N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 4/6/21 at 0529	**Patient Initials** A.R.	**Age** 20	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Customer Service Representative	**Marital Status** Single	**Allergies** NKA
Code Status Full Code	**Height** 165.1 cm	**Weight** 78 kg	**Father of Baby Involved** Yes; Present at bedside.

Medical History (5 Points)

Prenatal History: A.R.'s GTPAL designation is 11001.

Past Medical History: Asthma, seasonal allergies (self-reported).

Past Surgical History: Cesarean section, low transverse performed 4/6/21.

Family History: A.R.'s mother has heart disease and her father has diabetes mellitus.

Social History (tobacco/alcohol/drugs): The patient denies past or present use of tobacco, alcohol, or illicit drugs.

Living Situation: A.R. lives with her boyfriend.

Education Level: A.R. has completed some college. This nurse does not expect that her education level will represent a significant barrier to learning.

Admission Assessment

Chief Complaint (2 points): Breech presentation

Presentation to Labor & Delivery (10 points):.

A.R. is a 20-year-old female that reported to the unit at 0529 on 4/6/21 for a scheduled cesarean section due to breech presentation. Her pregnancy has otherwise been without complication. The patient is primiparous at 39 weeks and 0/7 days gestation. She arrived at the unit accompanied by her boyfriend, who is the father of the baby. A.R.'s vital signs at admission were BP 125/77

mmHg, P 97 bpm, RR 16 per minute, T 98.8 degrees F, and O_2 Saturation 100% on room air. A.R. is a full code, has no known allergies, has a history of asthma, and has no prior surgeries. Upon admission, Dr. Cooper verified breech presentation by ultrasound. The patient was subsequently taken to surgery for a cesarean section. A.R.'s cesarean section was performed by Dr. Delind, who used a low transverse incision. There were no significant complications during the procedure, and the infant was successfully delivered.

Diagnosis

Primary Diagnosis on Admission (2 points):.Scheduled cesarean section due to breech presentation.

Secondary Diagnosis (if applicable): n/a

Postpartum Course (18 points)

A.R. delivered by cesarean section on 4/6/21, one day before our encounter. Dr. Delind removed A.R.'s placenta as a part of this procedure. The fourth stage of labor, by definition, starts after the expulsion of the placenta and ends when the mother is physiologically stable (Ricci et al., 2021). According to Ricci et al. (2021) the mother typically completes this stage 1-4 hours after birth. At the time of this student's encounter with A.R., she is one day postpartum and hemodynamically stable. Thus, it would be incorrect to describe her as being in the fourth stage of labor. However, it is with the fourth stage of labor that the postpartum period begins, the first six weeks of which are known as the puerperium period (Ricci et al., 2021). During this period, the woman undergoes physiological and psychological adjustments as her body transitions to its prepregnant state (Holman et al., 2019; Ricci et al., 2021).

Changes during the puerperium period impact the entire body including the reproductive system, cardiovascular system, respiratory system, endocrine system,

musculoskeletal system, and urinary system (Ricci et al., 2021). Key changes the nurse will observe in the immediate postpartum period include uterine involution and changes in the breasts, perineum, cardiovascular system, urinary system, and gastrointestinal system (Holman et al., 2019). The nurse should expect that the uterine fundus descends from the umbilicus at a rate between 1-2 cm a day (Holman et al., 2019). Furthermore, the fundus should be firm to palpation and midline (Ricci et al., 2021). During our encounter, A.R.'s fundus was approximately 1 cm beneath the umbilicus, which is appropriate for a woman who is one day postpartum. Furthermore, the nurse observes a scant quantity of lochia rubra on A.R.'s pad. Lochia rubra is anticipated for up to 4 days following birth and women who deliver by cesarean typically secrete less lochia (Ricci et al., 2021). The perineum often features redness, edema, hematomas, or hemorrhoids following delivery (Holman et al., 2019). A.R. delivered by cesarean section, thus avoiding the perineal trauma associated with vaginal delivery. Although her external genitalia exhibit modest swelling, her perineum is intact and free from hematomas or laceration. The breasts appear full and secrete colostrum for the first 2-3 days following birth (Holman et al., 2019). Although this nurse did not observe A.R. feeding or expressing colostrum, A.R. is aware of colostrum and that she is still expressing it. Regarding gastrointestinal changes, in the postpartum period women may experience increased appetite, constipation, and hemorrhoids (Holman et al., 2019). A.R. reports that her appetite is increasing and that she is tolerating a regular diet well. While she is yet to have a bowel movement following delivery, her bowel sounds are active in all four quadrants and she is passing flatus. Furthermore, A.R. has noticed that she is excreting large volumes of urine and that the edema to her feet and ankles is decreased versus her prenatal state. The increase in urine volume A.R. is experiencing is an

expected change; postpartal diuresis intiates less than one day after delivery (Ricci et al., 2021). The location of A.R.'s fundus at 1 fingerbreadth beneath the umbilicus and midline suggests and regular voiding indicates that she is not experiencing urinary retention (Holman et al., 2019). Because A.R. is early in her postpartum course, it is likely too early to appreciate changes in blood volume and levels of WBCs, hematocrit, coagulation factors, and fibrinogen (Holman et al., 2019). However, Holman et al. (2019) do note that a slight transient increase in blood pressure can occur in the puerperium period. A.R.'s blood pressure increased from 125/77 mm Hg on admission to 127/80 mm Hg during our encounter.

