

N432 Postpartum Care Plan  
Lakeview College of Nursing  
Princess Anne Hernandez

**Demographics (3 points)**

<b>Date &amp; Time of Admission</b> 06/09/2021 1650	<b>Patient Initials</b> A.M.	<b>Age</b> 25 years old	<b>Gender</b> Female
<b>Race/Ethnicity</b> White/Caucasian	<b>Occupation</b> Substitute Teacher	<b>Marital Status</b> Single/Not married	<b>Allergies</b> Shrimp- Anaphylaxis (severe)
<b>Code Status</b> Full Code	<b>Height</b> 5'3"	<b>Weight</b> 129 lbs.	<b>Father of Baby Involved</b> Yes, Father is at the bedside

**Medical History (5 Points)**

**Prenatal History:** GTPAL: Gravida 2, Term 1, Preterm 0, Abortion 1, Living 1. No complication on current pregnancy and previous pregnancy result in miscarriage or spontaneous abortion (SAB).

**Past Medical History:** Patient has mild anemia, postural orthostatic tachycardia syndrome and diagnosed with Ehlers Danlos syndrome at the age 19.

**Past Surgical History:** Patient's chart states no past surgical history.

**Family History:** Patient has no known family history.

**Social History (tobacco/alcohol/drugs):** Patient denies any past or current tobacco and smokeless tobacco use. Patient denies current alcohol consumption. Patient denies any use recreational drug or substance use.

**Living Situation:** Patient lives with her parents and pets—cat, birds, sugar gliders and lizard.

**Education Level:** Patient has a bachelor's degrees.

### **Admission Assessment**

**Chief Complaint (2 points):** Labor. The patient was complaining of contraction every 2-3 mins before coming to Carle.

**Presentation to Labor & Delivery (10 points):**

The patient is a 25-year-old female admitted to Carle Labor and Delivery on June 09, 2021, at 1650 at exactly 40 weeks gestation due to experiencing contraction every 2-3 minutes. She was 3 cm dilated, 80% effacement, no bloody show, and her membranes were still intact when she came in. She was fully dilated around 0920 of June 10, 2021 and began pushing for 3 hours and have a 1-hour rest between pushing efforts. She began to arrest on the second stage due to prolonged pushing effort and had an emergency section because she was concerned about laceration if they do vacuum. Her baby girl was born on 06/10/21 at 06:18 pm, weighing 7 lbs. 13.2 oz.

### **Diagnosis**

**Primary Diagnosis on Admission (2 points):** Labor management

**Secondary Diagnosis (if applicable):** Mild anemia, Postural orthostatic tachycardia syndrome, Ehlers Danlos syndrome

### **Postpartum Course (18 points)**

The patient is in the fourth stage of labor right now, which is the postpartum recovery phase. In stage four of labor, the placenta was delivered and, the patient had encompassed the first 2 hours of postdelivery (Swearingen & Wright, 2019). The patient is relatively stable. All of her vital signs are normal. She is almost in her 24 hours postpartum course. The patient's fundus was palpable one centimeter below the umbilicus at the midline and present with lochia.

Lochia is a discharge that will exude from the vagina for several weeks following birth (Ricci et al., 2020).

The patient lab result show elevated WBC and elevated neutrophil, which may be due to physical stress that the patient experienced during the cesarean section (Pagana et al., 2020). She had decreased RBC and decrease H&H levels, which are due to the blood loss during childbirth.

The patient is currently in the taking-in phase of maternally psychological adaption since she is only in her first 24 hours after giving birth (Ricci et al., 2020). She is exhausted and in pain. She relies upon the nurse and her boyfriend since she had an emergency cesarean section. The nurse and boyfriend provide basic needs such as food, fluids, and rest (Ricci et al., 2020).

A postpartum complication can happen to any mother after giving birth. Examples of postpartum complications are infection, postpartum hemorrhage, and postpartum mood disorder. The risk factor for infection includes diabetes, obesity, cesarean delivery, anemia, and premature rupture of membrane (Ricci et al.,2020). The patient is at risk of infection since she had a cesarean delivery and diagnosed with mild anemia.

