N432 Postpartum Care Plan

Lakeview College of Nursing

Name Candy Lewis

Demographics (3 points)

Date & Time of Admission	Patient Initials	Age	Gender
3/23/2021 0600	F. S.	23	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Hispanic	Housewife	Married	No known allergies
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full	160cm	71kg	Yes

Medical History (5 Points)

Prenatal History: This client is a 23-year-old female primipara. The patient was admitted yesterday at 0600 hours for oxytocin induction of labor secondary to postdates (41 4/7 weeks). She declined all pain medication during labor. The client delivered a vigorous female infant at 0605 hours with Apgar scores of 9 and 9 and weight of 4,082 g (9 lbs. 0 oz). The patient contracted a second-degree perineal laceration during delivery. The laceration has been repaired. The placenta was delivered manually at 0635. Bleeding was controlled by fundal massage and infusion of remaining oxytocin induction bag, which is still running at 20 mL/hr (20 mU/min); approximately 100 mL left in the bag.

GTPAL: Gravida:1 T: 1 P: 0 A:0 L:1

Past Medical History: This client has a past medical history of sickle cell trait and is currently not taking any medications.

Past Surgical History: This client has no surgical history.

Family History: The client's mother has a history of hypertension. The father has a history of diabetes.

Social History (tobacco/alcohol/drugs): This client has no history of tobacco, alcohol or drug use.

Living Situation: This client does not speak English fluently. She has only lived in the country for seven months. She resides with her husband.

Education Level: High school diploma

Admission Assessment

Chief Complaint (2 points): Induction

Presentation to Labor & Delivery (10 points):. This client is a 23-year-old female who was admitted to Labor and Delivery on 3/23/2021 at 41 weeks 4 days to gestation to be induced. The clients' husband is present at the time of delivery. The client refused any pain medications during labor.

Diagnosis

Primary Diagnosis on Admission (2 points):. Induction of labor.

Secondary Diagnosis (if applicable):. Postdate pregnancy at 41 weeks 4 days.

Postpartum Course (18 points)

On March 23rd the client was admitted to the hospital for an induction. The client was brought in for an induction because she was 41 weeks and four days gestation. The client declined any pain medication during labor. During the stages of labor, the client will go from 0-10 cm in dilation and become 100% effaced in the first stage. This client experienced a prolonged second stage of labor and delivered a healthy baby girl at 0605. This client experienced a second-degree perineal laceration that has been repaired. Her placenta was removed manually at 0635. The client did try to void with issues which can be normal during the postpartum period. This can be caused by the perineal lacerations she endured. (Ricci et al., 2020). It is a common complication of pregnancy/ postpartum to experience urinary atony. (Ricci et al., 2020). This client is also experiencing postpartum hemorrhage. Examination of the uterus was completed as well as manual massage of the uterus. Massaging the uterus and medications helps to stimulate contractions. Oxytocin was continued in the clients IV at 20ml/hr and intravenous fluids given.

Postpartum Course References (2) (APA):

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and Pediatric Nursing* (4th ed.). LWW.

Swearingen, P. L., & Wright, J. D. (2020). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. St. Louis, MO: Elsevier

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	3.50-5.20		5	5	
Hgb	11-16				
Hct	34-47%		43%	33%	
Platelets	140-400		245	245	
WBC	4-11.0		11	11	
Neutrophils	1.60-7.70				
Lymphocytes	1.00-4.90				
Monocytes	0-1.10				
Eosinophils	0-0.50				
Bands	NA				

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	A, B, O, AB	O+	O+		
Rh Factor	Negative or positive				
Serology (RPR/VDRL)	Nonreactive				
Rubella Titer	10.00 or above		Immune		
HIV	Non-reactive		Nonreactive		
HbSAG	Non-reactive		Negative		
Group Beta Strep Swab	Negative		Negative		
Glucose at 28 Weeks	<140				
MSAFP (If Applicable)	NA	NA	NA		

Syphilis	Positive or Nonreactive		Nonreactive		
Gonorrhea/Chlamydia	Positive or Nonreactive		Negative		

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

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)					Urine was negative for ketone, nitrate, glucose, protein, hemoglobin, and leukocytes

Lab Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis Company.

