

N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 11/07 1632	Patient Initials CR	Age 27	Gender Female
Race/Ethnicity White	Occupation Busey Bank	Marital Status Married	Allergies Latex - Rash
Code Status Full	Height 5'1"	Weight 232lbs	Father of Baby Involved Yes

Medical History (5 Points)

Prenatal History: Compliant/consistent with doctors' orders. G1P1. GHTN.

Past Medical History: Asthma, Hypertension, Depression, & Migraines.

Past Surgical History: C-section on 11/07

Family History: Bipolar (Brother), Breast cancer(mother & grandmother)

Social History (tobacco/alcohol/drugs): Pt denies illegal drug use. Pt denies using tobacco or cigarettes. Pt confirms she consumed alcohol prior to pregnancy.

Living Situation: Pt lives at home with her husband.

Education Level: Highschool

Admission Assessment

Chief Complaint (2 points): RUQ Pain

Presentation to Labor & Delivery (10 points): G1P1 presents to labor and delivery as a 27-year-old. at 37w2d via wheelchair from the ER. The patient was accompanied by her spouse and taken to a room in stable condition. In the chart, it says the patient states she is here for "hard and forceful contractions" that started at 0830 and "really sharp pain." Cervical dilation presenting of 1 cm with 50% effaced. Fetal movement was palpated once she got on the floor. Patient denied any vaginal bleeding, leaking of fluid, or abnormal discharge prior to arriving on the floor. Pt was assessed by the physician and explained a C-section is needed based on her diagnosis. Pt was sent to the OR at 2155. She left the OR at 2341. The pt gave birth to a healthy male.

Diagnosis

Primary Diagnosis on Admission (2 points): HELLP Syndrome

Secondary Diagnosis (if applicable): N/a

Postpartum Course (18 points)

On 11-07-2020, The patient gave birth to a healthy male. The mother is still being observed in the hospital due to abnormal lab values. The patient has a HELLP diagnosis. The patient's labs are improving but not at normal levels yet. The patient still has low HCT, HGB, Platelets, and RBC. GHTN was an issue during pregnancy, as well.

During the student nurse's care, the patient is in the fourth stage of labor. The patient has the understanding that she and her baby are now separate. The mother is attempting to breastfeed with good success. The mother and father seem eager to learn about how to care for their child. This is the couple's first child, and they are full of anxiety at times but are willing to try their best.

The mother is estimated by the student nurse to be in the taking hold phase. "During this phase, the mother tries for independence and autonomy" (Ricci et al., 2017). The mother wants to be independent with her child but struggles with weakness at times. The mother is being watched for postpartum depression.

The patient delivered by C-section and is being watched and monitored for bleeding or hemorrhage. Before leaving the hospital, the patient and her husband will receive education and teaching on the topics of Postpartum hemorrhage, infection, and postpartum mood disorders. (American College of Obstetricians and Gynecologists, 2015). The patient is at an increased risk of bleeding based on her medical conditions. (Ricci et al., 2017).

The patients' signs and symptoms are weight gain, fluid retention, and even facial swelling. The exact cause of HELLP syndrome is still unknown, and its pathophysiology is unclear to a scientist (American College of Obstetricians and Gynecologists, 2015). Although rare, individuals with HELLP Syndrome can be at risk of developing life-threatening complications like disseminated intravascular coagulation (DIC), Seizures, and Liver rupture. DIC is severe; it is when abnormal blood clots form throughout the patient's bloodstream (American College of Obstetricians and Gynecologists, 2015).

Postpartum Course References (2) (APA):

American College of Obstetricians and Gynecologists. *Labor and delivery. In: Your Pregnancy and Childbirth Month to Month.* 6th ed. Washington, D.C.: American College of Obstetricians and Gynecologists; (2015).

Ricci, S. S., Carman, S., & Kyle, T. (2017). *Maternity and pediatric nursing* (3rd ed.). Wolters Kluwer.