According to Ricci et al. (2021), the taking-in phase generally occurs for the first 48 hours after birth. However, A.R. exhibits behavior that this nurse believes is more consistent with the taking-hold phase. A.R. demonstrates interest in her own health and that of her infant by asking for instruction on wound care for her surgical incision and requesting a demonstration of her breast pump. She asks many questions relating to infant care. Ricci et al. (2021) note that during the taking-hold phase patients concern themselves about their health, and show a desire to assume responsibility for the care of themselves and their infant albeit with support from others. Furthermore, as opposed to the taking-in phase wherein the nurse would expect that mothers defer to the nurse with respect to their physiologic needs, A.R. makes active decisions about what she would like to do. For example, A.R. asks for snacks, ambulates to the bathroom independently, and is assertive about what she is feeling.

Risk factors for postpartum hemorrhage include uterine atony, overdistension of the uterus, a labor that is prolonged or induced, multiparity, uterine rupture, placenta previa or abruptio placentae, precipitous delivery, therapy with magnesium sulfate during labor,

subinvolution or uterine inversion, retained placental fragments, and coagulopathies (Holman et al., 2019). A.R. received intravenous oxytocin for 6 hours following delivery to prevent postpartum hemorrhage. Furthermore, at assessment, her fundus is firm to palpation and bleeding has been scant. During her cesarean section, she experienced a total quantitative blood loss of only 341 mL.

Postpartum Course References (2) (APA):

Holman, H. C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., McMichael, M. G., & Barlow, M. S. (2019). *RN maternal newborn nursing review module* (11th ed.). Assessment Technologies Institute, LLC.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th 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 ($x10^6$/mcL)	4.2-5.4 (Pagana et al., 2021).	3.77	3.93	4.01	Dilutional anemia due to increased blood volume during pregnancy can result in a low RBC count (Ricci et al., 2021).
Hgb (g/dL)	>11 g/dL in pregnant females. (Pagana et al., 2021).	11.3	11.5	11.8	Dilutional anemia due to increased blood volume during pregnancy can cause decreased hemoglobin (Ricci et al., 2021).
Hct (%)	>33% in pregnant females (Pagana et	33.1	34	34.9	n/a

	al., 2021).				
Platelets ($x10^9$/L)	150-400 (Pagana et al., 2021).	258	234	255	n/a
WBC ($x10^9$/L)	5-10 (Pagana et al., 2021)	14.3	14.1	19.7	Pregnancy and labor are associated with increased WBC levels (Pagana et al., 2021).
Neutrophils (%)	55-70 (Pagana et al., 2021).	77	74.7	85.2	Pregnancy is associated with an increased neutrophil count (Wang et al., 2016).
Lymphocytes (%)	20-40 (Pagana et al., 2021).	12.3	15.1	7.1	A decreased lymphocyte count is an expected occurrence during pregnancy (Orgul et al., 2016).
Monocytes (%)	2-8 (Pagana et al., 2021).	8.9	7.5	6.9	The number of circulating monocytes is increased during pregnancy (Faas & de Vos, 2017).
Eosinophils (%)	0-3% (Wolters Kluwer Health, 2019).	1.6	2.4	0.6	n/a
Bands (%)	3-5 (GlobalRPh, 2017).	n/a	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	A, B, AB, or O. (Pagana et al., 2021).	O	O	O	n/a
Rh Factor	Positive or Negative (Pagana et al., 2021).	Negative	Negative	Negative	n/a
Serology (RPR/VDRL)	Reactive or nonreactive	nonreactive	nonereactive	n/a	n/a

	(Pagana et al., 2021).				
Rubella Titer	Immune or non-immune (Pagana et al., 2021).	Immune	Immune	n/a	n/a
HIV	Reactive or nonreactive (Pagana et al., 2021).	nonreactive	nonreactive	n/a	n/a
HbSAG	Positive or Negative (Pagana et al., 2021).	negative	Negative	n/a	n/a
Group Beta Strep Swab	Positive or Negative (Pagana et al., 2021).	negative	negative	n/a	n/a
Glucose at 28 Weeks	<140 on 2-hr glucose tolerance test (Pagana et al., 2021).	116	n/a	n/a	n/a
MSAFP (If Applicable)	<40 (Pagana et al., 2021).	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

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)	38.1-70.5 mg/dL (Barto et al., 2017).	63.1 mg/ dL	n/a	n/a	n/a

Lab Reference (1) (APA):

Barto, D., Chamberlain, B., Glasofer, A., Griffiths, C. L., Headley, J., Hertel, K. A., O'Leary, G. M., Palatnik, A., & Thomas, S. B. (2019). Eosinophil count. *Nursing Critical Care*, *14*(3), 32. https://doi.org/10.1097/01.CCN.0000554836.64412.de

Faas, M. M., & de Vos, P. (2017). Maternal monocytes in pregnancy and preeclampsia in humans and rats. *Journal of Reproductive Immunology*, *119*, 91-97. https://doi.org/10.1016/j.jri.2016.06.009

GlobalRPh. (2017). *Laboratory values*. https://globalrph.com/laboratory-values/

Orgul, G., Soyak, B., Portakal, O., & Beksac, M. (2016). Total blood lymphocyte count alteration during and after pregnancy. *Gynecology Obstetrics and Reproductive Medicine*, *23*(1). 1-3. Https://doi.org/10.21613/GORM.2016.633

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2021). *Mosby's diagnostic and laboratory test reference* (15th ed.). Elsevier.