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

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	This client was in postdate pregnancy, so she was brought in to be induced at 41 weeks and 4 days gestation. This client was induced to prevent any possible increase in risks to herself or the baby. This client declined any pain medications during labor. Following a prolonged second stage, she delivered a vigorous female infant at 0605 hours with Apgar scores of 9 and 9 and weight of 4,082 g (9 lbs. 0 oz).
Current stage of labor	This client is currently in the fourth stage known as postpartum stage of labor.

Stage of Labor References (2) (APA):

Caughey, A. B. (2020, August 27). *Postterm Pregnancy: Overview, Timing of Delivery, Prevention of Postterm Pregnancy*. https://emedicine.medscape.com/article/261369-overview.

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and Pediatric Nursing* (4th ed.). LWW.

Current Medications (7 points, 1 point per completed med)
7 <u>different</u> medications must be completed

Home Medications (2 required)

Brand/Generic	Tylenol/ Acetaminophen	Ferrous sulfate/ Mol-Iron			
Dose	500mg	27mg			
Frequency	PRN for pain	q.d.			
Route	Oral	Oral			
Classification	Antipyretic	Anti-anemic			
Mechanism of Action	Blocks prostaglandin production and interferes with pain impulse in the PNS	Normalizes production of RBC's by being oxidized and stored as hemosiderin.			
Reason Client Taking	The client is taking this medication for pain during pregnancy	This client is taking this medication to increase iron during pregnancy			
Contraindications (2)	Hypersensitivity to acetaminophen, hepatic impairment	Hemolytic anemias, hemochromatosis			
Side Effects/Adverse Reactions (2)	Hepatoxicity, stomach pain, jaundice	Hemolysis, hypotension			
Nursing	Use cautiously	Take this pill			

Considerations (2)	if there are already hepatic impairment, do not exceed daily limit	orally with a full glass of water, do not crush the pill.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor renal function, monitor if liver hepatoxicity is occurring	Monitor for any other drug interaction or allergies, monitor hemoglobin and RBC count in client			

Hospital Medications (5 required)

Brand/Generic	Oxytocin/Pitocin	Methylergonovine/ Methergine	Carboprost tromethamine/Hemabate	Misoprostol / Cytotec	Butorphanol tartrate/stadol
Dose	20ml/hr	0.2 mg	0.25mg	600-1000mcg	2mg
Frequency	Continuous	Every 2-4 hours	Every 15-90min	One dose only	PRN
Route	Intravenous	IM	IM	Oral, sublingual, rectal	Intravenous
Classification	Oxytocic hormones	Analgesic and Uterotonic	Oxytocic hormones	Oxytocic hormones	Opioid

Mechanism of Action	Increases the intracellular Ca2+ promoting contractions	This medication affects the smooth muscle of a woman's uterus	This medication binds the prostaglandin E2 receptor, causing myometrial contractions, causing the induction of labor	This medication binds to myometrial cells to cause strong contractions leading to expulsion of tissue. This agent also causes cervical ripening with softening and dilation of the cervix	The exact mechanism of action is unknown but is believed to interact with an opiate receptor sit in the CNS
Reason Client Taking	The client was taking this medication to stimulate her contractions and help with postpartum hemorrhaging	The client was taking this medication to improve muscle tone and timing of contractions	This client is taking this medication is used to treat severe bleeding during postpartum	Patient is taking this medication to soften her cervix and to induce labor.	The client is takin this medication fo pain
Contraindications (2)	Hypertension, placenta previa	Hypertension, thrombophlebitis	Hypotension, asthma	Pelvic infection, hemodynamic instability	Respiratory depression, MI
Side Effects/Adverse Reactions (2)	Client can experience weakness, excessive bleeding after birth	Chest pain or discomfort, dizziness, change in skin color	Nausea, diarrhea, cough, headache	Urine atony, severe ongoing stomach discomfort, diarrhea.	Blurred vision, headache, trouble sleeping, sweating
Nursing Considerations (2)	Don't administer an undiluted rapid IV infusion because it can cause hypotension, monitor uterine activity	Don't administer if client is hypertensive, only give this medication after the baby is delivered	Monitor frequency, duration, and force of contractions and uterine resting tone. Monitor temperature and BP throughout treatment.	Reposition patient, administer IV bolus of fluid	Give medication undiluted, give at rate 2mg over 2-5 minutes

Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check for any drug interaction or allergies, always assess vital signs prior to administering	Careful monitor of BP, know this medication should be given slowly (no less than 60 seconds)	Monitor uterine contractions, report excessive vaginal bleeding	Monitory FHR and uterine activity before administering.	Monitor respirato rate, do not administer if rate less than 12. Schedule a gradua withdraw
Client Teaching needs (2)	Inform client to seek medical attention if she begins to experience severe headaches, nausea or vomiting. Let provider know if you feel uneasy or confused.	Do not breastfeed within 12 hours of taking this medication, inform patient this medication can cause cramps and nausea	Do not breastfeed while taking this medication, report abdominal pain or fever promptly.	IF taking orally wait 3 minutes for tablet to dissolve, explain to the client that this medication will help ripen the cervix and contractions will begin	Do not breastfeed while taking this medication, lie down to decrease possibility of nausea.

Medications Reference (1) (APA):

Jones & Bartless Learning. (2020). 2020 Nurse's drug handbook (19th ed.). Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	This client is alert and oriented x4. Client displays signs of pain with grimace and verbal exclamations “ouch”. Client rated her pain 5/10 in the stomach area.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	This clients’ skin is dry, warm and intact. Normal turgor is present. There are no present rashes or bruises noticeable. This client contracted a second-degree perineal laceration during delivery that has been repaired.
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	PERRLA is present. This clients’ ears are clear, pink with no visible drainage. NO nasal deviation present. Oral mucosa is pink and moist. Teeth are clean and in good condition, no false teeth present. Tympanic membrane is pearly grey and visible.
CARDIOVASCULAR (1 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	This client has a normal sinus rhythm with S1 and S2 both present. Radial and pedal pulses are both palpable. Normal capillary refill is normal at less than 3 seconds.
RESPIRATORY (1 points):	This clients’ breath sounds are normal and clear.

Accessory muscle use: Y☐ N ☒ **Breath Sounds: Location, character**	
GASTROINTESTINAL (5 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	This client is on a normal diet during stage four and at home. She currently weighs 71 kg (156 lb.) and is 160 cm (5ft 2 in) tall. No drains or incisions are present. Bowel sounds are normal in all four quadrants. Uterus is soft and boggy while palpating.
GENITOURINARY (5 Points): **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **Rupture of Membranes:** **Time:** **Color:** clear **Amount:** small **Odor:** no odor **Episiotomy/Lacerations:**	This client was just up to the bathroom and couldn't void Small amount of blood and lochia located on bed. Second degree perineal laceration has been repaired. The client does not have a catheter.
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** 0 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	This client is not a fall risk but should be monitored while out of the bed. She was up to the bathroom with assistance but could not void due to urine atony.
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐**	The clients' speech is clear. No LOC. Deep tendon reflexes are present. The patient is oriented and her mental status alert.

Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☒ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **DTRs:**	
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):**	The client does not attend church. She is fully developed and has a strong support system with her husbands' family.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	Delivery date: 3-24-2021 Type: Vaginal birth Female Apgar score: 9 Weight: 9lbs 0 oz Feeding method: Breastfeeding

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	118	101/60	18	98 F oral	98% RA
Labor/Delivery	114	105/64	17	98 F oral	98% RA
Postpartum	120/min	94/50	18	99 F oral	97% RA

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0635	0-10	stomach	7	Pain caused by labor during vaginal birth	Client planned for no medical intervention during labor
0830	0-10	stomach	5	Sharp abdominal pain	Stadol given

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	The IV site has no redness, swelling, infiltration, bleeding or drainage. The dressing is dry and intact. 18 gauge in the lower left forearm.