### **Postpartum Course References (2) (APA):**

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's diagnostic and laboratory test reference* (15th ed.). Elsevier.

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

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). 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	3.38	4.24	3.27	A decrease in red blood cells can be due to pregnancy, anemia, or increased blood loss (Pagana et al., 2020). The patient had mild anemia during pregnancy. In addition, the patient lost some blood during the cesarean section.
Hgb	11.0-16.0	10.5	13.5	10.2	A decrease in hemoglobin can be due to pregnancy, anemia, or increased blood loss (Pagana et al., 2020). The patient had mild anemia during pregnancy. In addition, the patient lost some blood during the cesarean section.
Hct	34.0-47.0%	32.7	40.8	31.8	A decrease in hematocrit can be due to pregnancy, anemia, or increased blood loss (Pagana et al., 2020). The patient had mild anemia during pregnancy. In addition, the patient lost some blood during the cesarean section.
Platelets	140-400	217	179	141	Normal platelets levels
WBC	4.00-11.00	10.91	11.62	18.52	An increase in white blood cells can be due to stress and inflammation (Pagana et al., 2020). The patient was under stress during admission due to labor. The patient had cesarean sections, which can cause stress and inflammation.
Neutrophils	1.60-7.70	9.55	8.68	16.09	An increase in neutrophils can be due to physical and emotional stress (Pagana et

					al., 2020). The patient’s pregnancy can put her in physical and emotional stress, and while in labor, she also experiences stress.
<b>Lymphocytes</b>	<b>11.8-46.9</b>	14.1	16.7	15.9	Normal lymphocytes levels
<b>Monocytes</b>	<b>4.4-12</b>	5.9	7.1	6.3	Normal monocytes levels
<b>Eosinophils</b>	<b>0-6.3</b>	0.1	0.3	0.1	Normal eosinophils levels
<b>Bands</b>	<b>0.01</b>	N/A	N/A	N/A	No lab drawn

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
<b>Blood Type</b>	<b>A, B, O, AB</b>	<b>O</b>	<b>O</b>	<b>O</b>	Normal
<b>Rh Factor</b>	<b>Negative or positive</b>	Positive	Positive	Positive	Normal
<b>Serology (RPR/VDRL)</b>	<b>Non-reactive</b>	Non-reactive	Non-reactive	Non-reactive	Normal lab finding
<b>Rubella Titer</b>	<b>10.00 or above</b>	Non-reactive	Non-reactive	Non-reactive	Normal lab finding
<b>HIV</b>	<b>Non-reactive</b>	Non-reactive	Non-reactive	Non-reactive	Normal lab finding
<b>HbSAG</b>	<b>Non-reactive</b>	Non-reactive	Non-reactive	Non-reactive	Normal lab finding
<b>Group Beta Strep Swab</b>	<b>Negative</b>	Negative	Negative	Negative	Normal lab finding
<b>Glucose at 28 Weeks</b>	<b>&lt;140</b>	105	N/A	N/A	Normal lab finding
<b>MSAFP (If Applicable)</b>	<b>N/A</b>	N/A	N/A	N/A	No lab 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
Covid-19 test	Non-reactive/ Negative	Negative	Negative	N/A	Normal lab finding

**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	N/A	N/A	N/A	No lab drawn

**Lab Reference** **(1)** (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's diagnostic and laboratory test reference* (15th ed.). Elsevier.

