N305 Postpartum Care plan

Student's Name Kelsey Reardon_____ Time/ Date of Care 2/20/19 7am-12pm_

Instructions: The care plan is to be typed into a WORD document and submitted to the Postpartum Drobox 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 _A.K.___ Client's Age 18___ Marital status __Single_____
Ht (in. and cms.) __5'4" (64in, 163 cm)___ Wt (lbs. and kg.) _163lbs, 73.9kg

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)

The patient presents to the labor and delivery unit at 0500 on 2/18/19 complaining of uterine contractions. She states she feels fetal movement and denies leakage of fluid. Patient's due date is 2/13/19, she presents as 40 weeks and 5 days of gestation. The patient is a G1 P0 T0 A0 L0 upon entering the labor and delivery unit. This is the patient's first pregnancy. The patient's medical history include anxiety. She was taking Zoloft for her anxiety until she found out she was pregnant. She hasn't taken anything for it since. The patient denies the current and previous use of tobacco/drugs/alcohol. She admits to previous use of Ecig/Evapor without nicotine. The patient has no allergies. The patient does not have a history of any surgical procedures. The patient did not receive prenatal care until 21 weeks of gestation. She had a total of 9 prenatal appointments and did not attend any appointments between 30-36 weeks of pregnancy. Patient did receive rhogam prior to delivery. The patient did not have any anesthesia during labor. She progressed quickly from 2cm dilated to 8cm. AROM was done at 0847. She delivered on 2/18/19 at 0935. She delivered vaginally and has a 1st degree perineal and vaginal laceration, which was repaired with a 2-0 vicryl and lidocaine.

Ethnic Information
Ethnic group
Caucasian
Any childbirth practices of this group that differs from our traditional practices? If so, what do they include? None

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.

This is the patient's 1st pregnancy

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

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 determine blood type	O	A, B, AB, or O	The patient's blood type is O, this is helpful in case a transfusion is needed
Rh Factor	To determine if the patient is Rh- or Rh+	-	Rh-, Rh+	The patient is Rh- so she will need rhogam in her pregnancy
Serology (RPR/VDRL)	To determine if the patient has syphilis	Nonreactive	Negative	The patient tested negative for RPR
Rubella titer	To determine if patient is immune or nonimmune	Nonimmune	Immune/nonimmune	The patient will need to receive a MMR vaccine after delivery
H & H (Hemoglobin and Hematocrit)	To test the patients levels to see if the mother has enough oxygen in her blood or determine if the patient is anemic.	Hgb: 10.5 Hct: 30.4	Hgb: 12.0-15.8 Hct: 36.0-47.0	The patient's levels are low so we will need to continue to monitor the patient's levels.
HIV	To determine if that patient has the HIV infection	Not detected	Negative	The patient does not have HIV, so she will not need treatment
HbSAG	It is important to know if the patient has	Not detected	Negative	The patient tested negative for hepatitis.

	Hepatitis so that we can prevent transmission from the mother to the baby.			
GBS (Group B Strep)	To determine if the patient carries the infection.	Positive	Negative/Positive	The patient is GBS+ so she will need antibiotics during labor and after labor
Glucose (at 28 weeks gestation)	To determine if patient will have gestational diabetes	Failed (no number of file)	Within normal range 70-99	The patient failed her 1 hour glucose and required a 3hr testing, however patient was not compliant and did not get this done
Urine protein	To look for protein in the urine, which can indicate kidney damage, medications, infection, stress, or preeclampsia.	Not tested	Negative	Patient tested negative for proteinuria.
Genetic Screening and diagnostic testing (AFP, CVS, Amniocentesis)	To look for any chromosomal abnormalties in the fetus	None tested	N/A	The patient did not get this test done.

Vital Signs :

- Prenatal (last set taken): Temp: 98.4 F (36.9 C) Pulse: 98 RR: 18 BP: 128/84 O2: 96 room air
- Labor (set during labor): Temp: 97.9 F (36.6 C) Pulse 111 RR: 16 BP: 122/61 O2: no result
- Today (the VS from your assessment today): Temp: 98.1 F (36.7 C) Pulse: 84 RR: 18 BP: 98/54 O2: 98

Prenatal Medications

Physician's Order (medication, dosage, route, frequency)	**Why was this medication ordered for THIS patient?**	**Common Side Effects**
Prenatal Vit-Fe fumarate-FA PO, once daily	To take daily throughout pregnancy to ensure all vitamins are taken	Constipation, diarrhea, upset stomach
Penicillin G	Patient is GBS+ so	Muscle spasm, mild