Phillips, J. K., McBride, C. A., Hale, S. A., Solomon, R. J., Badger, G. J., & Bernstein, I. M. (2017). Examination of prepregnancy and pregnancy urinary protein levels in healthy nulliparous women. *Reproductive Sciences*, *24*(3), 407-412. https://doi.org/10.1177/1933719116657198

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

Wang, H., Sun, J., Zhang, Z., & Pei, H. Pregnancy complicated with agranulocytosis. *Medicine*, *95*(2), e5717. Https://doi.org/10.1097/MD.0000000000005717

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

	Your Assessment
History of labor: **Length of labor:** n/a **Induced /spontaneous:** Patient delivered by cesarean section. **Time in each stage:** This patient had a scheduled cesarean section.	This patient delivered by scheduled cesarean section due to breech presentation.
Current stage of labor 4th stage	Because A.R. has achieved physiological stability and is one day postpartum, it would no longer be correct to say that she is in the fourth stage of labor, which typically lasts 1-4 hours (Ricci et al., 2021). However, the fourth stage of labor does mark the start of

	the postpartum period and is thus the most appropriate of the four stages to discuss in relation to A.R.'s status (Ricci et al., 2021). The fourth stage of labor begins following the expulsion of the placenta and membranes and ends when the mother achieves stability and makes initial physiologic changes (Ricci et al., 2021). A.R. is on her second post-partum day following her delivery by cesarean section on 4/6/21. During the fourth stage of labor, the uterine fundus is initially located at the midline between the umbilicus and symphysis pubis before rising to the level of the umbilicus during the first hour postpartum (Ricci et al., 2021). However, because this client is one day post-partum, a more useful guideline is that the fundus should descend approximately 1 to 2 cm from the umbilicus each postpartum day (Holman et al., 2019). At the time of assessment, A.R.'s fundus was about 1 fingerbreadth or 1 cm below her umbilicus. Following birth, lochia is initially similar to menstruation before transitioning to lochia rubra for 1 to 3 days after delivery (Holman et al., 2019). This nurse notes a scant amount of lochia rubra during his assessment of A.R.

Stage of Labor References (2) (APA):

Holman, H. C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., McMichael, M. G., & Barlow, M. S. (2019). *RN maternal newborn nursing review module* (11th ed.). Assessment Technologies Institute, LLC.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

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

Home Medications (2 required)

Brand/Generic	Claritin/ loratadine	Singulair/ montelukast	[redacted]
Dose	10 mg	10 mg	
Frequency	Daily	Daily	
Route	PO	PO	
Classification	antihistamine	**Chemical**: leukotriene receptor **Therapeutic**: Antiallergen, antihistamine	
Mechanism of Action	Loratadine and other antihistamines work by blocking the action of histamine. Histamine is involved in the pathophysiology of allergic symptoms.	This drug works by antagonizing cysteinyl leukotriene receptors. Cysteinyl leukotriene increases endothelial permeability and is involved in the pathophysiology of rhinitis.	
Reason Client Taking	The client takes this medication to manage her seasonal allergies.	The client takes this medication to manage her asthma.	
Contraindications (2)	1) Allergy to loratadine or desloratadine. 2) Liver or kidney disease	1) Hypersensitivity to montelukast or its components. 2) This drug should be used cautiously in patients with hepatic disease.	

Side Effects/Adverse Reactions (2)	1) Headache 2) Tachycardia	1) Diarrhea 2) Dental pain	[redacted]
Nursing Considerations (2)	1) This medication should be stored between 20 to 25 degrees Celsius and protected from excess moisture. 2) Loratadine may interact with a variety of OTC medications, vitamins, and herbal products. The nurse should be sure to collect an accurate list of medications the client takes and review them with the provider.	1) The client should be monitored for suicidal thoughts while taking montelukast, especially when starting therapy or dose changes are made. 2) The nurse should be aware that montelukast is not indicated for acute asthma attack or status asthmaticus.	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Because this medication is contraindicated in patients with kidney and liver disease, BUN, creatinine, and liver enzymes should be checked before starting therapy.	This drug should be used cautiously, if at all, in patients with hepatic disease. Accordingly, liver enzymes should be monitored before and during therapy as ordered.	
Client Teaching needs (2)	1) Advise the client that the regular tablet form of loratadine should not be crushed, chewed or broken. 2) The client should be advised to stop taking loratadine and call their doctor if their hives do not improve within 3 days of treatment or persist longer than 6 weeks.	1) Advise the client that they should not stop taking this medication abruptly. 2) The client should be advised that this drug can cause behavioral and mood changes. If they notice these changes, they should report them to their physician.	