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

	<b>Your Assessment</b>
<p><b>History of labor:</b></p> <p><b>Length of labor</b></p> <p><b>Induced /<u>spontaneous</u></b></p> <p><b>Time in each stage</b></p>	<p>The patient was admitted to Carle labor and delivery on June 09, 2021, at 1650. Upon arrival, her cervical dilation was 3 cm with effacement of 80%; engagement was achieved at -1; membrane was still intact, no bloody show. The patient was 10 cm dilated on June 10, 2021, at 0920. She had an artificial rupture of membranes at 1221 and had spontaneous labor. The infant was in vertex presentation as left occiput anterior position. However, she arrests on the second stage of labor and does not want to vacuum, which leads to an emergency c-section. The infant was born at the time 1818 and placental expulsion at 1819 on June 10, 2021. The length of her labor was 14 hours and 49 minutes.</p> <p>First stage: 6 hours</p> <p>Second stage: 8 hours and 48 minutes</p> <p>Third stage: 1 minute</p>
<p><b>Current stage of labor</b></p>	<p>The patient is currently in the fourth stage of labor. It is evidenced by delivery of the placenta, and she is past the first 2 hours of postdelivery (Swearingen &amp; Wright, 2019). The patient is almost onto her 24 hours into the postpartum phase. All of her vital signs are stable. The mother fundus is firm, midline and one centimeter below the umbilicus (Ricci et al., 2020) She has been eating and drinking well. She also breastfeeds her baby every 2</p>

	hours.
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**Stage of Labor References (2) (APA):**

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

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier.

**Current Medications (7 points, 1 point per completed med)  
\*7 different medications must be completed\***

**Home Medications (2 required)**

<b>Brand/Generic</b>	Prenatal Vitamin/Ferrous fumarate-folic acid	Tylenol/Acetaminophen
<b>Dose</b>	27 mg/1 capsule	500 mg
<b>Frequency</b>	Once daily	PRN Q 6 hours
<b>Route</b>	PO	PO
<b>Classification</b>	Vitamin	NSAID, antipyretic/nonopioid analgesic
<b>Mechanism of Action</b>	Replenish and prevent loss of vitamin and mineral essential to fetal growth and development	Inhibit the production of prostaglandin interfering with pain impulse generation in the peripheral nervous system
<b>Reason Client Taking</b>	Prophylaxis for potential vitamin deficiencies	For pain

<b>Contraindications (2)</b>	Iron overload Peptic Ulcer	Severe hepatic impairment Hypersensitivity to acetaminophen
<b>Side Effects/Adverse Reactions (2)</b>	Constipation GI upset	Hypotension hypokalemia
<b>Nursing Considerations (2)</b>	Monitor liver enzyme due to risk of elevation Deferoxamine should be prepared in case of iron toxicity	Ensure daily dose of acetaminophen from all sources does not exceed maximum daily limit. Monitor liver function test because this can damage the liver
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	Assess patient RBC, Hgb and Hct. Monitor iron level	Assess CBC and liver function test of patient.
<b>Client Teaching needs (2)</b>	Take medication with 8 oz of water. Take medication regularly to get full benefit.	Follow dosage guidelines of medication and do not exceed daily limit. Medication can be crushed or swallowed whole

### Hospital Medications (5 required)

<b>Brand/Generic</b>	Norco/ Hydrocodon e- acetaminophen	Mylicon/ Simethicone	Benadryl/ Diphenhydramine	Cepacol Sore throat/ Benzocaine- menthol	Zofran/ Ondansetron
<b>Dose</b>	5/325	100 mg	50 mg	12- 2.6 mg	4 mg
<b>Frequency</b>	PRN Q4-6 hours	PRN Q 4hours	PRN Q4 hours	PRN Q2 hours	PRN once daily
<b>Route</b>	PO	PO	PO	PO	IV
<b>Classification</b>	Analgesics, Opioid Combinatio	Gastrointestinal Agents	Antihistamine	Local anesthesia	Antiemetic

