

N432 Postpartum Care Plan

Lakeview College of Nursing

Chloe Stalcup

Demographics (3 points)

Date & Time of Admission 6/30/21	Patient Initials K.M.	Age 35	Gender F
Race/Ethnicity Caucasian	Occupation Teacher	Marital Status Married	Allergies Sulfa Antibiotics
Code Status Full	Height 5'7"	Weight 190	Father of Baby Involved Yes

Medical History (5 Points)

Prenatal History: Patient is G4-T1-P1-A2-L2 and is an advanced maternal age mother.

Past Medical History: No past medical history.

Past Surgical History: Tonsillectomy and wisdom teeth removal.

Family History: Mother (diabetes type 2, hypertension). Paternal father had lung cancer.

Social History (tobacco/alcohol/drugs): Smokes while not pregnant, no drugs or alcohol.

Living Situation: Lives with husband and three-year-old daughter.

Education Level: College bachelorette.

Admission Assessment

Chief Complaint (2 points): Induction of labor.

Presentation to Labor & Delivery (10 points): A 35-year-old mother was admitted on 6/30/21. She was admitted to be induced for labor. She was admitted because she was at term. The pain on admission was a 0 out of a scale of 1-10. She did not go anywhere prior to seek treatment.

Diagnosis

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

Secondary Diagnosis (if applicable):.**Postpartum Course (18 points)**

On 06/30/21 the patient was admitted to OSF labor and delivery department to be induced. The patient had planned induction date of 6/30. During the first stage of labor, the patient will go from 0-10 cm dilated and become 100% effaced. In the beginning, the patient will experience contractions every 5-10 minutes that last 30-45 seconds (Ricci et al., 2020). Towards the end of this first stage (active phase), the patient will have contractions every 2-5 minutes, and they last about 45-60 seconds (Ricci et al., 2020). In the third stage of labor, the baby is born, and the placenta is expelled (*Stages of labor and birth: Baby, it's time!*, 2020). The postpartum stage of labor is known as the fourth stage. This stage follows the birthing of the placenta.

Postpartum can span over a time period of six weeks, but the acute phase of the postpartum period happens over the first four hours after birth (Ricci et al., 2020). The fundus during the postpartum period is to be firm and midline; during the patients fundal check, her fundus was two fingerbreadths below the umbilicus, midline, and firm. During the postpartum period, the woman may experience "after pains." This is a normal finding and is a result of the uterus contracting, which constricts blood flow and prevents hemorrhage (Ricci et al., 2020). The patient was given acetaminophen QID PRN for her after pains which typically occurred while the patient was breastfeeding. Also, during the postpartum period, the woman may have trouble urinating. This can be caused by the epidural or lacerations to the perineum (Ricci et al., 2020). The patient has a stage two laceration to her perineum but upon assessment it seemed to be healing well. A complication of pregnancy/postpartum is called urinary atony (urinary retention) (Ricci et

al., 2020). The patient did urinate shortly after birth and has not had problems urinating since. The patient's vitals were also within the normal range. The patient also had scant rubra lochia in the pad after two hours. In the postpartum period, the mother and the baby also form an "attachment" or "bond" (Ricci et al., 2020). The patient did skin-to-skin holding once all the measurements were completed.

This patient was an advanced age mother which could pose many complications such as spontaneous abortion, chromosomal abnormalities, congenital malformations, increased risk for hemorrhage, and gene abnormalities (Ricci et al., 2020). This patient did not present with complications due to advanced maternal age, and the baby did not present with any birth defects or abnormalities.

During this phase of postpartum, the mother is adapting to having two children and is currently in the taking in phase. The patient relies heavily on her husband and the nurses to provide care for her.

Postpartum Course References (2) (APA):

Mayo Clinic. (2020, February 6). *Stages of labor and birth: Baby, it's*

xtime! <https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/stages-of-labor/art-20046545>.