Hospital Medications (5 required)

Brand/Generic	Motrin/ ibuprofen	Gas-X/ simethicone	Reglan/ metoclopramide	Miralax/ polyethylene glycol	Pitocin/ oxytocin
Dose	800 mg	160 mg	10 mg	17 g	30 u/500 mL
Frequency	Q8H PRN	BID	Q6H PRN	Once Daily PRN	Once, continuously for 6 hours postpartum.
Route	PO	PO	IV	PO	IV
Classification	**Chemical:** propionic acid derivative. **Therapeutic:** Analgesic, NSAID, antipyretic.	Anti-flatulent; antifoaming agent	**Chemical**: Benzamide **Therapeutic**: Upper GI stimulant	Osmotic laxative	**Chemical**: Exogenous hormones. **Therapeutic**: Oxytocics
Mechanism of Action	This drug interferes with prostaglandin synthesis by blocking the activity of cyclooxygenase.	This drug works by coating aqueous liquids in silicone antifoam, which decreases their surface tension and causes them collapse. It may also cause mucus-coated gas bubbles in the GI tract to coalesce, which facilitates their expulsion.	This medication prevents nausea and vomiting by blocking dopaminergic receptors in the chemoreceptor trigger zone.	This medication causes water to be retained in the stool, making it easier to pass.	This medication stimulates the contraction of uterine smooth muscle.
Reason Client Taking	A.R. takes this medication for the relief of mild to moderate pain.	A.R. takes this medication as a treatment for excess gas and flatulence.	A.R. takes this medication to treat nausea and vomiting.	A.R. takes this medication to prevent constipation and promote bowel regularity.	A.R. takes this medication to reduce the risk of postpartum hemorrhage.
Contraindications (2)	1) Bronchospasm 2) Hypersensitivity to ibuprofen or other fever reducing medications.	1) hypersensitivity to simethicone 2) No other contraindications are known, but this drug may interact with levoythyroxine, liothyronine, and liotrix.	1) Hypersensitivity to metoclopramide 2) GI hemorrhage, mechanical obstruction, or perforation	1) Known or suspected bowel obstruction. 2) Hypersensitivity to polyethylene glycol.	1) Hypersensitivity to pitocin 2) This drug is contraindicated in fetal distress when delivery is not imminent.
Side Effects/Adverse Reactions (2)	1) Abdominal cramps 2) GI bleeding	1) Constipation 2) Respiratory difficulty	1) Agitation 2) AV block		1) Bradycardia 2) Premature ventricular contractions
Nursing Considerations (2)	1) This medication should be given food to minimize the risk of GI symptoms.	1) This drug may be given with or without food; simethicone is not known to interfere with the absorption of	1) When giving by IV, it is not necessary to dilute doses of 10 mg or less. 2) Rapid IV delivery may cause anxiety,	1) This drug should be dissolved completely in 4-8 ounces of a beverage preferred by the patient.	1) Fluid intake and output should be monitored while using this drug due to its anti-diuretic

	2) Ibuprofen and other NSAIDs can increase the risk of thrombotic events. Accordingly, the nurse should monitor for signs and symptoms of thrombotic events during therapy.	nutrients or gastric secretion. 2) Simethicone tablets should be stored at <40 degrees Celsius and protected from humidity in a tight, well-closed container.	restlessness, and drowsiness.	2) The nurse should collect a thorough medical history including metabolic, endocrine, and neurogenic conditions to consider as contributing causes for constipation.	effect increasing the risk for fluid overload and water intoxication. 2) While using this medication, patients should be under the continuous supervision of staff members trained to identify complications of this drug.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	This medication can cause elevated liver enzymes, impaired renal function, and decreased hemoglobin and hematocrit. Accordingly, the nurse should monitor the patient's CBC, BUN, creatinine, and liver enzymes as ordered.	This medication is not known to be toxic and rarely causes adverse reactions. However, it is prudent to perform a physical assessment and collect a health history if patients have new onset flatulence to determine the cause.	Assess the client for bowel obstruction prior to administration.	The patient should be assessed for nausea, vomiting, abdominal pain, and distension before starting this medication to screen for bowel obstruction.	Because this drug can affect fluid volume, heart rate, and blood pressure, baseline vital signs should be taken and fluid volume status should be assessed before and during therapy.
Client Teaching needs (2)	1) Instruct the patient to take this medication with a full glass of water and food to minimize GI discomfort. 2) The patient should be advised to alert the nurse if they notice epigastric pain, black or tarry stools, or coffee ground emesis; these may indicate a GI bleed.	1) Patients should not exceed the dose indicated on OTC packaging unless directed by their physician. 2) The patient should be advised to only chew this medication if taking in the form of chewable tablets. Liquid-filled capsules should no be chewed.	1) Because this drug can cause CNS depression and confusion, the client should avoid hazardous activities until they know how the drug affects them. 2) Breastfeeding is not recommended while taking this drug because metoclopramide can cause adverse effects in the breastfeeding infant.	1) The patient should be educated about proper defecation habits, dietary changes, and lifestyle alterations that may assist in producing regular bowel movements. 2) The client should be advised that it may take 2-4 days using this product before a bowel movement is produced.	1) The nurse should explain the rationale for this drug's use to the patient. 2) The patient should be educated on adverse reactions of the drug including site irritation, nausea, bleeding, visual disturbances, dysphasia, respiratory distress, itching, and edema. They should report these effects immediately if they experience them.

Medications Reference (1) (APA):

Entringer, S. (2021, December 24). *Loratadine*. Drugs.com. https://www.drugs.com/lorazepam.html

Drugs.com. (2020, May 22). *Loratadine tablet*. https://www.drugs.com/pro/loratadine-tablet.html

Drugs.com. (2020, October 22). *Polyethylene glycol*. https://www.drugs.com/pro/polyethylene-glycol.html#s-34089-3

Drugs.com. (2020, August 24). *Simethicone*. https://www.drugs.com/monograph/simethicone.html

Jones & Bartlett Learning. (2019). *2019 nurse's drug handbook* (18th ed.). Jones & Bartlett Learning, LLC.