	n				
<b>Mechanism of Action</b>	Bind to opiate receptors in the CNS. Alter the perception of and response to painful stimuli while producing generalized CNS depression: Suppress the cough reflex via a direct central action	This medication is a non-systemic surfactant, decreasing the surface tension of gas bubbles in the GI tract, resulting in coalescence and dispersion of the gas bubbles allowing their removal from the GI tract.	Bind to central and peripheral H1 receptor, competing with histamine for these sites and preventing it from reaching its site action	Causes temporary numbness/loss of feeling to skin	Blocks serotonin receptor centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminal in the intestine
<b>Reason Client Taking</b>	Pain level rating 4-6	Gas discomfort	Itching	Sore throat/discomfort	Nausea/vomiting
<b>Contraindications (2)</b>	Hypersensitivity to hydrocodone. Acute bronchial asthma	Phenylketonuria, hypersensitivity	Hypersensitivity to diphenhydramine Breastfeeding	Hypersensitivity to benzocaine and its component Anemia	Hypersensitivity to ondansetron and its component Concomitant use of apomorphine
<b>Side Effects/Adverse Reactions (2)</b>	Sedation Respiratory depression	Constipation Headache	Palpitations Drowsiness	Tachycardia Lightheadedness	Hypotension Tachycardia
<b>Nursing Considerations (2)</b>	Monitor vital sign closely for any sign of respiratory depression. Monitor for excessive sedation or changes in	Carbonated beverages can counteract this medication. This medication should be administered	Keep elixir container tight closed protecting from light. Do not use if patient is breastfeeding	Monitor for respiratory depression. Monitor for compromised myocardial function because of risk of electrolyte	When used as to treat postoperative nausea and vomiting, drug is administered undiluted intravenously.

	mood and behavior	after meals.		imbalances	Monitor for any sign and symptom of hypersensitivity.
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	Assess patient level of consciousness and pain level.	Assess the patient's level of bloating.	Assess patient for hypersensitivity. Confirm patient desire to breastfeed infant	Assess electrolyte labs values.	Assess patient for hypersensitivity to ondansetron
<b>Client Teaching needs (2)</b>	Instruct patient to take medication as prescribed and do not adjust dosing. Instruct patient to take medication as whole do not crush or chew.	Avoid carbonated beverages. Avoid caffeinated beverages.	Advise to take drug with food to minimize motion sickness. Caution patient to avoid hazardous activity due to sedating effect of it.	Instruct patient they will feel numbness on their throat. Do not eat or drink for at least 1 hour after using	Advise patient to seek immediate medical attention if she is experiencing worsening symptoms. Advise patient to report sign of hypersensitivity such as rash

**Medications Reference (1) (APA):**

**Jones & Bartlett Learning. (2019). *2020 nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.**

**Assessment**

**Physical Exam (18 points)**

<p><b>GENERAL (0.5 point):</b>  <b>Alertness:</b>  <b>Orientation:</b>  <b>Distress:</b>  <b>Overall appearance:</b></p>	<p>Patient is aware alert and oriented X4 person, place, time, and situation.                  Comfortable, no acute distress.                  Well-groomed, well-developed, well-nourished</p>
<p><b>INTEGUMENTARY (2 points):</b>  <b>Skin color:</b>  <b>Character:</b>  <b>Temperature:</b>  <b>Turgor:</b>  <b>Rashes:</b>  <b>Bruises:</b>  <b>Wounds/Incision:</b> .   <b>Braden Score:</b>  <b>Drains present:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b></p>	<p>Normal for race                  Dry/Normal                  Warm                  Normal Turgor                  No noted rashes                  No noted bruises                  The patient has low transverse incision due to cesarean section.                  Braden score: 21                  No drain present.                  N/A</p>
<p><b>HEENT (0.5 point):</b>  <b>Head/Neck:</b>   <b>Ears:</b>   <b>Eyes:</b>   <b>Nose:</b>   <b>Teeth:</b></p>	<p>Head and Neck symmetrical/midline without deviation. No lesions or rashes noted.                  Ears are clear and pink. Tympanic membrane is visible and pearly grey. No lesion, discharge, or rashes.                  Sclera was white, cornea was clear, conjunctiva was pink with no lesions or discharge noted.                  Septum midline. No drainage or bleeding noted.                  Good dentition overall</p>
<p><b>CARDIOVASCULAR (2 point):</b>  <b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>   <b>Capillary refill:</b>  <b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Edema</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Location of Edema:</b></p>	<p>S1, S2 present with no murmur. No friction rubs or gallop.                  Normal sinus rhythm. Normal heart rate                  Peripheral pulses (radial and dorsalis pedis) are palpable and 2+ bilaterally.                  Normal capillary refill less than 3 second                  No neck vein distension                  No edema                  N/A</p>
<p><b>RESPIRATORY (1 points):</b>  <b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Breath Sounds: Location, character</b></p>	<p>No accessory muscle use                  Breath sounds bilaterally clear, no adventitious</p>