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

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	3.5-5.2	4.53	4.00		
Hgb	12-16	12.6	12.1		
Hct	36-47	38.4	35.1		The patient lost blood

					during delivery (Pagna, 2018)
Platelets	140-440	204	155		
WBC	4.0-12	7.8	10.40		
Neutrophils	45-73	86.2	76.8		Neutrophils were elevated due to stress of delivery (Pagna, 2018)
Lymphocytes	12-42	25.2	31.0		
Monocytes	4.0-12	4.1	5.9		
Eosinophils	0-5	0.1	0.8		
Bands	0-5.1	-	-		

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, O	O	O	O	
Rh Factor	-/+	+	+	+	
Serology (RPR/VDRL)	Non-reactive.	Non-reactive.	-	-	
Rubella Titer	Immune	Immune	-	-	
HIV	Non-detected	Non-detected	-	-	
HbSAG	Non-detected	Non-detected	-	-	
Group Beta Strep Swab	Negative	Negative	-	-	
Glucose at 28 Weeks	<140	Not on chart.	-	-	
MSAFP (If Applicable)	Not on chart.	-	-	-	

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)	N/A	N/A	N/A	N/A	

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

Pagana, K. D., & Pagana, T. J. (2018). *Mosby's manual of diagnostic and laboratory tests* (7th ed.). Elsevier

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

	Your Assessment
History of labor:	The patient had an estimated delivery date of 06/30/21. She

<p>Length of labor</p> <p>Induced /spontaneous</p> <p>Time in each stage</p>	<p>admitted to the unit to get induced on 06/30/21. The patient was induced which can pose risks to mom and baby. The patient had Pitocin started at 1020, an epidural at 1334, and her membranes artificially ruptured at 1407. The patient was actively pushing for 12 minutes and delivered the placenta 2 minutes after birth of the baby. Baby was born at 1551.</p>
<p>Current stage of labor</p>	<p>The patient is currently in the postpartum stage of labor. The fourth stage.</p>

Stage of Labor References (2) (APA):

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

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

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

Home Medications (2 required)

Brand/Generic	Prenatal Vitamin/Ferrous fumarate capsule	MiraLAX, Polyethylene glycol 3350				
Dose	325 mg (1 cap)	17 g packet				
Frequency	Once Daily	Once daily				
Route	Oral	Oral				
Classification	Vitamin	Osmotic laxative				
Mechanism of Action	This medication replenishes, or prevents, losses of vitamins and minerals essential to fetal growth and development.	Causes water to be retained by stool; making stool soft and easy to pass.				
Reason Client Taking	Deficiency prophylaxis/replenishment	To treat and prevent constipation.				
Contraindications (2)	Peptic ulcer, iron overload	Dysphagia Pt's with bowel obstructions.				
Side Effects/Adverse Reactions (2)	Dark-colored stools, loss of appetite	Diarrhea Dehydration				
Nursing Considerations (2)	This medication may increase liver enzymes. Iron toxicity can be reduced with deferoxamine.	Check patient's electrolyte levels if diarrhea occurs. Help patient administer medication.				
Key Nursing Assessment(s)/Lab(s)	Review the patient's RBCs, Hgb, and Hct.	N/A				

) Prior to Administration	Review the patient’s iron levels.					
Client Teaching needs (2)	Store this medication in the original container and at room temperature. Take this medication with eight ounces of water.	Educate patient that laxative dependence may occur. Educate patient on the side effects such as diarrhea.				

Hospital Medications (5 required)

Brand/Generic	Oxytocin/ Pitocin	Lidocaine / Xylocaine	Fentanyl / Actiq	Tylenol / Acetaminophen	Zithromax/Azithromycin
Dose	10 units	20mL	50 mcg	500mg	500 mg (250 mL/hr)
Frequency	Once	PRN	Q2H PRN	PRN for pain.	Once
Route	IM	Spinal injection	Sub Q	orally	Intravenous
Classification	Exogenous hormones.	Local anesthetic	Opioid	antipyretic, nonopioid analgesic	Macrolide antibiotic
Mechanism of Action	Causes stimulation of uterine contractions.	Blocks nerve impulses by decreasing sodium permeability; creating local anesthesia.	Binds to opioid receptor sites; altering response to pain.	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system	This medication interrupts bacterial protein synthesis, causing cell death via the inability for mRNA translation.
Reason Client Taking	To induce labor.	Epidural.	Pain related to contractions.	The patient is taking for pain.	GBS prophylaxis
Contraindications (2)	Patient’s that shouldn’t deliver vaginally. Premature deliveries.	Hypersensitivity. Patients with Adams-Stokes syndrome.	Upper airway obstructions. Respiratory impaired patients.	Severe hepatic impairment, Hypersensitivity to acetaminophen or its components.	Chronic kidney disease, hypokalemia
Side Effects/Adverse Reactions (2)	Seizures Coma	Hyperthermia Seizures	Respiratory depression. Hypotension.	Hypokalemia, Hepatotoxicity.	Renal impairment, ocular disturbances
Nursing Considerations (2)	Patient should be under continuous observation. Discontinue drug if fetal distress occurs.	Don’t use in patient’s with hepatic or renal disease. Observe for respiratory depression.	Should not be used for breast feeding mothers. Use with caution in the elderly population.	Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease, ensure that the daily dose of acetaminophen from all sources does not exceed maximum	This medication is nephrotoxic. This medication can cause vision problems.

