

N432 Postpartum Care Plan
Lakeview College of Nursing
Shawn Weber

Demographics (3 points)

Date & Time of Admission 06/02/2021 @ 1545	Patient Initials S.T.	Age 21 yr. (07/28/1999)	Gender Female
Race/Ethnicity White/Caucasian	Occupation Server (Red Lobster)	Marital Status Married	Allergies NKDA
Code Status Full Code	Height 4'11" (149.9cm)	Weight 141 lb. (64 kg)	Father of Baby Involved Yes

Medical History (5 Points)

Prenatal History: G3 P2 T2 A1 L2

Past Medical History: HSV-1 Positive, anemia, anxiety, hemorrhoids, pilonidal abscess, preeclampsia, first pregnancy at 16 years old.

Past Surgical History: C-section, post-partum care

Family History: Paternal: Alzheimer's disease (grandma) **Maternal:** Bipolar disease (Mom, grandma), diabetes (grandma) Leukemia (brother)

Social History (tobacco/alcohol/drugs): Smokes 0.5 a pack a day or "3-4 cigarettes per day"
Denies and drug or alcohol use.

Living Situation: Client lives with husband in home in Danville, IL.

Education Level: High School Graduate

Admission Assessment

Chief Complaint (2 points): Induction of Labor

Presentation to Labor & Delivery (10 points): 21-year-old woman presents to labor and delivery unit for previously scheduled induction of labor. Patient was G3P1T0A1L1. 39 weeks and 6 days of gestation. Previous pregnancy of client was complicated by due too client's adolescence. Client suffered from preeclampsia that resulted in a cesarian section of a premature

baby. Client's cervix was ripened at 06/02 at 1613 with a foley bulb. Induction of labor was begun at 1623 with the administration of oxytocin. Fentanyl-ropivacaine epidural was begun at 1730. Labor onset began at 1755. Membranes were artificially ruptured at 2002. Full dilation was complete at 2234, and the client began pushing at 2239. Daughter was delivered at 2310. Placenta was delivered at 2314.

Diagnosis

Primary Diagnosis on Admission (2 points): Artificial Rupture of Membrane

Secondary Diagnosis (if applicable):

Postpartum Course (18 points)

Postpartum Course References (2) (APA):

The postpartum phase is a transitional stage for a mother where her body adjusts from all the changes of being pregnant to going back to normal (Ricci et al., 2020, p. 515). It can often be seen as a taxing time on the body, as moms go through vast amounts of physical and psychological changes. They must also come to terms with new changes in familial areas as their family has grown.

The client's reproductive system slowly returns to the pre-pregnancy state. The uterus will slowly shrink back to its original size and place in a process called involution. A result of involution is a vaginal discharge present for 4-8 weeks post-delivery called lochia. Lochia typically has three phases, which are rubra (red) serosa (pinkish brown), and alba (white/light brown). If a client has reoccurring red after rubra has ceased, this may signify a problem and

needs immediate evaluation by a provider. Clients may also experience afterpains because of contractions. These pains may seem stronger if the client is breastfeeding as the oxytocin produced through feeding creates stronger contractions. The contractions are a part of a process called involution, which is where the uterus begins to return to its normal size. These contractions also help reduce risk of postpartum hemorrhage by occluding blood flow. The client's cervix should return to its normal state over 6 weeks. Other parts of the mom's anatomy, such as the perineum and the pelvic floor, can take up to six months to heal, though some damage can lead to incontinence later in their life (Ricci et al., 2020, p. 519).

This client is currently in the taking-in phase. This phase takes place during the first 24/48 hours after delivery. This phase is characterized by dependent behavior, as a mom requires much rest, and the rest of her needs to be maintained by others as she recuperates and begins to establish milk for the child. She relies on staff, friends, or family to help her maintain her basic needs during this time. The next phase will be the taking hold phase. This is where the mother will begin independent maternal behavior. The last phase is the letting-go phase, which is where she reestablishes relationships with the rest of society again since her establishment as a new mother ("Postpartum changes: Physical and emotional adjustments after pregnancy," 2017).

Postpartum nursing care involves frequent monitoring for signs of hemorrhaging or infection for the mom. Vital signs are frequently collected just after delivery. This client suffers from anemia which puts her at greater risk for infection.

References

Nurselabs. (2017, January 18). *Postpartum changes: Physical and emotional adjustments after pregnancy*. <https://nurseslabs.com/postpartum-changes/>

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing* (4th ed.).