	breath. Respirations are bilateral regular, even and nonlabored, symmetrical. No shortness of breath and cough. No wheeze, crackles.
<b>GASTROINTESTINAL (2 points):</b> <b>Diet at Home:</b> <b>Current Diet:</b> <b>Height:</b> <b>Weight:</b> <b>Auscultation Bowel sounds:</b> <b>Last BM:</b> <b>Palpation: Pain, Mass etc.:</b>  <b>Inspection:</b>  <b>Distention:</b> <b>Incisions:</b>  <b>Scars:</b>  <b>Drains:</b> <b>Wounds:</b>	Normal diet Normal Diet 5'3" 129 lbs. Normoactive bowel sound all four quadrants Prior to admission No mass or guarding. Slight pain and tenderness on palpation due to cesarean section but this is to be expected. No skin abnormalities and mass through inspection No distention The patient has low transverse incision due to cesarean section. There is a cesarean section scar that is healing well. No drains Cesarean wounds
<b>GENITOURINARY (3 Points):</b> <b>Fundal Height &amp; Position:</b>  <b>Bleeding:</b> <b>Lochia Color:</b> <b>Character:</b> <b>Quantity of urine:</b> <b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> <b>Inspection of genitals:</b> <b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> <b>Type:</b> N/a <b>Size:</b> N/a <b>Rupture of Membranes:</b> <b>Time:</b> <b>Color:</b> <b>Amount:</b> <b>Odor:</b> <b>Episiotomy/Lacerations:</b>	Midline, 1 cm below umbilicus, firm without massage Scant (less than 2.5 cm on pad per hour) Rubra The patient is voiding regularly 750 mL of urine No pain with urination The patient genitals are clean and intact No catheter  AROM Occurred on 06/10/2021 at 1221. Clear Small No odor No episiotomy or laceration
<b>MUSCULOSKELETAL (2 points):</b> <b>ADL Assistance:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> <b>Fall Risk:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> <b>Fall Score:</b> <b>Activity/Mobility Status:</b>	Moderate fall risk 35 The patient has active ROM bilaterally.

<p><b>Independent (up ad lib)</b> <input checked="" type="checkbox"/>  <b>Needs assistance with equipment</b> <input type="checkbox"/>  <b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p>The patient is sore, but she is ambulating to the bathroom independently</p>
<p><b>NEUROLOGICAL (1 points):</b>  <b>MAEW:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> <b>if no -</b>  <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b>   <b>Mental Status:</b>  <b>Speech:</b>  <b>Sensory:</b>  <b>LOC:</b>  <b>DTRs:</b></p>	<p>.</p> <p>The patient is oriented to person, time, place, and situation.          Negative for altered mental status.          Normal speech and appropriate for age          Normal sensory and appropriate for age          Alert          Deep tendon reflexes present</p>
<p><b>PSYCHOSOCIAL/CULTURAL (2 points):</b>  <b>Coping method(s):</b>  <b>Developmental level:</b>  <b>Religion &amp; what it means to pt.:</b>  <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b></p>	<p>The patient copes with deep breathing, talking to her boyfriend, and listening to music.          The patient identifies no religion.          The patient has available family support. Her boyfriend was at the bedside. She lives with her parents and pets.</p>
<p><b>DELIVERY INFO: (2 point)</b>  <b>Delivery Date:</b>  <b>Time:</b>  <b>Type (vaginal/cesarean):</b>  <b>Quantitative Blood Loss:</b>  <b>Male or Female</b>  <b>Apgars:</b>  <b>Weight:</b>  <b>Feeding Method:</b></p>	<p>The baby was delivered on 06/10/2021.          The time of delivery was 1818.          Via cesarean section          612 ml of blood loss          Female          1 minute= 8    5 minutes= 9          7 lbs. 13.2 oz          Breastfeeding</p>