5 million units IV bolus Then 2.5 million units every 4h	the patient needs antibiotics during labor and after delivery	skin rash, nausea, vomiting, upset stomach, diarrhea, headache, IV site reactions (pain, redness, swelling, bruising, irritation)

Intrapartum (Labor)

Membranes ruptured: artificial or spontaneous Date/Time 2/18/19 at 0847
Characteristics – color, odor, etc. Clear fluid, 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 PP_____

Delivery Date 2/18/19 Time _0935_ Type (vaginal/cesarean) Vaginal-spontaneous ____
Episiotomy/Lacerations 1st degree laceration _____
EBL (estimated blood loss) _200_____ ccs/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 check patient's levels to determine if there are any major concerns or infections	WBC- 13 PLT- 217	WBC- 4-12 PLT- 140-440	Patient's WBC is elevated this could be due to GBS+, a slightly elevated WBC count is typically normal .
Blood Type & Screen	To determine patient's blood type and Rh factor	O-	Any of the blood types	Patient is Rh -, so need to make sure patient has had rhogam
Others?	N/A	N/A	N/A	N/A

Postpartum Period (After delivery)

Today's Assessment

System	Your Assessment
Vital Signs	**BP- 98/54 Temp- 98.1 F Pulse- 84 RR- 18 O2- 98%**
Presence of HA (headache)	**No presence of headache**
Skin	**Skin is pink, warm and dry. Skin turgor <2 seconds. Striae present on abdomen.**
Breath Sounds	**Auscultated all quadrants. All quadrants clear. No wheezing present. No accessory breathing noted.**
Bowel Sounds	**Active and present in all 4 quadrants.**
Incision (if C/S)	**Not available**
Breasts	**No tenderness noted. Patient is breastfeeding. No problems with breastfeeding currently.**
Fundus	**Palpated, umbilicus 2cm midline.**
Bladder	**No difficulty urinating. No burning, urgency.**
Lochia	**Rubra (bright red) color, light amount (less than 10cm on pad/hr), no odor present**
Perineum	**Patient had a 1st degree laceration (perineal skin and vaginal mucous membrane). All normal except redness and swelling.**
Homan's Sign	**Accessed and negative.**

IV Site	**Removed 2/19 at 1030.**
Emotions/bonding	**Patient appears happy and ready to go home with her baby. Partner present and supportive. Partner is participating in newborn care. Both parents are doing well and ready to start their journey.**
Pain	**Patient reports 1/10 pain level. She states that it is mainly just soreness.**

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	To determine patient's levels after delivery and losing blood during delivery.	WBC- 13 RBC- 3.54 Hgb- 10.5 Hct- 30.4 Absolute neutrophils- 9.4 Absolute monocytes- 1.10	WBC- 4-12 RBC- 3.80-5.30 Hgb- 12.0-15.8 Hct- 36.0-47.0 Abs neutrophils- 1.6-7.7 Abs monocytes- 0.2-1.0	Patient's WBC count is high Patient's RBC count, Hgb, and Hct is low due to blood loss in delivery.
Glucose 2/19	To determine if the patients levels were increased	73	70-99	The patient's glucose levels are in the normal range so interventions are not needed.

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
Pitocin 500ml bag through IV once	To prevent PP hemorrhage	Loss of appetite, nausea, vomiting, cramping, stomach pain, runny nose, IV site reactions	Monitor IV site, monitor for adverse reactions, check bag and tubing frequently
MMR vaccine Once	Patient is rubella nonimmune so this is given	Injection site reactions, fever, rash, headache, dizziness, muscle pain, nausea, vomiting	Patient declined this vaccine

Rhogam	Given to suppress antibodies response in future pregnancy	Nausea, vomiting, diarrhea, stomach pain, dizziness, weakness, muscle pain, flushing, mild itching, sweating	Monitor for adverse reactions
Acetaminophen 650mg PO Q4h or PRN Mild/severe pain or fever	Given to relieve pain or reduce fever PP	Nausea, stomach pain, loss of appetite, itching, rash, headache	Monitor for reactions, assess for pain and fever
Benzocaine 1 spray topical Q4h or PRN Laceration	Given to help keep laceration clean and prevent infection	Stinging, burning, itching, skin tenderness, redness, dry white flakes	Teach patient how to properly use and what side effects to look for
Witch hazel glycerin 1 spray Topical Q1h or PRN Hemorrhoids	To reduce pain, itching, and bleeding until hemorrhoids heal	Bloody diarrhea, pain/bleeding/irritation of skin around rectum	Teach patient how to properly use and what side effects to look for
Ibuprofen 800mg PO Q8h or PRN Mild/severe pain	To reduce pain PP	Heartburn, nausea, vomiting, bloating, gas, diarrhea, constipation, dizziness, headache, tinnitus	Monitor for reactions, assess pain level