Key Nursing Assessment(s)/Lab(s) Prior to Administration	Timing and strength of contractions.	Pain assessments.	Respiratory rate. Blood pressure.	daily limits. Monitor liver function tests (AST, ALT, bilirubin, and creatinine). These must be monitored to ensure liver hepatotoxicity has not occurred. Monitoring renal function is also important.	Review the patient's renal labs. Review the patient's WBC count.
Client Teaching needs (2)	Explain use of drug to patient and family. Educate patient on side effects.	Educate patient that they will feel numbness. Educate patient to report any difficulty speaking, breathing, numbness, vision changes, or tingling.	Warn patient not to take with any other drugs or alcohol. Warn patient to not stop drug without referring to their provider.	Do not take with alcohol. Do not take more than prescribed dose.	Take full course of antibiotics. Report signs of hepatic impairment.

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): A&O x 4 Alertness: Orientation: Distress: Not distressed. Overall appearance: Appropriately dressed</p>	
<p>INTEGUMENTARY (2 points): Skin color: Normal for race. Character: Dry, intact. Temperature: Warm. Turgor: Rapid rebound. Rashes: None. Bruises: None. Wounds/Incision: Second degree perineum tear. Braden Score: 17 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	
<p>HEENT (0.5 point): Head/Neck: Ears:</p>	<p>The patients head is symmetrical (midline with no deviations). The patient has dark brown hair with no</p>

<p>Eyes: Nose: Teeth:</p>	<p>balding or patches. The patient’s ears are clear and pink with no drainage. The tympanic membrane is visible and is pearly grey. PEERLA is present. The patient does not have nasal deviation. The oral mucosa is pink and moist. The patient’s teeth are clean and in good condition.</p>
<p>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:</p>	<p>The patient was in normal sinus rhythm. S1 and S2 present. The patient’s radial and pedal pulses are palpable. There is no peripheral edema. Normal capillary refill: less than 3 seconds. The patient has no neck vein distension.</p>
<p>RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>The patient’s breath sounds are normoactive bilaterally. The breath sounds are clear and normal.</p>
<p>GASTROINTESTINAL (2 points): Diet at Home: Regular Current Diet: Regular Height: 5’7” Weight:190 Auscultation Bowel sounds: Normoactive in all four quadrants. Last BM: 07/1/21 Palpation: Pain, Mass etc.: Inspection: Distention:None. Incisions:None Scars:None Drains: None Wounds: Second degree tear.</p>	<p>Abdomen is slightly tender upon palpation due to giving birth yesterday. The fundus if two fingerbreadths below the umbilicus.</p>
<p>GENITOURINARY (3 Points): Fundal Height & Position: Bleeding: Lochia Color: Character:</p>	<p>Fundus is 2cm below umbilicus, midline, firm without massage. Bleeding amount: scant (less than 2.5 cm on pad per hour). Lochia color: Rubra</p>

<p>Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input type="checkbox"/> Type: Size: Rupture of Membranes: Time: Color: Amount: Odor: Episiotomy/Lacerations:</p>	<p>The patient is voiding regularly. The patient’s genitals are clean and intact. The patient is not experiencing pain with urination. The patient does not have a catheter. AROM occurred on 6/30/21 at 1409 Color: clear Amount: small Odor: no odor Second degree tear.</p>
<p>MUSCULOSKELETAL (2 points): ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>The patient has active ROM bilaterally. The patient is sore, but she is ambulating to the bathroom independently. The patient Is not a fall risk. Fall score: 0 The patient does not use assistive devices or support with walking.</p>
<p>NEUROLOGICAL (1 points): MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC: DTRs:</p>	<p>The patients grip strength is equal bilaterally in the upper and lower extremities. PERLA is present. The patient is oriented and mental status is normal. The patient’s speech is clear and normal (makes sense). No LOC. Deep tendon reflexes present.</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>The patient doesn’t have a specific faith. The patient copes through the support of her husband and enjoys hiking. Patient has a support system of her husband and mother.</p>
<p>DELIVERY INFO: (2 point) Delivery Date: 6/31/21 Time: 1551 Type (vaginal/cesarean): Induced vaginal Quantitative Blood Loss: 150 mL Male or Female: Male</p>	