**Vital Signs, 3 sets (5 points)**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	119 bpm	120/62  Semi fowler	18 bpm	98.9 F orally	100% at room air

		Right arm			
<b>Labor/Delivery</b>	96 bmp	103/63 Semi fowler Right arm	18 bpm	98.1 F orally	100% at room air
<b>Postpartum</b>	88 bmp	116/72 Semi-fowler right arm	16 bpm	98.2 F orally	100% at room air

**Vital Sign Trends:**

The vital signs were consistent. All the vital signs are within normal range/stable. However, the pulse during prenatal was slightly elevated. The patient was nervous before giving birth which may cause a slight elevation.

**Pain Assessment, 2 sets (2 points)**

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
1240	Numeric	Lower abdomen (incision)	8/10	Dull and achy	She was given pain medication/ Norco.
1629	Numeric	Lower abdomen (incision)	5.5/10	Dull and achy	Encourage to relax and do breathing technique. Offer some warm/hot compress.

**IV Assessment (2 Points)**

<b>IV Assessment</b>	<b>Fluid Type/Rate or Saline Lock</b>
<b>Size of IV:</b> 20 G <b>Location of IV:</b> Left forearm <b>Date on IV:</b> 06/09/2021 <b>Patency of IV:</b> Patent and easily flushed. <b>Signs of erythema, drainage, etc.:</b> No sign	Saline lock

of erythema, drainage, swelling or tenderness. <b>IV dressing assessment:</b> Dry and intact	
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**Intake and Output (2 points)**

<b>Intake</b>	<b>Output (in mL)</b>
The intake was not measured. The patient was drinking water regularly.	The patient urine output as of 06/09/11 was 750 mL.

**Nursing Interventions and Medical Treatments During Postpartum (6 points)**

<b>Nursing Interventions and Medical Treatments (Identify nursing interventions with “N” after you list them, identify medical treatments with “T” after you list them.)</b>	<b>Frequency</b>	<b>Why was this intervention/ treatment provided to this patient? Please give a short rationale.</b>
Assessing fundus during recovery time (N)	Every time an assessment is performed	It is important to assess the fundus during postpartum period to ensure it is firm and bleeding will not be a concern.
Assessing incision site	Every time an assessment is performed	Since the patient had a cesarean section, it is essential to assess the incision site to ensure it is healing well and no infection.
Assessing pain level (N)	Q 4 hours	Since the patient had a cesarean section, she is experiencing pain. It is important to assess the pain level of the pain to ensure proper intervention is given.
Administering pain medication such as hydrocodone-acetaminophen (Norco) (T)	Q 4-6 hours	Since the patient had a cesarean section, she is experiencing soreness and pain upon ambulation around the incision site. The Norco is provided to relieve her pain.

**Phases of Maternal Adaptation to Parenthood (1 point)**

**What phase is the mother in?** The mother is in the taking-in phase.

**What evidence supports this?** The patient is only in the first 24 hours after giving birth and relies upon the nurse and her boyfriend to tend to her basic needs (Ricci et al., 2020).

**Discharge Planning (2 points)**

**Discharge location:** At home with her boyfriend and parents

**Equipment needs (if applicable):** Breastfeeding pump.

**Follow up plan (include plan for mother AND newborn):** The patient will be receiving a routine follow up appointments in 2 weeks and 6 weeks. The newborn will be receiving a routine follow up appointment within 24-48 hours.

**Education needs:** Since the mother wants to breastfeed exclusively and a first-time mother, it is vital to educate her about breastfeeding techniques. It is also essential to address incision care since she had a cesarean section and prevent any infection. Lastly, it is essential to educate the mother and father about preventing sudden infant death syndrome, such as lying the infant on his back to sleep, no co-sleeping, and no pillow or blanket in the crib while sleeping.