MedlinePlus. (2018, May 17). *Loratadine*. https://medlineplus.gov/druginfo/meds/a697038.html#:~:text=Loratadine%20is%20also%20used%20to,body%20that%20causes%20allergic%20symptoms.

RxList. (2020, October 27). *Claritin*. https://www.rxlist.com/claritin-drug.htm#description

Woods, A. D. (2019). *Nursing 2019 drug handbook* (39th ed.). Wolters Kluwer.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** Alert **Orientation:** Place, person, time, and situation. **Distress:** No evident distress. **Overall appearance:** A.R. appears to be in good physical health.	A.R. is A/O x4. She does not exhibit any apparent signs of stress. The client appears to be her stated age and in good physical health.
INTEGUMENTARY (2 points): **Skin color:** Pale-pink **Character:** Dry and intact **Temperature:** warm	A.R.'s skin color is pale-pink and appropriate for her ethnicity. Her skin is warm to the touch, dry, and grossly intact with elastic turgor. No rashes are noted. There is some purple-brown bruising

Turgor: elastic **Rashes:** n/a **Bruises:** bruising to IV site on right hand. **Wounds/Incision:** The surgical incision from A.R.'s cesarean section on 4/6/21 is well-approximated. No drainage, redness, or added warmth is noted. **Braden Score:** 23 **Drains present: Y☐ N ☒** **Type:**	to the IV site on her right hand. The surgical incision to A.R.'s lower abdomen from her cesarean section on 4/6/21 is approximately 6 inches long and is well approximated. No drainage, erythema, or added warmth associated with the incision is noted. A.R. does not have any drains placed. Her Braden Score is 23.
HEENT (0.5 point): **Head/Neck:** Normocephalic. No JVD. Lymph nodes non-palpable. Trachea midline. Thyroid non-palpable. Oral mucosa is pink, moist, and intact. **Ears:** Tympanic membranes pearly grey and intact bilaterally. **Eyes:** PERRLA and EOMI **Nose:** Septum midline. No excess drainage or epistaxis. **Teeth:** Dentition is intact and off-white in color. Noted fillings in right upper first molar, right upper second molar, and left upper first molar.	A.R.'s head is normocephalic and her scalp is covered with dense brown hair. No lymph nodes are palpable. No jugular venous distension is noted. Her trachea is midline and her thyroid is non-palpable. A.R.'s tympanic membranes are intact and pearly grey in color bilaterally. No excess accumulation of cerumen is noted in either ear. Bilateral conjunctiva are pink in color and non-inflamed bilaterally. No ocular drainage is noted in either eye. PERRLA and EOMI. A.R.'s nasal septum is midline. No excess nasal drainage or epistaxis is noted. Dentition is intact and off-white in color. A.R. has filling in her right upper first molar, right upper second molar, and left upper first molar. Her oral mucosa is pink, moist, and intact. .
CARDIOVASCULAR (1 point): **Heart sounds:** S1, S2 **Cardiac rhythm (if applicable):** Regular **Peripheral Pulses:** 3+ bilaterally in upper and lower extremities. **Capillary refill:** <3 seconds bilaterally **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:** Trace edema to bilateral feet and ankles.	Auscultated S1 and S2 heart sounds. No murmur is noted. A.R.'s apical pulse is 98 beats per minute at the time of assessment. Heart rhythm is regular. Pedal and radial pulses are 3+ bilaterally. Capillary refill is <3 seconds bilaterally. No jugular venous distension is noted. This nurse observes trace edema to bilateral feet and ankles. A.R. states that this level of swelling represents an improvement versus her prenatal period.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒**	A.R.'s breath sounds are clear throughout all lobes posteriorly, anteriorly, and bilaterally. She

Breath Sounds: Breath sounds are clear throughout all lobes posteriorly, anteriorly, and bilaterally.	denies any dyspnea. Her respiratory rate is 16 respirations per minute at the time of assessment. No use of accessory muscles is observed.
GASTROINTESTINAL (5 points): **Diet at Home:** Regular **Current Diet:** Regular **Height:** 165.1 cm **Weight:** 78 kg **Auscultation Bowel sounds:** Active in all four quadrants. **Last BM:** 4/6/21 **Palpation: Pain, Mass etc.:** Some tenderness proximal to the surgical incision site. Uterine fundus is palpable and firm. No unexpected masses are palpated. Abdomen feels soft to the touch in general. **Inspection:** **Distention:** A.R.'s abdomen is slightly distended but appears normal for a postpartum state. **Incisions:** Well approximated surgical incision to lower abdomen from cesarean section on 4/6/21. The incision is approximately 6 inches long. No drainage, erythema, or added warmth to the area is noted. **Scars:** n/a **Drains:** n/a **Wounds:** n/a	A.R. has a regular diet at home and is consuming a regular diet as tolerated at OSF. Her height is 165.1 cm and her weight is 78 kg. Bowel sounds are active in all four quadrants. A.R. states her last bowel movement was on 4/6/21. She further states that she has been passing gas since her surgery. The abdomen is slightly distended but appears as expected in a post-partum client. It is soft and non-tender in general. The uterine fundus is palpable in firm. Otherwise, no masses are palpated. There is a surgical incision measuring approximately 6 inches to A.R.'s lower abdomen from her cesarean section on 4/6/21. The incision site is free from drainage, erythema, or added warmth. The immediate area around the incision is tender to palpation. No scars, drains, or wounds are noted.
GENITOURINARY (5 Points): **Fundal Height & Position:** Fundus is midline and 1 cm below umbilicus. **Bleeding amount:** scant **Lochia Color:** rubra **Character:** This nurse did not observe A.R.'s urine. **Quantity of urine:** Unknown. The client voids spontaneously 2x this shift. **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **Rupture of Membranes:** A.R.'s membranes were artificially ruptured during	A.R.'s uterine fundus is firm, midline, and 1 cm below the umbilicus. Her bleeding is scant with rubra lochia noted. This nurse did not observe A.R.'s urine output. The client voids spontaneously twice this shift. She denies any pain or discomfort with urination. A.R. does not have a urinary catheter. A.R.'s membranes were ruptured artificially during her cesarean section on 4/6/21 at 0802. The surgeon noted a moderate amount of clear, odorless amniotic fluid. No episiotomy was performed and A.R.'s perineum is intact.