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**	**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".**	**Include whether the goal/outcome has been met or not met and why.**

	be specific and individualized for THIS patient. Make them measurable.	**Interventions could include assessment, client teaching, procedures and prn medications.. List rationales for each intervention and using APA format, list the source.**	
Diagnosis 1. **Risk of knowledge deficit related to patient's age and first pregnancy as evidenced by patient's hesitation with asking questions.**	Patient will be able to demonstrate breastfeeding techniques by discharge. Patient will be able to perform self-care and able to administer topical medications by herself by discharge. Patient and partner will feel comfortable leaving with newborn baby by discharge.	Assess motivation and willingness of patient to learn. Rationale: learning requires energy and patient must see a need/purpose for learning. Provide an atmosphere of respect, openness, trust, and collaboration. Rationale: Conveying respect is important when providing education to patients with different values and beliefs about health and illness. Include the patient in creating the goals of care. Rationale: Goal-setting allows the patient to know what will be discussed and expected and this helps them feel in control of their plan of care. Educate the patient on how to apply topical medications. Rationale: this ensures the patient knows how to safely administer medications at home. Ask the patient what is important for them during this learning process. Rationale: Allowing the patient to	**Patient exhibits confidence on breastfeeding on her own without any help before she leaves the hospital.** **Patient asks questions regarding topical medications and verbalizes that she understands how to apply them and how often.** **Patient states she is still nervous about leaving with her newborn, but she is excited to get to be home with the baby.** **Patient verbalizes understanding to pointed out phone numbers to call if she has any problems or concerns.**

		identify the most significant content is most effective in teaching. Support self-directed learning. Rationale: Patients know what difficulties will happen in their own environments, and they must be encouraged to approach learning activities from their priority needs. Use the teach-back technique to determine the patient's understanding of what was taught. Rationale: this helps the patient to learn how to perform tasks at home. Encourage questions. Rationale: questions facilitate open communication between patient and health care professionals. Help patient identify resources for continuing information and support. Rationale: Community resources can offer financial and educational support. ("Deficient Knowledge – Nursing Diagnosis & Care Plan", 2019)	
Diagnosis 2. **Risk for acute pain related to postpartum physiologic changes (1st degree**	Patient will be able to verbalize when pain is too extreme during clinical. Patient will be able to confirm decreased pain during clinical.	Assess location, type, and quality of pain. Rationale: to direct intervention. Explain to patient source and reasons for pain, it's expected duration, and	**Patient understands to let the nurse know when her pain is excruciating.** **Patient states her pain level is at a 1/10 before**

laceration, hemorrhoids) as evidenced by woman exhibiting signs of increased discomfort.		treatments. Rationale: to decrease anxiety and increase sense of control. Administer prescribed pain medications. Rationale: to provide pain relief. Encourage sitz baths using cool water for the first 24 hours, use warm water after the first 24 hours. Rationale: to reduce discomfort and promote circulation. Apply witch hazel as needed. Rationale: to reduce pain, bleeding, itching of hemorrhoids. Teach the patient how to use prescribed topical medications. Rationale: to help the wound heal. Explain to patient and partner that intercourse is not recommended during the process of wound healing and to wait for clearance from the primary provider. Rationale: to prevent complications such as wound infection. ("Nursing Care of the Family During the Postpartum Period", 2016)	**discharge. She states that it is only a soreness type of pain.**

Resources

Deficient Knowledge – Nursing Diagnosis & Care Plan. (2019). Retrieved from https://nurseslabs.com/deficient-knowledge/

Nursing Care of the Family During the Postpartum Period. (2016). Retrieved from https://nursekey.com/nursing-care-of-the-family-during-the-postpartum-period/

N305 Postpartum Care Plan
GRADING RUBRIC

Name: _____ Date _____ 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 <u>must have a desired outcome timeline</u>. (Must be measurable, specific, & objective) (Ex: patient will ambulate around the nurse's station **<u>once</u>** during clinical or patient will verbalize **<u>3</u>** 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	
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 _____