Walters 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	3.8-5.3	3.37	3.93	3.45	Client suffers from anemia, and blood loss from birthing process would contribute to this value being low.
Hgb	12-15.8	8.7	10.3	8.9	Anemia and blood loss from vaginal birth cause low value.
Hct	36-47	26.2	31	27.6	Anemia and blood loss from vaginal birth cause low value.
Platelets	140-440	207	187	161	Normal finding.
WBC	4-12	8.5	7.4	10.0	Normal finding.
Neutrophils	47-73	82.3	75.8	78.9	Raised as part of inflammatory response in relation to vaginal birth.
Lymphocytes	18-42	11.3	18.2	13.7	High levels of stress on the body from the pregnancy process, or malnutrition may cause this lab value to be reduced.
Monocytes	4-12	5.5	4.1	6.0	Normal finding.
Eosinophils	0-5	0.6	1.7	0.9	Normal finding.
Bands	0-1	Not drawn	Not drawn	Not drawn	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
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Blood Type	A, B, AB, O	A	A	A	
Rh Factor	+/-	+	+	+	
Serology (RPR/VDRL)	Non-reactive	-	Not drawn	Not drawn	
Rubella Titer	Immune	Immune	Not drawn	Not drawn	
HIV	Nonreactive	Negative	Not drawn	Not drawn	
HbSAG	Nonreactive	Negative	Not drawn	Not drawn	
Group Beta Strep Swab	Negative	Negative	Not drawn	Not drawn	
Glucose at 28 Weeks	<140	Negative	Not drawn	Not drawn	
MSAFP (If Applicable)	Low risk, chromosomal abnormalities	Negative	Not drawn	Not drawn	

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)	0-254 mg	Not drawn	Not drawn	Not drawn	N/A

Lab Reference (1) (APA):

Hinkle, J. L., & Cheever, K. H. (2017). *Clinical handbook for Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Lippincott Williams & Wilkins.

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing* (4th ed.). Walters Kluwer.

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

	Your Assessment
<p>History of labor:</p> <p>Length of labor</p> <p>Induced /spontaneous</p> <p>Time in each stage</p>	<p>Client was reported to OSF L&D for scheduled induction of labor. Cervical ripening with foley at 1613, oxytocin drip started at 1623, and onset of labor at 1755.</p> <p>AROM at 2002, fluid was clear.</p> <p>Dilation complete 2234, started pushing at 2239.</p> <p>Delivered 2310, cord clamped at 2312. Spontaneous vaginal delivery.</p> <p>Placenta delivered at 2314.</p> <p>1st stage: 6 hr. 26 min.</p>

	<p>2nd stage: 0 hr. 21 min.</p> <p>3rd stage: 0 hr. 4 min.</p> <p>Position: MOA Presentation: Vertex</p>
<p>Current stage of labor</p>	<p>4th stage postpartum (Assessment Technologies Institute, 2019, p. 129).</p> <p>This client is about 18 hours postpartum. Her vital signs are trending stable, within normal limits for this client. Uterus is palpable and midline 1 cm below umbilicus. Light lochia is present. Mother is alert oriented and attentive to her new daughter. Newborn is being exclusively bottle-fed formula every 2-3 hours by either mom or grandma.</p>

Stage of Labor References (2) (APA):

Assessment Technologies Institute. (2019). *RN maternal newborn nursing edition 11.*

0 (11th ed.).

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing* (4th ed.). Walters

Kluwer.

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

7 different medications must be completed

Home Medications (2 required)

Brand/Generic	Zenata/ Prenatal Vitamins	Valtrex/ Acyclovir			
Dose	27-0.8mg	400 mg			
Frequency	Nightly	TID for 7 days			
Route	PO	PO			
Classification	Multivitamin	Antiviral			
Mechanism of Action	Supplement's vitamins that are essential to pregnancy	Inhibits DNA synthesis of HSV-1			
Reason Client Taking	To promote healthy pregnancy	Prophylaxis for HSV-1 + diagnosis			
Contraindications (2)	Hypersensitivity, avoid if also taking potassium supplements	Hypersensitivity, severe hepatic impairment.			
Side Effects/Adverse Reactions (2)	Indigestion, headache	Anaphylaxis, renal impairment			
Nursing Considerations (2)	Assess client for prescriptions and herbal supplements for contraindications. Should be separated from other meds by 2 hr.	Maintain good fluid intake to prevent risk of renal damage. Monitor for CNS reactions			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Potassium	Liver and renal enzymes			
Client Teaching needs (2)	Tablets should be taken with food, at the same time. Do not take with antacid as it inhibits	Avoid sexual contact when lesions are present. Inform client that this is not a cure.			

	absorption.				
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Hospital Medications (5 required)