her cesarean section on 4/6/21. **Time:** 0802 **Color:** clear **Amount:** moderate **Odor:** no odor **Episiotomy/Lacerations:** n/a	
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score (CPM assessment tool): 0** **Activity/Mobility Status:** **Independent (up ad lib)** ☐	A.R. is up ad lib and ambulates to the bathroom spontaneously without assistance. Her fall risk score is 0 by both the Morse Fall Scale and CPM fall assessment tool used at OSF. A.R. demonstrates 5/5 strength in bilateral upper extremities. The nurse did not assess the strength of A.R.'s lower extremities against resistance to avoid unnecessary abdominal strain. However, he notes that the client can ambulate without assistance.
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** Oriented to place, person, time, and situation. **Mental Status:** Appropriate. The client is calm and demonstrates organized thought process. **Speech:** Clear **Sensory:** Sensorium is intact. **LOC:** Alert **DTRs:** 2+. No clonus noted bilaterally.	A.R. demonstrates appropriate AROM and strength in her upper and lower extremities bilaterally. Hand grips are strong and equal bilaterally. PERRLA. The client is alert and calm. She is oriented to place, person, time, and situation. A.R. demonstrates an organized pattern of thinking and speaks in clear and coherent English. Her sensorium is intact with no sensory deficits noted. DTRs 2+. No clonus is noted bilaterally.
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s):** Artwork. **Developmental level:** Appropriate for age. **Religion & what it means to pt.:** The client identifies as a Christian and believes that her faith is a source of personal strength. **Personal/Family Data (Think about home environment, family structure, and available family support):** A.R. lives at home with her boyfriend, whom has been present with A.R. throughout her stay at OSF. She believes she is safe and has an adequate support network that includes her parents and her boyfriend's parents.	A.R. states that she enjoys painting and finds her artwork to be an effective means of relieving stress. Her developmental is appropriate for her age. A.R. identifies as a Christian and believes her faith is a source of personal strength. A.R. lives at home with her boyfriend, who is present with her at the bedside. She feels that her support network is reliable and adequate. In addition to her boyfriend, she identifies her parents and her boyfriend's parents as dependable support resources.

DELIVERY INFO: (1 point) **Delivery Date:** 4/6/21 **Time:** 0804 **Type (vaginal/cesarean):** Cesarean **Quantitative Blood Loss:** 341 mL **Male or Female:** Female **Apgars:** 8/9 **Weight:** 3845 gm **Feeding Method:** Breastfeeding	A.R. delivered by cesarean section on 4/6/21 at 0804. During the procedure, the surgeon noted a quantitative blood loss of 341 mL. She gave birth to a 21" long female infant that weighed 3845 grams. The infant's apgar scores at 1 and 5-minutes were, respectively, 8 and 9. A.R. is breastfeeding her infant.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	94 beats per minute	122/66 mm Hg	18 respirations per minute	97.5 degrees Fahrenheit	100% on room air
Labor/Delivery	97 beats per minute	125/77 mm Hg	16 respirations per minute	98.8 degrees Fahrenheit	100% on room air
Postpartum	98 beats per minute	127/80 mm Hg	16 respirations per minute	98.2 degrees Fahrenheit	100% on room air

Vital Sign Trends:

Pulse

A.R.'s pulse has increased modestly between each set of vitals, from 94 beats per minute during the prenatal set to 98 beats per minute during the postpartum set. An increase in heart rate is an expected physiological change during pregnancy (Ricci et al., 2021).

Blood Pressure

A.R.'s systolic blood pressure increased modestly between each set of vitals, from 122 mm Hg in the prenatal set to 127 mm Hg in the postpartum set. Her diastolic blood pressure increased significantly from 66 mm Hg in the prenatal set to 77 mm Hg in the labor/delivery set to 80 mm Hg in the postpartum set. However, even her highest blood pressure recording of 127/80 mm Hg does not meet the criteria for gestational hypertension; the clinical diagnosis of gestational hypertension requires a systolic blood pressure of more than 140 mm Hg or a diastolic blood pressure of more than 90 mm Hg occurring after 20 weeks gestation (Ricci et al., 2021). Nevertheless, the American College of Cardiology and American Heart Association consider a systolic blood pressure between 120 and 129 mm Hg elevated, and regard a diastolic blood pressure of 80 to 89 mm Hg as meeting the criteria for Stage 1 hypertension (Whelton et al., 2017, as cited in Alexander, 2019).

