present will verbalize the effects a postpartum wound infection may have on the mother and likely treatments for the possible infection before end of shift and before discharge. 2. Patient and family will be able to verbalize signs and symptoms of infection and complications to report after hospital discharge by end of shift and before discharge home. 3. Patient and significant other will verbalize understanding of postponing sexual intercourse for at least 6 weeks postpartum to prevent introducing bacteria that may result in an infection or delayed healing time by end of shift and before discharge.	1. Teach the pt, significant other, and family about the effects a postpartum wound infection may have on the mother and the likely treatments for the infection prior to end of shift and before discharge. Information helps patient adhere to treatments, report symptoms in a timely matter, and understand consequences of nonadherence. Effects an infection may have on the mother include pain, fever, chills, wound dehiscence, sepsis,and increased morbidity/mortality. Likely treatments include IV antibiotics and fluids, wound packing, secondary wound closure, and possible lengthy hospitalization or home treatments. (Swearingen, 2016, p. 644) 2. Teach signs and symptoms of infection and its complications that should be reported after hospital discharge by end of shift and before discharge. This enables the patient/family to recognize and report signs of infection such as fever, foul smelling discharge, failure of lochia to progress from furbra to serosa, to alba, and its timely completion, severe pain, drainage from infection sight. Early evaluation and treatment results in decreased maternal morbidity. (Swearingen, 2016, p. 644) 3. Explain to patient and partner that intercourse is not recommended during the process of wound healing, especially when at risk for infection or with an infection by end of shift and before discharge. Usually intercourse is not recommended until 6 weeks postpartum. This time frame allows the placental attachment site to heal, cervical closure, lochia to stop, and incisions to heal without risk of	1. Goal was met as the patient and her significant other were able to describe the effects a postpartum wound infection may have on the mother and likely treatments for the possible infection prior to discharge. 2. Goal was achieved. Patient and significant other verbalized signs and symptoms to look for suggesting an infection and complication to report following their discharge. Verbalization of understanding of this material occurred prior to discharge. 3. Goal was met when mother and significant other agreed to understanding to abstain from sexual intervourse for at least 6 weeks before they were discharged home.

		introducing bacteria. (Swearingen, 2016, p. 644)	
Diagnosis 2. Acute pain related to post delivery of a neonate as evidenced by 1st degree laceration and birth of a child. (Swearingen, 2016, p. 645)	1. Patient is aware she will be asked to report her pain level hourly, prior to and after giving medications. She verbalized understanding of monitoring her pain and why it is important. 2. Patient verbalized the importance of reporting her pain based on a numeric scale, 1-10, 0 being none and 10 being the worst pain she has ever felt. She understands that rating her pain prior to and after medication administration allows a baseline and to monitor effectiveness of the medication. 3. Patient understands why and what medication her provider has ordered for her for pain management. She verbalized reasons for reducing pain including being more comfortable, a, increased mood, and the ability to care for her infant effectively.	1. Assess patient's pain hourly, prior to and after giving medications. This intervention is done to routinely monitor the patients pain and allow ample time to intervene if needed. Pain management is essential in a new mother .(Swearingen, 2016, p. 645) 2. Educate the patient on reporting pain on a numeric scale and requesting medication before the pain becomes unbearable during my shift. This intervention allows the nurse and patient to get ahead of pain, reducing the risk of the pain, pain worsening, and identifying if pain is occuring for another reason other than post delivery of her baby and her 1st degree laceration. (Swearingen, 2016, p. 645) 3. Educate/administer medication per physician request and based upon patients pain rating/ severity during my shift. This is essential to decreasing the patients pain that they describe/report. Reducing pain promotes an overall better mood, comfortability, and allows mother to care for her new infant. (Swearingen, 2016, p. 645)	1. Outcome was met evidenced by hourly rounds including pain ratings followed by pain ratings by the patient before and after medication administration. This was done continuously throughout my shift. 2. Outcome was met as the patient rated her pain on a numeric scale 0-10 and verbalized the understanding of reporting her pain before it became unbearable (although that did not occur throughout my shift). 3. Outcome was partially met. Patient is educated and verbalized her understanding of why and what medications were prescribed to her to manage her pain. Patient did not require medication administration during my shift.