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80-5.30		2.62	3.20	A low RBC reading is "common during pregnancy due to low

					iron or vitamin levels" (Jones & Bartlett Learning, 2018).
Hgb	12.0-15.8%		7.8	8.4	A low Hgb reading can "represent normal anemia during pregnancy" (Jones & Bartlett Learning, 2018).
Hct	36-47%		22.7	30.2	A low Hct level can be seen in "pregnancies where the mother is experiencing iron-deficiency anemia" (Jones & Bartlett Learning, 2018).
Platelets	140-440		111	130	A low platelet reading can be seen as "Gestational thrombocytopenia as it is a common condition with most pregnant women" (Jones & Bartlett Learning, 2018).
WBC	4-12		11.2	10.4	
Neutrophils	47-73%		66.8%	66.2%	
Lymphocytes	18-42%		18.7%	18.8%	
Monocytes	4-12%		8.0%	8.0%	
Eosinophils	0-5%		0.3%	0.3%	
Bands	45-74		n/a	n/a	

Other Tests **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	N/A	O	O	O	
Rh Factor	N/A	Positive	Positive	Positive	
Serology (RPR/VDRL)	Nonreactive	Nonreactive	Nonreactive	Nonreactive	
Rubella Titer	Immune	Immune	Immune	Immune	
HIV	Negative	Negative	Negative	Negative	
HbSAG	Nonreactive	Nonreactive	Nonreactive	Nonreactive	
Group Beta Strep Swab	Negative	Negative	Negative	Negative	
Glucose at 28 Weeks	<140	98	98	98	
MSAFP (If Applicable)	N/A	N/A	N/A	N/A	

Additional Admission Labs **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Covid-19	Negative	Negative	Negative	Negative	

Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Explanation of Findings
Urine Creatinine (if applicable)	N/a	N/a	N/a	N/a	

Lab Reference (APA):

Jones & Bartlett Learning. (2018). *2018 Manual of Diagnostic and Laboratory Tests (19th ed.)*.

Stage of Labor Write Up, APA format (15 points):

	Your Assessment
History of labor: Length of labor Induced /spontaneous Time in each stage	<p>This is the patient's first pregnancy. Pt was spontaneously ruptured at 1844.</p> <p>She delivered via C-section, low transverse via pfannenstiel skin incision. She was taken to the OR at 2155. Procedure started at 2216. Procedure ended at 2341. Pt left the OR at 2342.</p>

<p>Current stage of labor</p>	<p>Fourth stage of labor. (Ricci et al., 2017). Pt delivered a healthy baby boy. Pt has started to breastfeed and is practicing skin-to-skin contact. (Centage Learning, 2018).</p>
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Stage of Labor References (2) (APA):

Ricci, S. S., Carman, S., & Kyle, T. (2017). *Maternity and pediatric nursing* (3rd ed.). Wolters Kluwer.

Centage Learning. (2018). *2018 Manual of postpartum nursing* (4th ed.). Centage Learning.

Current Medications (7 points, 1 point per completed med)

7 different medications must be completed

Home Medications (2 required)

<p>Brand/Generic</p>	<p>Prenatal Vit-Fe Fumarate-FA Nature Made Brand</p>	<p>Tylenol acetaminophen</p>
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Dose	200mg	600mg
Frequency	Once a day.	Q4 PRN
Route	PO	PO
Classification	Antianemics Vitamin	antipyretics, nonopioid analgesics
Mechanism of Action	Necessary for formation of coenzymes in metabolic systems.	The mechanism of action of acetaminophen in reducing pain is unknown but may be due to an inhibition of central prostaglandin synthesis (specifically cyclooxygenase (COX)-2) and an elevation of the pain threshold. Acetaminophen reduces fever by inhibiting the formulation and release of prostaglandins in the CNS and by inhibition endogenous pyrogens at the hypothalamic thermoregulatory center
Reason Client Taking	Pregnancy	Pain
Contraindications (2)	Hypersensitive to preservatives. Hypersensitive to saccharin.	Hypersensitivity to acetaminophen or any other components of the product Severe hepatic impairment
Side Effects/Adverse Reactions (2)	Discoloration of urine. Rash	rash, urticaria