Brand/Generic	Tylenol/ acetaminophen	Ferrous sulfate	Pitocin/ oxytocin	Zofran/ ondansetron	Motrin/ ibuprofen
Dose	650mg	325 mg	0.06-0.3 units/min	4 mg	400 mg
Frequency	Q6H PRN pain	BID	Once to induce labor	Q6H PRN nausea	Q6H PRN pain
Route	PO	PO	IV	SL	PO
Classification	analgesic	Supplement	Hormone	Antiemetic	NSAID
Mechanism of Action	Inhibits enzymes responsible for body's pain response.	Provides supplemental iron for RBC production.	Synthetic form of hormone released at beginning stages of labor.	Block serotonin receptors in the trigger zone near the vagal nerve, inhibiting nausea.	Reduces inflammatory response and relieves pain.
Reason Client Taking	Pain relief	Prevent iron deficiency	Induce labor	To treat nausea	Pain relief
Contraindications (2)	Hepatic impairment, hypersensitivity	Hemolytic anemias, hemochromatosis	Hypersensitivity. Unfavorable fetal position	Prolonged QT, hypersensitivity	Asthma, GI bleed
Side Effects/Adverse Reactions (2)	Hepatotoxicity, Stevens-Johnson's syndrome	Hemolysis, angioedema	Intense contraction, cramping	Serotonin syndrome, arrhythmias	GI hemorrhage, renal injury
Nursing Considerations (2)	Monitor liver and renal function for	Give with full glass of water. Inform client stools	Maintain good patient IV. Monitor for uterine	Avoid direct skin contact to prevent absorption,	Women past 30 weeks pregnant

	clients using long term therapy	may be darker.	overstimulation in case of overdose.	monitor for hypersensitivity	should not take. Avoid in clients with recent MI
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Liver enzymes	RBC Hgb Hct	Assess client for readiness to begin labor.	Potassium	Assess current pain level
Client Teaching needs (2)	Keep in locked cabinet away from children. Tabs may be taken whole or crushed.	Do not chew or crush. Avoid food that impairs absorption such as milk.	This will intensify contractions. You may experience some confusion.	Place disintegrating tablet under tongue	Take with full glass of water. Take after meal to reduce GI distress.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2019). *2020 Nurse’s Drug Handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

<p>GENERAL (0.5 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Alert and oriented x3, time place and person. Client has appropriate appearance. Client is in mild discomfort due to cramping pains. Client appears to be attending to ADLs.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Skin color is pale/appropriate for ethnicity. Dry and intact. Temperature is warm. Turgor is elastic, <2seconds. Inspected for rashes none found. No bruising. Perineal lacerations. Blood noted, no signs of purulent discharge or infection. Covered with absorbent pad. Braden score 20 (Low risk).</p>

HEENT (0.5 point): Head/Neck: Ears: Eyes: Nose: Teeth:	Skull and facial features symmetrical, in line with c-spine. Neck midline. Ear and eyes symmetrical without signs of irritation or drainage. Teeth are white and intact. Nose is midline with patent nares, and without discharge. Moist/pink mucous membranes
CARDIOVASCULAR (2 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 checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:	Normal Sinus Rhythm. S1 and S2 sound auscultated, no gallop or murmur. Bilateral 3+ pulse felt both radial and pedal. Capillary refill < 2 seconds.
RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character	Auscultated anterior and posterior, clear bronchovesicular in all lobes. Chest rise and fall symmetrical with no signs of labored breathing. Client claims no signs of shortness of breath.
GASTROINTESTINAL (2 points): Diet at Home: Current Diet: Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds:	Regular Diet at home Currently on regular diet. 4'11" 141 lb. Active bowel sounds auscultated in all 4 quads. 06/03/2021 at 1015, is passing gas. No pain with palpation. No distention. No incisions. C-section scar visible. No drains. No wounds present in abdominal region.
GENITOURINARY (3 Points): Fundal Height & Position: Bleeding: Lochia Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	1 cm below the umbilicus. Bleeding at perineal laceration. Lochia is dark red. Multiple blood clots. Light, less than 10 cm. 500mL

<p>Size: Rupture of Membranes: Time: Color: Amount: Odor: Episiotomy/Lacerations:</p>	<p>AROM 6/2/21 @ 2002 Clear Moderate No odor No episiotomy. Small 2-degree laceration in perineal area. Being treated with tucks pad.</p>
<p>MUSCULOSKELETAL (2 points): ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Fall Score 15 (No risk) Client is active and mobile with strong gait. Full active ROM of all 4 extremities with 5+ strength.</p>
<p>NEUROLOGICAL (1 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC: DTRs:</p>	<p>Mental status is alert. Oriented to person/place and time. Speech is clear and appropriate. No sensory impairments. Full level of consciousness. DTRs 2+.</p>
<p>PSYCHOSOCIAL/CULTURAL (2 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>Client is alienated to mother and has no relationship with father. Appears to have good coping methods and emotional support from husband and his family. Client's first daughter lives with her father, she sees her at least once a week. Client well developed, and capable of making own decisions. No religious preference.</p>
<p>DELIVERY INFO: (2 point) Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight:</p>	<p>06/02/2021 2310 Vaginal 275 mL Female One minute: 9 Five minute: 9 2705 g (5lb. 15.4 oz.)</p>