Intake and Output (2 points)

Intake	Output (in mL)
	Measurement of bed pads
1000 mL of IV fluids	**1090 mL** **Bleeding rate of 2040ml/hr**

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them, identify medical treatments with "T" after you list them.)	**Frequency**	**Why was this intervention/ treatment provided to this patient? Please give a short rationale.**
Administration of Stadol. T	PRN for pain	This treatment was provided for the client based on her pain level due to suffering a postpartum hemorrhage.
Assess the fundus during the recovery period. N	When assessments are performed	**The client needs a fundus assessment done during the postpartum phase. This particular patient doesn't have a firm fundus due to bleeding that needed addressed.**
Encouraging the mother to consume fluids N	Throughout her postpartum phase	This client needs to consume fluids due to the blood loss caused by postpartum hemorrhage. She also needs to remain hydrated in order to breastfeed.
Replacing and weighing pads from the client N	**Every 4 hours**	**This client needs to have her pads changed and weighed frequently to monitor her blood loss.**

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? The mother is in the taking-in phase of maternal adaptation to parenthood.

What evidence supports this? This mother is experiencing complications of her delivery by the postpartum hemorrhage and is oriented primarily to her own needs. The mother is not initiating contact with the infant, not out of disinterest but in order to take care of the complications she is

experiencing and pain she is enduring. She is dependent on the father to hold and bond with the newborn at the bedside.

Discharge Planning (2 points)

Discharge location: The mother and baby will be discharged to their home with the husband and father of the baby.

Equipment needs (if applicable): The mother does not need any equipment.

Follow up plan (include plan for mother AND newborn): The mother is going to have a follow up appointment with her doctor in 6 weeks once released and will have the baby checked out in one week.

Nursing Diagnosis (30 points)
Must be NANDA approved nursing diagnosis and listed in order of priority
Two of the Nursing Diagnoses must be education related i.e. the interventions must be education for the client."

2 points for correct priority

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	**Rational (1 pt each)** Explain why the nursing diagnosis was chosen	**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.	**Evaluation (1 pt each)** • How did the patient/ family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to tissue trauma as evidenced by postpartum hemorrhage	This patient is experiencing pain and blood loss in the abdomen due to hemorrhaging after delivery	**1.**External uterine massage and bimanual compression are generally used as first-line treatments **Rationale:** These compression techniques encourage uterine contractions that counteract atony. **2.**Monitor for signs and symptoms of excess fluid loss or shock (check BP, pulse, temperature) **Rationale:** blood loss may increase pulse, decreased BP, cause disorientation, irritability, and LOC	The client responded well to treatment and described her pain decreasing. Her blood loss has decreased, and vitals were stable. Will continue to monitor before discharging.
2. Risk for fluid volume deficit related to uterine atony as evidenced by excessive bleeding following the birth of the baby	The patient is having blood loss due to postpartum hemorrhage	**1.** Assess and record the type, amount. Count and weigh perineal pads **Rationale:** The amount of blood loss and the presence of blood clots will help to determine the appropriate replacement need of the patient. **2.** Observe for signs of voiding difficulty **Rationale:** This will help determine fluid loss	The client is being monitored frequently for blood loss and vitals are being monitored consistently.

3. Knowledge deficit related to caring for a child as evidenced by this being her first child.	This client has no other children	**1.** Educate the patient on changing diapers, swaddling techniques **Rationale:** Patient has no other children and needs to be educated on daily tasks caring for the child. 2. Educate the patient on sleeping habits for the baby **Rationale:** The client is a first time mother and needs to be educated on sleeping techniques, what can be allowed in the crib and how to lay the infant down.	This client is feeling more comfortable about going home when discharged and being able to manage all tasks that are required to care for the infant
4. Inadequate information related to breastfeeding evidenced by this being her first child.	The patient has never breastfed before and is concerned she needs adequate teaching	**1.** Teach mother how to breastfeed with help from lactation **Rationale:** The mother has never breastfed before, so it is important she gets education before discharge **2.** Assist the client by helping the infant grasp the nipple correctly **Rationale:** The mother has never breastfed before and needs assistance before doing it on her own.	The patient was very cooperative and willing to learn with the help from other team members. Arrangements will need to be made for more assistance when she is more stable before being discharged for more support.

Other References (APA):

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing*. Wolters Kluwer.

Swearingen, P. L., & Wright, J. D. (2020). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. St. Louis, MO:Elsevier.