Apgars: 8&9 Weight: 3230 Feeding Method: Breastfeeding.	
----------------------------------------------------------------------------------------	--

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	92	130/79	16	98.6	99
Labor/Delivery	68	111/66	16	98.3	98
Postpartum	75	114/65	16	98.6	98

Vital Sign Trends: The patients vitals were overall stable throughout the stay. The prenatal BP was elevated and the labor and postpartum BP's were slightly lower than normal range.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0930	1-10	N/A	0	N/A	N/A
1500	1-10	N/A	0	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 Location of IV: left forearm. Date on IV: 6/30/21 Patency of IV: Patent, flushes and infuses. Signs of erythema, drainage, etc.: None. IV dressing assessment: Clean, dry, and	N/A

intact.	
----------------	--

Intake and Output (2 points)

Intake	Output (in mL)
500mL	800 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.
Administration of Tylenol. T	Every 4 hours PRN for pain.	Tylenol was provided for this patient because of after pains.
Encourage parent-infant attachment. N	After the baby is born, and during the hospital stay (frequently).	The parents and baby need to bond shortly after the baby is born. Encouraging skin to skin and family time is important.
Assess fundus during the recovery period. N	Every time an assessment is performed.	The fundus needs to be assessed during the postpartum period to ensure that it is firm so that bleeding won’t be a concern.
Discharge teaching of newborn care.	Once.	The mother has not discharged from the hospital with a newborn for 3 years and will need a refresher.

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? The mother is in the “taking-hold phase”.

What evidence supports this? The taking-hold phase is when the mother is typically 2-3 days postpartum and is described as the mother settling into her new role and becoming independent while still being slightly dependent (Ricci et al., 2020). The patient is showing independence in caring for herself and her baby, but she still needs reassurance.

What evidence supports this? The mother asks for reassurance from the father and asks the nurses to educate her on newborn care since it has been three years since taking home her last newborn.

Discharge Planning (2 points)

Discharge location: The mother and baby are living at home with the husband in Champaign, IL.

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

Follow up plan (include plan for mother AND newborn): The mother has her follow up appoint for baby 07/1/21 at 0800. The mothers follow up appointment will be in six weeks.

Education needs: The parents need newborn teaching of safety and daily care. The mother will also be given mental health teaching in case of postpartum depression.

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 of infection related to open wound as evidenced by second degree tear.</p>	<p>The patient has a tear on the perineum and is at risk for infection.</p>	<p>1. Monitor the patient's temperature and vital signs. Rationale: fever is indicative of infection. 2. Monitor tear for redness, discharge, and swelling Rationale: discharge, redness and swelling are indicative of infection of a wound.</p>	<p>The patients temp and tear site was monitored and showed no signs of infection.</p>
<p>2. Risk of impaired nutrition less than body's requirements related to breastfeeding as evidenced by not eating enough.</p>	<p>The patient is at risk for being nutritionally deficient while breast feeding if their intake is less than body requirements.</p>	<p>1. Monitor patients' intake. Rationale: Monitoring intake allows for a true picture of nutritional status. 2. Encourage mom to eat enough to sustain breast feeding and encourage an increase in calories around 300 cal. Rationale: Breastfeeding requires more calories.</p>	<p>The patients nutritional state was monitored, and the patient increased their calorie intake to support breast feeding.</p>
<p>3. Knowledge deficit related to newborn care as evidence by patients report of knowledge deficit.</p>	<p>The patient reported a knowledge deficit as a result of having a newborn three years ago.</p>	<p>1. Educate patient on safety precautions for newborns and daily cares. Rationale: The patient needs a refresher of newborn safety and care. 2. Have the patient repeat back the education given. Rationale: The patient will confirm the learning by repeating it.</p>	<p>The patient was able to repeat back the safety considerations and daily cares of a newborn.</p>
<p>4. Risk for altered home environment related to changing dynamics as evidenced by taking home a newborn.</p>	<p>The patients home environment will be altered by bringing home a new family member.</p>	<p>1. Educate the patient about making a new routing that include the newborn and child at home. Rationale: Creating a new routine will assist in adapting. 2. Make a plan with the patient about the new</p>	<p>The newborn made a plan to implement when returning home that included the newborn and child at home.</p>

		routine. Rationale: A new routine will assist in adapting.	
--	--	---------------------------------------------------------------------------	--

Other References (APA)