Feeding Method:	Bottle feeding ProAdvance formula every 2-3 hours.
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Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	68	108/72	18	98.2	99%
Labor/Delivery	89	117/65	18	98.1	99%
Postpartum	79	119/69	18	98.3	99%

Vital Sign Trends: Vital signs are stable. Does not appear to be affected by medication.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1540	Numeric	Abdomen	8/10	Cramping	Ibuprofen 800mg administered @ 1541.
1630	Numeric	Abdomen	4/10	Cramping	Heat pack given @ 1645, pain was affectively relieved!

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:	18 Gauge Left wrist 06/02/2021 @ 2050 IV patent and saline locked. No signs of erythema or drainage. Transparent dressing.

Intake and Output (2 points)

Intake	Output (in mL)
Dinner - 100%	Urine – 550mL
Water - 600 mL	Blood - 400mL
Juice - 480 mL	Total - 950 mL
Total – 1080 mL	

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.
Heat pack, and disposable heating pad to the abdomen – N	3–4-hour PRN pain	Client was experiencing abdominal cramping pain postpartum. Pain was well handled with the application of warmth.
Ibuprofen for pain. – T	Q8H PRN pain	Client was given this medication due to the abdominal cramping. It reduced the pain but did not get rid of it completely.
Position Changes – N	Q2H	Frequent changes of position helps relieve mother of pressure on skin and reduces the chances of her experiencing pressure ulcers.
Witch Hazel Tucks Pads – T	Q1H PRN	Offer the client relief to perineal laceration, that resulted from birth.

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? Client is in the taking-in phase.

What evidence supports this? The client is still recovering from the effects of labor and delivery. She is dependent on family and hospital staff for help.

Discharge Planning (2 points)

Discharge location: Home with her husband and her new daughter.

Equipment needs (if applicable): No equipment needed.

Follow up plan (include plan for mother AND newborn): Follow up with family care pediatrician two days after discharge for infant check up where infant will be weighed and assessed for jaundice. Mother will follow up at OBGYN in 6 weeks for postpartum check up for vaginal delivery.

Education needs: Client, father, and mother-in-law received education on formula feeding from the floor nurse.

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

<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 (2 pts 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>1. Risk for infection related to laceration/blood loss from childbirth as evidenced by low hgb.</p>	<p>Client has experienced blood loss in addition to client already being anemic.</p>	<p>1. Monitor client for changes in vital signs, and for other signs such as swelling, redness, pain, color/odor of lochia. Rationale Performing vital signs very 2-3 hours increases the likelihood of seeing trends that imply infection. 2. Teach client to use clean technique when changing</p>	<p>The client remains infection free.</p>

		gauze on perineal tear. Rationale Teaching client will reduce risk of contaminating wound and decrease healing time.	
2. Risk for acute pain related to postpartum cramping and damaged perineal as evidenced by client's 8/10 pain score.	Birth can be traumatic on the mother's body and leave her in	1. Assess pains with vital signs and before/after pain interventions. Rationale Frequent assessment and documentation of pain detects when interventions are needed and when they are affective. 2. Teach relaxation techniques to client to reduce pain discomfort and anxiety. Rationale Offer client a nonpharmacological methods of pain management.	Client reports a reduction or elimination of pain.
3. Risk for altered parent-infant attachment as related to anxiety to new role as full time parent as evidenced by not knowing information related to bottle feeding.	Client is in a stage of motherhood where the bonding with the infant is essential in establishing loving relationship.	1. Teach mom the importance skin-to-skin contact has in relation to bonding. Rationale Skin-to-skin contact with mom facilitates bonding and attachment. 2. Provide mom opportunities to perform infant care independently. Rationale By performing infant care herself mom is bonding with her daughter and boosting her own confidence as a caregiver.	Client shows signs of bonding with daughter.
4. Risk for deficient knowledge related to newborn care as evidenced by lack of knowledge	Informing both mom and dad about basic childcare can help them feel more confident in their parenting	1. Educate regarding proper handling/preparation of baby formula as well as how to get the most out of WICC. Rationale Ensures mother feeds her daughter the proper formula for her	Client participates in learning which will enhance parenting abilities.

<p>related to formula.</p>	<p>ability.</p>	<p>nutritional needs. 2. Ask client questions about the new information she has been given. Rationale Establishes that client has a firm understanding of new information.</p>	
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Other References (APA)

Nurselabs. (2019, June 1). *8 postpartum hemorrhage nursing care plans*. <https://nurseslabs.com/postpartum-hemorrhage-nursing-care-plans/7/>

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing* (4th ed.). Walters Kluwer.