**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><b>Nursing Diagnosis (2 pt each)</b> Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components</p>	<p><b>Rational (1 pt each)</b> Explain why the nursing diagnosis was chosen</p>	<p><b>Intervention/Rational (2 per dx) (1 pt each)</b> 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><b>Evaluation (2 pts each)</b></p> <ul style="list-style-type: none"> <li>How did the patient/family respond to the nurse's actions?</li> <li>Client response, status of goals and outcomes, modifications to plan.</li> </ul>
<p>1. Acute pain related to cesarean section delivery evidence by facial expression</p>	<p>The patient had a hard time ambulating due pain experiencing on the lower abdomen. She expresses her</p>	<p>1. Administer Norco Q4-6 hours PRN <b>Rationale:</b> Norco will help reduce mild to moderate pain (Swearingen &amp; Wright, 2019). 2. Encouraging the patient to relax and do some</p>	<p>Goal: Reduce patient's pain. The patient willing took Norco at 1240 which help reduce her pain. During assessment at 1629, she verbalizes pain as 5.5. She cannot</p>

<p>and verbalization of pain.</p>	<p>pain is 5.5 when being assessed.</p>	<p>breathing techniques. <b>Rationale:</b> Relaxation and breathing technique will help lower physical response of pain and promote adequate oxygenation in the body (Swearingen &amp; Wright, 2019).</p>	<p>take her PRN pain med since it is not due. The nurse encourages her to relax.</p>
<p>2.</p>	<p>The patient is at risk of infection due to incision in the lower abdomen.</p>	<p>1. Assess the patient’s incision site Q4 hours. <b>Rationale:</b> Monitoring the patient’s incision site for signs of infection will help develop a potential care plan and prevent possibility of rehospitalization (Swearingen &amp; Wright, 2019). 2. Provide abdominal support or binder after cesarean delivery. <b>Rationale:</b> Abdominal binder will help decrease tension of the muscle in the abdomen and promotes healing (Swearingen &amp; Wright, 2019).</p>	<p>Goal: to prevent infection The patient is assessed every Q4h and remained negative for signs and symptoms of infection. She was also given an abdominal binder.</p>
<p>3. Knowledge deficit related to breastfeeding as evidenced by being a first-time mother</p>	<p>The patient is a first-time mom and wanted to exclusively breastfeed her baby. It is important for her to understand how she can effectively breastfeed her baby.</p>	<p>1. Educate her about the proper technique on how to breastfeed. <b>Rationale:</b> Assisting the mother with one-on-one instruction would help her to know the proper position and latching of the baby (Ricci et al., 2020) 2. Spend time with the mother allowing her to ask questions and tell concern. <b>Rationale:</b> Sometimes, the first-time mother feels frustrated if breastfeeding does not go smoothly. It is best to spend time with the</p>	<p><b>Goal:</b> to learn proper breastfeeding techniques Goal: to learn proper breastfeeding techniques If this nursing action is performed, the patient will be able to demonstrate breastfeeding correctly and voiced the techniques to get the infant to latch.</p>

		mother and allow her to ask questions (Ricci et al., 2020)	
4. Knowledge deficit related to incision site care as evidenced by verbalization of questions.	During the assessment, the patient asked the nurse how to take care of her incision and promoting healing.	<p>1. Demonstrate to the patient how to clean the incision properly.  <b>Rationale:</b> Demonstrating how to clean the incision will help patient visualizes how to properly take care of it.</p> <p>2. Educate signs and symptoms of infection.  <b>Rationale:</b> Educate the patient about recognizing signs and symptoms of infection to report it immediately to their doctor and prevent any further complications (Swearingen &amp; Wright, 2019).</p>	<p>Goal: To learn the proper technique of taking care of incision site.  The nurse demonstrates how to clean her incision site, and the patient verbalizes understanding about it.  The nurse also educates the patient about the sign and symptoms of infection.</p>

**Other References (APA):** N/A