Respirations

A.R.'s respiratory rate is slightly lower in the labor/delivery and postpartum sets versus her prenatal set. Her prenatal respiratory rate was 18 respirations per minute. In the labor/delivery and postpartum vital sets, her respiratory rate was 16 respirations per minute.

Temperature

A.R.'s temperature increased from 97.5 degrees Fahrenheit in the prenatal set to 98.8 degrees Fahrenheit in the labor/delivery set. A.R.'s postpartum temperature was higher than her prenatal temperature and lower than her labor/delivery temperature at 98.2 degrees Fahrenheit.

Pulse Oximetry

A.R.'s oxygen saturation remained constant at 100% on room air during all three sets of vitals.

References:

Alexander, M. R. (2019). *Hypertension guidelines*. Medscape. https://emedicine.medscape.com/article/241381-guidelines

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1330	numeric	Headache, generalized	5/10	Throbbing	Administered scheduled dose of ibuprofen 800 mg PO.
1530	numeric	n/a	0/10	n/a	The nurse will continue to assess for pain using the numeric scale every 2 hours and as needed.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV:** Right hand **Date on IV:** 4/6/21 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** n/a **IV dressing assessment:** The dressing is clean, dry, and intact.	This nurse removed A.R.'s IV during his assessment at 1531. Prior to removal, the IV was saline-locked.

Intake and Output (2 points)

Intake	Output (in mL)
960 mL water	Voids spontaneously x2 this shift. Scant lochia noted on pad.

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.
The nurse performs a pain assessment using the numeric scale (N).	Every 2 hours and PRN.	Appropriate post-procedural care for patients that have undergone a cesarean section includes the management of pain (Holman et al., 2019). The accurate assessment of pain is crucial to effective pain management (Gulanick & Myers, 2017).
The nurse encourages the patient to ambulate as tolerated throughout the day (N).	TID and as tolerated.	Patients that have underwent a cesarean section are at an increased risk for deep vein thrombosis (Holman et al., 2019). Early and frequent postpartum ambulation is an effective measure for the prevention of deep vein thrombosis (Holman et al., 2019).
The nurse administers Pitocin 30 u/500 mL as ordered (T).	Continuously for 6 hours postpartum.	Oxytocin stimulates uterine contraction and is indicated to decrease postpartum bleeding (Holman et al., 2019; Jones & Bartlett Learning, 2019).
Sequential compression devices are left on the client's legs unless ambulating or showering (T).	Continuous, except during ambulation or showering.	Sequential compression devices are indicated post-operatively until ambulation is established to reduce the incidence of thrombotic events (Holman et al., 2019).

References:

Gulanick, M., & Myers, J. L. (2017). *Nursing care plans: Diagnoses, interventions, & outcomes* (9th ed.). Elsevier.

Holman, H. C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., McMichael, M. G., & Barlow, M. S. (2019). *RN maternal newborn nursing review module* (11th ed.). Assessment Technologies Institute, LLC.

Jones & Bartlett Learning. (2019). *2019 nurse's drug handbook* (18th ed.). Jones & Bartlett Learning, LLC.

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in?

A.R. is currently in the taking-hold phase of maternal adaption (Ricci et al., 2021).

What evidence supports this?

The taking-hold phase typically begins on the second or third post-partum day (Ricci et al., 2021). At the time of our encounter, A.R. is on her second post-partum day. The phase is marked by the mother reclaiming autonomy over her bodily functions, demonstrating an interest in the present, and expressing concern for the state of her health as well as her infant's health (Ricci et al., 2019). Furthermore, a client in this stage desires increased independence and wants to learn more about how to care for her newborn (Ricci et al., 2019). A.R. shows interest in and keeps track of her bladder and bowel activity. The client also frequently holds and breastfeeds her infant. Finally, she makes explicit requests to receive instruction on postoperative wound care and the use of her breast pump. These observations are consistent with the taking-hold phase (Ricci et al., 2021).

Reference:

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

Discharge Planning (2 points)

Discharge location: A.R. and her newborn will discharge to their home.

Equipment needs (if applicable): At this time, it is not expected that A.R. will require any equipment. The patient already acquired a breast-pump prior to her admission and will be discharged with supplies to care for her surgical wound.

Follow up plan (include plan for mother AND newborn):

This nurse anticipates that A.R. will follow up with her obstetrician and surgeon as directed. These appointments will be made prior to discharge. A.R.'s newborn will need to attend well-baby visits with the pediatrician her parents select.

Education needs: A.R. has requested a demonstration of her breast pump, which will be provided prior to discharge. Additionally, the patient shares with this nurse that she would like to learn more about care for her surgical incision.