Nursing Considerations (2)	<p>Assess pt for adverse reaction</p> <p>Teach to take no more than recommended.</p>	<p>Help patients explore other nonpharmacologic methods to reduce chronic pain.</p> <p>Implement appropriate manual therapy techniques.</p>
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Skin lesions, color; adventitious sounds; CBC, Hgb, Hct, serum folate levels, serum vitamin B12 levels, Schilling test.	<p>Monitor hepatic panel.</p> <p>Monitor signs of leukopenia and neutropenia</p>
Client Teaching needs (2)	<p>Do not take more than it says on the bottle.</p> <p>Contact your physician if you develop a new rash.</p>	<p>Instruct patients about the signs of liver toxicity and renal failure.</p> <p>Advise patients to reduce alcohol intake.</p>

Hospital Medications (5 required)

Brand/Generic	Tums calcium carbonate	Fentanyl Duragesic	Carboprost Hemabate	levothyroxine - synthroid	Acetaminophen TYLENOL
Dose	1000mg	50mcg	250mcg	75 mcg	160mg

Frequency	Q6 PRN	Q8 PRN	Every 15 minutes PRN	every morning before breakfast	Q4 PRN
Route	PO	Epidural	IM	Oral	PO
Classification	Antacid	opioid analgesics	abortifacients	Thyroid hormone replacement	Analgesic
Mechanism of Action	It works by lowering the amount of acid in the stomach.	Fentanyl binds to opioid receptors, especially the mu opioid receptor, which are coupled to G-proteins. Activation of opioid receptors causes GTP to be exchanged for GDP on the G-proteins which in turn regulates adenylate cyclase, reducing concentrations of cAMP.	hormone-like substance that occurs naturally in the body. It helps to control functions in the body such as blood pressure and muscle contractions.	Replaces thyroid hormone by controlling DNA translation and protein synthesis	Inhibits the synthesis of prostaglandins that may serve as mediators of pain and fever, primarily in the CNS. Has no significant anti-inflammatory properties or GI toxicity.
Reason Client Taking	Heartburn	Severe Pain	Bleeding	Hypothyroidism	Pain or to reduce fever.
Contraindications (2)	Calcium blocks absorption of tetracyclines. May affect absorption of other drugs. Absorption blocked by	Can interact w/MAO-I's. Can interact with grapefruit juice & other CNS depressants.	Do not use it in pts with acute PID. Do not use it if you have active cardiac,	Acute MI; adrenal insufficiency	Previous hypersensitivity; Products containing alcohol, aspartame, saccharin, sugar, or tartrazine (FDC yellow dye #5) should be avoided in patients who have hypersensitivity or

	corticosteroids, foods such as rhubarb, spinach, bran.		pulmonary, renal or hepatic disease.		intolerance to these compounds.
Side Effects/Adverse Reactions (2)	Hypercalcemia, hypercalciuria .	laryngospasm, itching	uterine rupture, fever	Anxiety; arrhythmias	neutropenia, pancytopenia
Nursing Considerations (2)	Make sure the patient does not have a dairy allergy. Monitor for cardiac arrhythmias.	Screen for addiction. Monitor for respiratory depression.	Use w/caution in pts with a hx of asthma. Monitor BP, pulse, watch for hemorrhage.	Monitor blood glucose; Not used for weight loss .	not to exceed 5 doses/24 hr
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Calcium levels need to be monitored with long term use.	Fentanyl interferes with respiratory function and pupil reaction. Watch for respiratory depression.	Examine for cervical trauma. Monitor for Hypotension.	assess PT	Assess overall health status and alcohol usage
Client Teaching needs (2)	Tell your doctor if your condition persists or	Alcohol will enhance the drug's hypotensive and sedative effects.	Do not consume alcohol while on this medication.	Take at least 30 minutes before breakfast; take with a full glass of	Assess amount, frequency, and type

	worsens. Do not take the maximum dose of the medication for more than 2 weeks unless directed by your doctor.	Avoid activities that require alertness	Get emergency medical help if you have any of these signs of an allergic reaction: hives; difficult breathing; swelling of your face, lips, tongue, or throat.	water	of drugs taken in patients self-medicating, especially with OTC drugs To prevent fatal medication errors, ensure dose in milligrams (mg) and milliliters
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Medications Reference (APA):