References:

Swearingen, P. L. (2016). *All-In-One Nursing Care Planning Resource* (4 ed.). St. Louis, Missouri: ELSEVIER.

N305 Postpartum Care Plan
GRADING RUBRIC

Name: Addison Pavlick Date: 2/27/19 Grade _____

Section	Definition	Possible Points	Final Points
Age/Weight/Height	Age, Ht and wt written	2	
Nursing Note	GPTAL, due date, number of weeks of gestation, significant medical or obstetrical history, reason for coming to hospital and pertinent information about their labor and birth	2	
Obstetric History	Accurate information about each pregnancy for month/year, gestation, delivery outcome, infant weight, complications	2	
Prenatal lab and Ultrasound studies	Prenatal labs, lab work, genetic screening and testing, Indicate abnormal results, follow up, treatment plan /interpretation of results	2	
Vital Signs	All vital signs prenatal (last set taken), during labor, and today	2	
Prenatal Medications	Include all medications taken by client prenatally	2	
Intrapartum information	All information is filled out in the Intrapartum section, if anything is missing 1 pt is received, if nothing is filled in 0 points are received	2	
Intrapartal labs and diagnostic	Information provided for intrapartal lab tests or diagnostics	2	
Clinical Day Maternal Assessment	Head to toe physical assessment with comments (not just WNL) address any concerns found with assessment	2	
Postpartum labs and diagnostic test	Postpartum labs and tests listed or N/A marked if there are none	2	
Postpartum medications	Include all medications administered by the student or that student observed administered by nurses during clinical time	2	
Nursing Diagnosis # 1 Related to or AEB	Nursing diagnosis is pertinent to patient condition/diagnosis. Reflects and supports current primary medical diagnosis R/T the pathophysiology for the current primary diagnosis/condition (not medical diagnosis). AEB: signs and symptoms that support the nursing diagnosis	2	
Expected Outcomes	Patient will/Family will…. and must have a desired outcome timeline. (Must be measurable, specific, & objective) (Ex: patient will ambulate around the nurse's station **once** during clinical or patient will verbalize **3** signs and symptoms of infection by the end of clinical day).	2	
Nursing Interventions	What nursing interventions will you do to support meeting the patient outcomes and give rationale for	5	

	each intervention of why this intervention is important? (Need at least 2 interventions per outcome)		
Evaluations & What's Next	Goal met/partially met/not met, why or why not, what's next? (Explain your evaluation of outcomes met, partially met, or not met (i.e., patient/family was not able to verbalize 3 signs and symptoms of infection) What's next? (What is/are the next intervention/s for the patient/family to help them meet the intended outcome)?	5	
Nursing Diagnosis #2 Related to or AEB	Nursing diagnosis is pertinent to patient condition/diagnosis. Reflects and supports current primary medical diagnosis R/T the pathophysiology for the current primary diagnosis/condition (not medical diagnosis). AEB: signs and symptoms that support the nursing diagnosis	2	
Expected Outcomes	Patient will/Family will…. and must have a desired outcome timeline. (Must be measurable, specific, & objective) (Ex: patient will ambulate around the nurse's station **once** during clinical or patient will verbalize **3** signs and symptoms of infection by the end of clinical day).	2	
Nursing Interventions	What nursing interventions will you do to support meeting the patient outcomes and give rationale for each intervention of why this intervention is important? (Need at least 2 interventions per outcome)	5	
Evaluations & What's Next	Goal met/partially met/not met, why or why not, what's next? (Explain your evaluation of outcomes met, partially met, or not met (i.e., patient/family was not able to verbalize 3 signs and symptoms of infection) What's next? (What is/are the next intervention/s for the patient/family to help them meet the intended outcome)?	5	
	Total Points Possible	**50**	

(You must achieve 38.5 points to pass) Total points for this care plan _____