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 surgical procedure as	This diagnosis was ranked first because it represents an	**1.**The nurse will assess A.R.'s pain using the numeric pain scale every two hours and PRN.	A.R. responded well to the interventions. Although she did not complain of pain to her

	evidenced by patient complaint of pain at incision with activity (Gulanick & Myers, 2017).	actual and immediate problem for the patient. Acute pain is a known complication of surgery (Gulanick & Myers, 2017).	**Rationale:** Effective pain management begins with an assessment of the pain experience (Gulanick & Myers, 2017). The patient is considered the best source of information regarding their pain (Gulanick & Myers, 2017). **2.** The nurse will administer ibuprofen 800 mg PO every 8 hours as ordered**.** **Rationale:** Ibuprofen is indicated for the management of mild to moderate pain (Jones & Bartlett Learning, 2019).	incision during this shift, during the nurse's first pain assessment she complained of a headache. At that time, she received her scheduled dose of ibuprofen 800 mg. During her follow up pain assessment, A.R. denied any pain. **Goal**: A.R. will maintain a level of pain of 5/10 or less on the numeric scale for the duration of her stay at OSF. This goal remains in progress. While A.R. has so far maintained a pain level of 5/10 or less on the numeric scale, she remains an inpatient at OSF.
2.	Risk for deep vein thrombosis related to decreased postoperative activity as evidenced by this nurse's observation that A.R. spends the majority of this shift resting in bed.	This diagnosis was ranked second because it represents a potential problem rather than an actual problem. Giving birth by cesarean section doubles the risk of deep vein thrombosis in the post-partum period (Holman et al., 2019).	**1.** The nurse will keep sequential compression devices in place on A.R.'s lower extremities continuously as ordered. **Rationale:** The use of sequential compression devices to prevent thrombotic events in post-operative clients is indicated until ambulation is established (Holman et al., 2019). Sequential compression devices increase venous blood flow and prevent venous stagnation (Gulanick & Myers, 2017). **2.**The nurse will encourage	A.R. tolerated the interventions well. Her sequential compression devices remained in place this shift except during ambulation, toileting, and during her head-to-toe assessment. A.R. gets up and ambulates to the bathroom spontaneously and agrees to take a walk after eating dinner. Goal: A.R. will remain free from deep vein thrombosis while at OSF. This goal remains in

		A.R. to ambulate as tolerated. **Rationale:** Muscular contraction during ambulation facilitates venous return (Gulanick & Myers, 2017).	progress. While there is no evidence to suggest A.R. has a deep vein thrombosis at this time, she remains an inpatient at OSF.
3. Deficient knowledge related to insufficient information about postoperative wound care as evidenced by patient request for instructions regarding appropriate wound care for her surgical incision.	Teaching A.R. about how to care for her wound and how to recognize problems promotes safety and allows her to be an active participant in her care (Gulanick & Myers, 2017).	**1.** The nurse will reinforce and provide a printed copy of the surgeon's postoperative wound care instructions with A.R. prior to discharge (Gulanick & Myers, 2017). **Rationale:** Providing instruction on appropriate wound care is consistent with the principle of patient-centered care and promotes safety (Gulanick & Myers, 2017). Ensuring the patient is able to provide self-care facilitates shorter hospital stays and earlier discharges (Gulanick & Myers, 2017). **2.** The nurse will instruct the patient to contact her surgeon if she experiences fever, foul-smelling wound drainage, redness, or unusual pain at the site of her incision (Gulanick & Myers, 2017). **Rationale:** Teaching the patient to identify problems improves their chances for a successful recovery (Gulanick & Myers, 2017). Infection is a known potential complication of surgery, including cesarean birth (Ricci et al., 2021).	Ideally, A.R. will be an active participant in her teaching. She could demonstrate this by asking follow up questions and teaching back what she has learned to the nurse. At this time, the nurse has not yet provided information on wound care to A.R. **Goal**: A.R. will teach back appropriate wound care for her incision and warning signs of infection to the nurse prior to discharge. This goal remains in progress. The nurse has not yet provided A.R. with teaching on wound care. However, she will receive this information from nursing staff prior to discharge.
4. Deficient knowledge related to	This diagnosis was selected because it was	**1.** The nurse will provide a clear explanation of how to use a breast pump to the	Ideally, A.R. will respond well to teaching on how to use her breast

	insufficient information regarding use of home medical equipment as evidenced by patient request for instruction on how to use her breast pump.	identified as a priority by the patient. Furthermore, effective use of her pump facilitates feeding A.R.'s infant with breast milk. Encouraging exclusive breastfeeding for the first 6 months of life is considered the modern standard of care (Ricci et al., 2021). This diagnosis was ranked fourth because, while important, it does not represent an immediate or potential homeostatic threat to the patient.	patient. **Rationale:** Providing accurate and clear instruction helps the patient assume responsibility for their care (Gulanick & Myers, 2017). **2.** The nurse will allow A.R. to practice the use of her breast pump and provide feedback on her performance. **Rationale:** Allowing the patient to practice a skill in the presence of the nurse allows them to use their learning immediately, enhances retention, and allows them to make guided corrections as opposed to practicing the skill incorrectly later (Gulanick & Myers, 2017).	pump and correctly demonstrate its use to the nurse. **Goal**: A.R. will correctly demonstrate the use of her breast pump prior to discharge. This goal remains in progress. A.R. has not yet received instruction on how to use her breast pump. However, the lactation consultant will provide this teaching to A.R. prior to her discharge.

Other References (APA)

Gulanick, M., & Myers, J. L. (2017). *Nursing care plans: Diagnoses, interventions, & outcomes* (9th ed.). Elsevier.

Holman, H. C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., McMichael, M. G., & Barlow, M. S. (2019). *RN maternal newborn nursing review module* (11th ed.). Assessment Technologies Institute, LLC.

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