Jones & Bartlett Learning. (2020). *2020 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): Alertness: Orientation: Distress: Overall appearance:	A/O x 4, appearance is appropriate for age, appropriate/good grooming, normal speech, no distress, relaxed with some discomfort
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<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: Drains present: Y<input type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>Skin color r/t ethnic background, skin intact/moist no abnormalities, no ecchymosis, temp normal 98.3 F, no tenting <3 sec cap refill, mucous membranes moist and intact, no drains present, Braden score of 20</p>
<p>HEENT (0.5 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Normocephalic, eyes symmetrical/ even, no drainage, sclera white, ears intact with pearly grey TM, 5 and 7 o'clock cone of light, no deviated septum, patent nostrils bilaterally</p>
<p>CARDIOVASCULAR (1 point): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p>	<p>..S1/S2 present w/out murmurs or gallops, regular heart rhythm, 3+ peripheral pulses, < 3 sec cap refill, no neck vein distention, Slight edema in the lower legs. Equal edema on both sides.</p>
<p>RESPIRATORY (1 points): Accessory muscle use: Y<input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>.Breath sounds auscultated clear, no wheezing or stridor noted, regular respirations, equal chest expansion, no use of expiratory muscles, no pursed lip breathing, no accessory muscle use</p>

<p>GASTROINTESTINAL (5 points): Diet at Home: Current Diet: Height:5'1” Weight:232lbs Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Fundal Height & Position:</p>	<p>normoactive bowel sounds noted, last BM on 11-09 AM regular/soft, no distension, no drains, no wounds to abdomen, diet is normal at home, Diet is normal following birth with the mother wanting to increase her vegetable intake. The fundus is 1 cm or fingerbreadth below the umbilicus.</p>
<p>GENITOURINARY (5 Points): Bleeding: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input type="checkbox"/> Type: Size: Rupture of Membranes: Time: Color: Amount: Odor: Episiotomy/Lacerations:</p>	<p>No current urinary issue, no dysuria, color in normal yellow, genitals normal in structure, no catheterization required currently, membrane rupture on 11/07 at 1844. color is clear/normal, no odor, medium amount, no episiotomy. Pfanstiel skin incision.</p>
<p>MUSCULOSKELETAL (2 points): ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) Needs assistance with equipment Needs support to stand and walk</p>	<p>.Nail Bed r/t ethnic background, no cyanosis or clubbing, extremities are pink/normal, no diaphoresis, independent assistance, no fall risk, With first shower pt will require supervision.</p>

<p>NEUROLOGICAL (1 points): MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC: DTRs:</p>	<p>.A/Ox 4, normal cognition, able to follow commands, intact memory, PERRLA intact, upper and lower extremities bilaterally normal in strength, does MAEW, orientation, mental status, speech. Sensory, LOC, deep tendon reflexes are all normal</p>
<p>PSYCHOSOCIAL/CULTURAL (1 points): Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>. Developmental level is normal for age, coping well with post labor situation, does not have a set religion, married 2 years, home life is positive/stable with family pets, several family support resources/</p>
<p>DELIVERY INFO: (1 point) Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:</p>	<p>Pt gave birth via C-section on 11/07. The procedure started at 2216 and ended at 2341. Quantitative blood loss was 1083ml. Pt gave birth to a healthy male. Apgars 7 & 8. Weight of the child at birth was 7lbs and 3oz. Mother is wanting to breastfeed.</p>

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	98	140/94	16	97.6	100% RA

Admission to Labor/Delivery	103	134/83	18	97.9	98% NC 2L
During your care	80	123/80	16	98.3	100% RA

Vital Sign Trends: Within normal limits and stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1110	Numeric	n/a	0	N/a	Instructed pt to use call light if she needs anything or pain level changes.
1612	Numeric	Lower Back	4	Pt described it as "a stiffness."	Position to side. Will continue to monitor and

					<p>check back q15 to recheck. Pt did not want PRN medication at this time.</p>
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IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
<p>Size of IV: 18 gauge placed/single lumen</p> <p>Location of IV: R AC</p> <p>Date on IV: 11/07</p> <p>Patency of IV: Present and verified/recorded</p> <p>Signs of erythema, drainage, etc.: No signs of erythema or drainage</p> <p>IV dressing assessment: Clean, dry, and intact</p>	<p>PT does not have anything running through her IV at this time.</p>

Intake and Output (2 points)

Intake	Output (in mL)
0	650ml of urine

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N")	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.

after you list them, identify medical treatments with “T” after you list them.)		
N - Assist the pt with her first shower following birth.	PRN	The Pt has not had a shower for a couple days. The first shower post C-section needs assistance from nursing staff. A great time for the nurse to visualize the incision and chart it.
M - Monitor Lab Values	Per physicians orders.	Based on the Pt’s diagnosis. Lab values are abnormal and need extra attention.
M - Monitor the Incision site.	Per hospital policy. Per physician.	The pt delivered via C-section. The scar will need to be monitored for complications. The nurse should be inspecting it and charting when appropriate.

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? Taking hold

What evidence supports this? The mother seems to be more independent. The mother is focusing on tasks such as positioning the baby, grooming, and how to breastfeed.

Discharge Planning (2 points)

Discharge location: The mother and child will be discharged home with her husband.

Equipment needs (if applicable): n/a

Follow up plan (include plan for mother AND newborn): Mother is to follow up with a pediatrician for the infants needs and vaccine schedule. Mother will monitor the incision site and report any complications. Mother will follow up with her PCP.

Education needs: The mother and father will be offered education prior to discharge. The mother will receive education on her diagnosis and when to report situations to the provider.

Nursing Diagnosis (30 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Two of them must be education related i.e. the interventions must be education for the client.”

2 points for correct priority

<p>Nursing Diagnosis (2 pt each) Identify problems that are specific to this patient. Include full nursing diagnosis with “related to” and “as evidenced by” components</p>	<p>Rational (1 pt each) Explain why the nursing diagnosis was chosen</p>	<p>Intervention/Rational (2 per dx) (1 pt each) Interventions should be specific and individualized for his patient. Be sure to include a time interval such as Assess vital signs q 12 hours.” List a rationale for each intervention and using APA format, cite the source for your rationale.</p>	<p>Evaluation (1 pt each)</p> <ul style="list-style-type: none"> · How did the patient/family respond to the nurse’s actions? · Client response, status of goals and outcomes, modifications to plan.
<p>Ineffective tissue perfusion r/t vasoconstriction of blood vessels AEB pt’s blood pressure.</p>	<p>This aligns with the pt’s diagnosis.</p>	<p>1. Promote bed rest in a recumbent position to aid in the secretion of sodium. Rationale This will help to lower the blood pressure. (Ricci et al., 2017). 2. Provide emotional support. Rationale This will help the mother to feel comfortable and establish trust. (Ricci et al., 2017).</p>	<p>Pt verbalized an understanding of the teaching.</p> <p>Pt feels comfortable talking with the nurse.</p>
<p>Anxiety R/t mother’s diagnosis AEB both husband & wife expressing their nerves.</p>	<p>This is the couple's first baby.</p>	<p>1. Explain the procedures, nursing interventions, and treatment regimen Rationale This is done to build trust with the couple. 2. Keep communication open to help calm the patient. (Ricci et al., 2017). Rationale Both the pt and the husband need to be informed about what is going on.</p>	<p>Patient will verbalize understanding of individual situations and possible outcomes.</p>

<p>Deficient knowledge R/t complex medical diagnosis AEB mother and father not understanding it.</p>	<p>The mother & father asking for more education and answers to questions.</p>	<p>1. Identify signs and/or symptoms that should be reported immediately to their nurse or provider. (Ricci et al., 2017). Rationale This needs to be taught to the client for safety. 2. Assess the ability to learn. Rationale The pt just gave birth and the couple may feel rather overwhelmed with too much information coming at them.</p>	<p>A nurses Prompt evaluation and interventions can improve the outcome of the pregnancy & avoid complications.</p>
<p>Acute Pain R/t Post C-section surgery AEB Pt rating pain a 4.</p>	<p>Pt said her pain was at a 4.</p>	<p>1. Q15 pain assessment. Rationale The nurse should be frequently assessing to prevent the pt from experiencing preventable pain. (Ricci et al., 2017). 2. Provide comfort measures Rationale The nurse can provide appropriate comfort measures to ensure the pt is safe and comfortable.</p>	<p>Pt will verbalize reduction of pain. Pt will use appropriate techniques to maintain control.</p>

Other References (APA)

Ricci, S. S., Carman, S., & Kyle, T. (2017). *Maternity and pediatric nursing* (3rd ed.). Wolters Kluwer.